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Narratives of Clients' Experiences of Cognitive-Behaviour Therapy

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Abstract

Clients' perspectives on the process and outcomes of CBT have been given little attention in CBT research. This research sought to obtain and explore clients' perspectives of the process and outcomes of CBT with the aims of informing clinical practice and suggesting new avenues for future research, while at the same time giving clients an opportunity to voice their experiences. The narratives of twelve adult male and female CBT clients were elicited during unstructured interviews. Participants were encouraged to speak freely about the aspects of therapy most significant to them. A critical approach based on a social constructionist epistemology was taken toward the interview data, and this revealed the influences of cultural discourse - including popular ideas about psychology - on the clients' narratives. A narrative analysis of the data showed a wide diversity among CBT clients, with respect to the problems they hoped to address, the therapy process they depicted, and the outcomes they valued. Some of the clients' narratives aligned with the way CBT has been conceptualised by theorists and practitioners while others did not. The findings showed clients to be active participants and agential in extracting from CBT what they perceived they needed. Clients who conceptualised their problems as mental health issues and stress tended to seek, obtain, and value the acquisition of practical CBT techniques that assisted them to cope with ongoing emotional distress and associated behaviours. Clients who sought to understand the effects of their personal history on their sense of self and identity emphasised the importance of gaining insight and self-understanding, and used their experience of CBT to re-author previously held unhelpful self-narratives with positive alternatives. Although the therapy relationship is typically depicted as only facilitative of change in CBT literature, participants in this study represented the therapy relationship as a crucial component of therapy that was both facilitative and, in some cases, curative in itself. The findings suggest that CBT clients place greater emphasis on the significance of the therapy relationship than do CBT theorists and researchers. The findings also show that cultural discourse influences how clients experience CBT, and that clients may adapt CBT for purposes other than symptom reduction. Implications for practice and research are discussed and possible avenues for future research are suggested.

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Chapter 1

CBT and Clinical Outcome Research

Overview

This study examines narratives of clients' experiences of cognitive-behavioural therapy (CBT) with a view to gaining a greater understanding of their idiosyncratic experiences of CBT and what they have taken away from this encounter. The rationale for the research is threefold. First, in psychotherapy outcome research, therapy outcome is usually measured by changes in a client's symptoms according to diagnosis, which is customarily assessed by standardised assessment protocols (Bohart, Tallman, Byock, & Mackrill, 2011; Valkonen, Hanninen, & Lindfors, 2011). The predominant research focus has been on the efficacy and effectiveness of CBT with respect to the treatment of symptoms (Epp & Dobson, 2009), but little research has investigated clients' perspectives on their therapy experiences (Valkonen, Hanninen, & Lindfors, 2011). The strong focus upon symptom reduction in psychological research has resulted in clients' perspectives being largely overlooked. Two overarching questions in the field of mental health and psychotherapy outcome research are: what qualifies as evidence of therapeutic success, and how should the changes that occur in psychotherapy be measured? (Hill & Lambert, 2004; Norcross, Beutler, & Levant, 2006). It has been argued, however, that deciphering what constitutes effective therapy may not be the important question, but rather whether the experiences clients have as consumers have brought about the changes they desire (Duncan, Miller, & Sparks, 2004). Qualitative studies into clients' perspectives have reported findings that indicate clients value therapy outcomes that are not related to symptom change (Karatza & Avdi, 2011; Levitt, Butler, & Hill, 2006; Rennie, 1994a, 1994b; Shine & Westicott, 2010). Kazdin (2008) asserts that in clinical practice, psychotherapy is more often concerned with coping with life than it is with the elimination of symptoms but that researchers in the field rarely address this issue.

Second, what remains poorly understood is how CBT brings about change for clients and what mechanisms are involved in change processes (Brewin, 2006). For

example, research has indicated that while clients may find the specific therapeutic interventions employed by their therapists beneficial, they do not necessarily associate these techniques with the positive outcomes they identify, such as an increased understanding of themselves and others, or improved styles of relating in their personal relationships (Levitt, Butler, & Hill, 2006). It has been argued that research into the CBT treatment process and the mechanisms of change has been a largely neglected area and further research is needed to increase our understanding of how CBT works (Emmelkamp, Ehring, & Powers, 2010). The degree of invested interest the client typically has in the process of therapy, combined with the fact that ultimately, it is only the client that can realise change in his or her own life, makes the client the logical point of focus when attempting to understand the mechanisms involved in therapy (Carter et al., 2012).

Many believe the field of psychology has been at fault because researchers have dominated the processes of description and explanation without giving participants any right to voice (Gergen & Gergen, 2008). If psychotherapy is to be viewed as a service, then it could be argued that clients as consumers are best placed to offer authoritative opinions as the recipients of that service (Rennie & Toukmanian, 1992). Clients can provide contextual information that clarifies the meaning of their therapeutic experiences, and the examination of their perspectives is central if we are to advance our theoretical understanding of the mediational processes that translate therapist interventions into change (Elliott & James, 1989).

Third, it has been noted that it is important for researchers to appreciate that clients are not reducible to their illnesses but need to be perceived within their personal biographical and social context (Kuhnlein, 1999). Most therapy research lacks attention to contextual and cultural factors that may influence the outcome of therapy (Nastase & Schensul, 2005), and yet participants cannot be extricated from their cultural environment and understood objectively as if in a value-free research environment. These influences are complex and may shape the therapy experience in a myriad of ways. Clients' relationships with others and cultural mores and values influence the kinds of problems clients construct, what effects they are seeking from therapy, and how clients utilise therapy to create these effects. In this regard, therapeutic outcome may be understood as that which has been constructed by social knowledge (McLeod, 2011).

This study takes the form of an open, narrative inquiry into clients' perspectives on CBT, allowing participants as much room as possible to shape the research agenda. The intention was to gain an increased understanding of clients' subjective perspectives on CBT in the hope that it will inform theory and clinical practice, and suggest new avenues for future research.

The thesis will be organised in the following manner: Chapter 1 provides a brief outline of the theory and practice of CBT, and discusses issues related to CBT research and researching clients' perspectives. Chapter 2 covers the theoretical framework that underpins the study. Chapter 3 outlines the epistemological approach and the research methods that were used to gather and analyse the data. The first section of Chapter 4 presents the analysis and discussion of the data. Chapter 5 then presents the conclusions and implications of the study in relation to clinical practice and clinical research.

In this chapter I will first provide a brief outline of CBT theory and principles of practice with the intention of orientating the reader toward the CBT concepts and techniques that the participants refer to. Second, I discuss the main reasons why clients' experiences of therapy have not been a significant part of mainstream clinical research into CBT to date, and argue that exploring clients' perspectives of CBT is an important addition to previous psychotherapy research in this area. I then present and discuss prior research that has focused on the client, with an emphasis on a number of interview-based, qualitative studies that have explored clients' perspectives on therapy from a number of angles.

Cognitive-Behaviour Therapy: Theory and Practice

Judith Beck (1995) describes the cognitive model 'in a nutshell' as one that asserts that "distorted or dysfunctional thinking (which influences the client's mood and behaviour) is common to all psychological disturbances" (p. 1). CBT conceptualises an individual's thoughts as being comprised of three strata or 'levels': 'negative automatic thoughts' that arise from 'conditional beliefs', both of which are rooted in 'core beliefs' (sometimes referred to as 'schemas'; for example, "I am a bad person") (Grant, Townend, Mills, & Cockx, 2008). The theory posits that a person's early, formative, childhood experiences may result in longstanding core beliefs that underpin the conditional beliefs and negative automatic thoughts that operate in the

present (Dryden, 2012; Neenan, 2012). ‘Core beliefs’ are conceptualised by cognitive theorists as ‘internal models’ that are said to produce a construction of reality that is personal and subjective; an approximation of experience constructed by information processing that is egocentric and a biased representation of reality (Craske, 2010). Core beliefs are said to concern the self, others, or the world, and perform a powerful maintenance function for an individual’s problems (Padesky, 1994). Cognitive-behaviour theory posits that although some amount of negative thinking is ‘normal’, there is a ‘tipping point’ where negative functioning can predominate and prevent people from achieving what they need or want to do in the pursuit of desired goals (Dryden, 2012).

It is argued that the cognitive model provides a framework for hypothesising about the aetiology and maintenance of problems, as well as a map for planning therapy (Grant et al., 2008; Kazantzis, Reinecke, & Freeman, 2010; Neenan, 2012). Cognitive-behavioural approaches theorise that internal and covert processes (‘thinking’ or ‘cognition’) occur, and that changes in behaviour are mediated by these cognitive ‘events’ (Dobson & Dozois, 2010). In addition to the cognitive conceptualisation, CBT recognises behavioural learning theories that posit that behaviour is controlled by context: antecedents, events that cue or elicit the behaviour, and consequences, events that follow on from the behaviour (Persons, 2008). A ‘functional analysis’ (also known as ‘behavioural analysis’) is deemed to be an essential and central part of a cognitive-behavioural assessment (Gournay, 2012; Grant et al., 2008). It is an assessment process wherein the therapist identifies the content and processes of thought that are producing a client’s unhelpful behaviour, the ‘function’ of the unhelpful behaviour is identified, and an appropriate behavioural intervention is determined (Grant et al., 2008). CBT also uses a number of different functional models such as the ‘five-part model’ (Padesky & Mooney, 1990), which is said to identify thoughts, physical sensations, behaviour, emotions, and the situational context. This is said to assist clients and therapists gain greater understanding of the components of the presenting problem. This can facilitate an awareness of clients’ internal processes, and how they are situationally specific, that is, how they manifest within a given context (Grant et al., 2008).

CBT typically explores and works to modify what are conceptualised as three levels of thought (negative automatic thoughts, conditional beliefs or assumptions, and core

beliefs) (Neenan, 2012). One premise of therapy is that with attention and training, clients can become aware of the thoughts that are causing their emotional responses (Dobson & Dobson, 2009). Interventions aim to enhance adaptive coping and reduce distress by the alteration of these maladaptive beliefs and the provision of new information-processing skills (Hollon & Beck, 2004). The techniques involve “identification of situational misappraisals and underlying distorted beliefs, rational disputation or logical consideration of the evidence to refute such misappraisals and core beliefs, behavioral practices designed to collect further data to disconfirm such misappraisals, and the generation of alternative, more evidence-based appraisals and core beliefs” (Craske, 2010, pp. 1). It is theorised that ‘corrective experiences’ are facilitated by a client’s repeated exposure to information that violates negative expectancies and disrupts negative behaviour cycles (Hayes, Beck, & Yasinski, 2012). Therapy aims to gather information from the client’s environment that competes with dysfunctional thinking, and stimulates discussions and disputation of the evidence at hand, generating compensatory beliefs that deactivate those that are less helpful (Craske, 2010). The approaches do contend, however, that behavioural changes need not necessarily involve elaborate cognitive mechanisms and that the analysis of thoughts may not be prominent, with some interventions depending heavily on behaviour change (Dobson & Dozois, 2010). Through a number of different forms of between-session tasks clients can apply therapeutic insight, adaptive strategies and new skills to everyday life situations (Branch, 2012).

There are a number of basic principles that are common to cognitive-behavioural interventions (Beck, 2011). CBT aims to be a time-limited, structured approach that is goal oriented and problem focused, paying particular attention to the present rather than the past (Beck, 2011). Typically, CBT focuses on how present problems can be overcome rather than spending a lot of time speculating about why they occurred, and concentrates on the cognitive and behavioural processes that are maintaining problems in the here and now (Neenan, 2012). However, for long lasting improvement in a client’s mood and behaviour, cognitive-behavioural approaches encourage clinicians to work on deeper levels of cognition: client’s fundamental core beliefs about themselves, other people, or the world (Beck, 2011). CBT also emphasises a sound therapeutic alliance and active participation on the part of the client (Beck, 2011). Importance is placed on ‘collaborative empiricism’, which refers

to the idea that together, clients and therapists set about testing the validity of a client's thought processes, because therapists do not assume in advance whether or not a client's thoughts or beliefs are valid (Beck, 2011). An important aspect of the collaborative approach is the regular elicitation of client feedback at the end of each therapy session so that any difficulties or misunderstandings may be aired and addressed (Beck, 2011). Therapists are encouraged to give and receive feedback to and from the client about treatment on an on-going basis (Wills, 2009). Although CBT therapists' claim to place the client at the heart of the recovery process it does not prohibit the therapist from containing, guiding, and controlling the pace of therapy, nor does it suggest that clients in some sense have to 'heal themselves' (Gilbert & Leahy, 2007). Rather, cognitive-behavioural therapists teach clients to identify, evaluate, and respond to their dysfunctional thoughts and beliefs, and assist the client to become their own therapist to prevent relapse (Beck, 2011; Branch, 2012).

CBT remains in a stage of ongoing development (Westbrook, Kennerley, & Kirk, 2007). Cognitive-behaviour therapy has gone through three 'waves'. Outlined by Hayes (2004), the first wave encompassed treatments based on behaviour and learning principles. The second wave emphasised the role cognitive processes play in the development, maintenance, and treatment of disorders, such as cognitive therapy and rational emotive therapy. These therapies emphasise identifying and modifying negative, distorted, and irrational thoughts. The first and second wave approaches have been widely integrated both theoretically and practically. The third wave integrates the methods of the first two with concepts such as acceptance and mindfulness. Over the last 20 years mindfulness has gained popularity among therapists using cognitive and behavioural therapies (Huxter, 2007). The practice involves the client learning to direct their attention to their thoughts, feelings, and their actions, as they appear in the present moment (Katzow & Safran, 2007). Prominent among third wave approaches is 'ACT' (Acceptance and Commitment Therapy), which purports to work by asking clients to change their relationship with their thoughts by not confusing thought with reality (Dienes, Torres-Harding, Reinecke, Freeman, & Sauer, 2011), privileging the examination of the functional utility of thought and behaviour over the accuracy of perception (Dobson & Dozois,

2010). This is primarily accomplished by the use of mindfulness skills and acceptance experiences (Hayes, 2004).

Mainstream Methods of Clinical Research and the Neglect of Clients' Perspectives

There have been a number of influences that have steered research away from exploring clients' perspectives on their experiences of CBT. One influential factor is that therapy outcome research has been guided by the principles of the positivist scientist-practitioner model, which strives to develop methods for studying therapeutic interventions and outcomes in a scientific fashion (Kendall, Holmbeck, & Verduin, 2004). Positivist research in psychology puts a strong emphasis on empiricist science and asserts that gaining knowledge about people and their experiences can be secured through measurement and statistical data analysis (Goodwin, 2005; Slife, 2004). It is argued that in order for studies of treatment outcome to be meaningful, they must fit within the 'guidelines of science', and that "uncontrolled studies of therapeutic results that fail to pinpoint the effects that can be accurately attributed to therapy provide, at most, speculative knowledge" (Kendall, Holmbeck, & Verduin, 2004, p. 17). The view of psychology as a science underlies the rationale for conducting randomised controlled clinical trials (RCTs) (Uttal, 2007) which are used as a means to establish causality.

The dominance of the RCT has also been due to the pressures of the modern health care system, which led to the belief that psychological treatment is like medical treatment, and which influenced therapy to become an approximation of the latter (Wampold, 2001). The resemblance is evident in the terminology: diagnosis, pathology, and treatment and - spawning from the notion that clients are sick and in need of medical treatment - a multitude of techniques have developed which are believed to have specific effects upon clients (Wampold, 2001). Typically, from the medical model perspective, behavioural change is brought about through the delivery of a change agent and is assessed when a reduction in the specified symptoms of various disorders is observed (Levitt et al., 2005). Client improvement is then attributed to specific therapist techniques (Lambert & Ogles, 2004). The ideology behind these research methods is that they are intended to be replicable procedures that produce objective descriptions, providing little to no space for the exercising of personal judgment (Eisner, 2003). Conditions are measured prior to treatment, and

participants are randomly assigned to an experimental procedure and compared to a ‘no treatment’ group or comparison treatment group (Howe, 1996). One consequence of this has been that research has focused upon behaviour, rather than ‘mind’, as the phenomena to be studied, due to the fact that behaviour is measurable but mind is not (Eisner, 2003).

The emphases on scientific standardisation and the development of manualised techniques underpin the philosophy of evidence-based practice that emerged in the 1980s within the medical profession first, evolving as a result of concerns that the knowledge being acquired from research was not being routinely used in clinical practice (Emmelkamp, Ehring, & Powers, 2010; Littell, 2010). This development was seen as signalling scientific progress in the discipline (Slife, 2004). The development of the philosophy of ‘evidence-based practice’ originated in Great Britain and increased in popularity in the United States and around the globe (Norcross, Beutler, & Levant, 2006). Evidence-based practice (as it has been conceptualised), requires a certain kind of evidence-based assessment, so that any effects of treatment can be measured and re-evaluated if required (Dobson & Dobson, 2009). Due to the swing toward evidence-based practices, task forces initiated by the American Psychological Association identified and listed a number of empirically supported treatments (ESTs) (Norcross, Beutler, & Levant, 2006). ESTs are identified by researchers as meeting specific evidentiary criteria that determine which treatments work for various conditions (Littell, 2010). However, Imel and Wampold (2008) note that “the predictions of specificity and the medical model in psychotherapy are predominantly inconsistent with research evidence ... little treatment-specific understanding of client improvement has emerged from empirical research” (p. 254).

The factors involved in the drive toward ESTs, and the trend toward deciphering which forms of therapy are most effective for which disorders, have led to an emphasis on viewing symptom reduction or removal as the central goal of psychological treatment, and have had a significant impact upon the nature of CBT outcome research (Lambert, Bergin & Garfield, 2004). There have been relatively few studies exploring CBT outside a clinical trial context (Dobson & Dozois, 2010). Currently, the EST approach is endorsed by the majority of CBT researchers (Emmelkamp, Ehring, & Powers, 2010). CBT has been shown to be efficacious in

over 500 clinical trials for a diverse range of populations and a wide range of disorders (Antony & Roemer, 2011; Beck, 2011; Epp & Dobson, 2010; Hollon & Beck, 2004). Due to the fact CBT has fared so well in these trials it has become “the most frequently endorsed empirically supported treatment on the list compiled by the Task Force on Promotion and Dissemination of Psychological Procedures, across disorders and age groups” (Epp & Dobson, 2010, p. 39). CBT has become a highly popular and dominant approach in many parts of the world, including New Zealand (Blampied, 1999).

It is traditional for CBT research to measure change in particular ways (Levitt et al., 2005). Generally speaking, the two indices that are used by researchers in this field to measure change are cognition and behaviour (Dobson & Dozois, 2010). As a hypothetical example, it may be predicted that an individual’s agoraphobia may diminish as a therapist increases the amount of exposure homework given to the client; the more homework that is given and undertaken, the more a client’s symptoms should diminish. Client improvement, therefore, is attributed to specific therapist techniques (Lambert & Ogles, 2004). Research of this ilk is implicitly based upon the medical paradigm; the effects of therapy are assessed as if it were a pharmaceutical drug, the researcher varying the ‘dose’ and then measuring its effectiveness to remove certain symptoms (Kuhnlein, 1999). Most research has sought to control ‘extraneous factors’ in order to have confidence that treatment was the cause of any observed change (Kendall, Hombeck, & Verduin, 2004). This works well when researching the effectiveness of various drug treatments for physical ailments, but is problematic when attempting to understand psychological and social phenomena (Howe, 1996). Dobson and Dobson (2009) note that “because clients are randomly assigned to treatments, emphasis in these studies is on the independent variable, which is the therapy(ies) under investigation. Consequently, client variables are considered relatively unimportant in such research” (Dobson & Dobson, 2009, p. 236).

However, research has not shown with any certainty that the effects of CBT can be attributed to its ‘underlying mechanisms’ (Emmelkamp, Ehrling, & Powers, 2010). A significant number of quantitative studies have indicated that the effects of the behavioural and cognitive components of CBT appear to be ‘nonspecific’ in that the behavioural components of therapy may influence a client’s cognition and

conversely, cognitive components can affect behaviour, making it impossible to conclude which therapy techniques are responsible for improvement in which area (Emmelkamp, Ehring, & Powers, 2010). Research has evidenced that “the ingredients of the most conspicuous treatment on the landscape, cognitive-behavioral treatment, are apparently not responsible for the benefits of this treatment” (p. 148). Similarly, Hayes (2004) concludes that recent research findings are suggesting that cognitive change may not be required for clinical improvement. In addition, because treatment has been the focus in these studies, there have been precise guidelines for participant inclusion and exclusion, leading to homogenous samples that limit generalisability, when clients in actual clinical practice often present with multiple and complicated problems (Dobson & Dobson, 2009). Moreover, qualitative studies into clients’ perspectives on therapy have reported that clients value therapy outcomes unrelated to symptom change (Karatza & Avdi, 2011; Levitt, Butler, & Hill, 2006; Rennie, 1994a, 1994b; Shine & Westicott, 2010).

Increasingly, research is supporting the idea that “clients are as much independent variables operating on therapy as they are “dependent variables” influenced by therapist operations” (Bohart & Wade, 2013, p. 245). Bohart, Tallman, Byock and Mackrill (2011) argue that “it is not clear that such models [randomised controlled clinical trials] are appropriate for the complex human phenomenon which is psychotherapy. Many have argued that psychotherapy is a nonlinear, recursive, interactive process” (p. 104). Bohart, Tallman, Byock and Mackrill (2011) suggest that as an alternative to the idea of there being a ‘strict’, ‘hard causal view’ of how change occurs in therapy, there may be a ‘soft causal change’ that occurs; therapy does not necessarily precipitate or create change in a causal, mechanistic way. Therapy may, for example, provide the setting or the context (e.g. a warm, supportive environment) within which changes occur, mobilising the clients’ own resources and thereby increasing the likelihood of positive outcomes (Bohart et al., 2011). Similarly, Duncan, Miller and Sparks (2004) argue that “change principally results from the client’s pre-existing abilities and participation - the client is the star of the therapeutic drama” (p. 22).

Clients are not inert objects upon which interventions operate but are actively involved in producing the effects of therapy by extracting meaning from the therapy interaction (Bohart, 2007). Clients relate, respond to, use and interpret therapy in a

myriad of ways that are unique to them (Rennie, 2010; Valkonen, Hanninen, & Lindfors, 2011). How a client learns is affected by their degree of involvement, how well they resonate with their therapists and the treatment, and how they interpret and then implement the input they have received (Bohart & Wade, 2013). The degree of interest the client typically invests in the process of therapy, combined with the fact that ultimately it is only the client that can realise change in his or her own life, makes the client the logical point of focus when attempting to understand the mechanisms of change involved in therapy (Carter et al., 2012). Moreover, who can or should decide what should qualify as evidence of change and positive outcome? Some have argued that clients as users of these services should decide (Duncan, Miller & Sparks, 2004). For the most part, however, clients have been given little right to voice in clinical research (Gergen & Gergen, 2008). The client has been identified as the ‘neglected factor’ in psychotherapy outcome research (Bohart & Tallman, 2010). Most clinical research to date has focused on therapists’ interventions and how clients respond to them (Bohart & Wade, 2013). Little credence has been given to clients’ ideas about their own theories of change (Duncan & Miller, 2000).

An overall conclusion appears to be that a number of factors have contributed to a dominant form of outcome research that has caused clients’ subjective perspectives to be largely overlooked. This trend has side-lined clients’ experiences and perspectives and inadvertently contributed to the neglect of an area of cognitive-behavioural research that might produce findings highly applicable to clinical theory and practice. Exploring clients’ perspectives may provide insight into the way in which clients are active participants in the therapy process and in the production of particular outcomes. In the next section, I briefly look at findings from quantitative studies about client variables and therapy outcome, make an argument for the use of qualitative research in this area, and then present some of the qualitative studies to date that have explored clients’ perspectives of therapy.

The Client in Psychotherapy Research

Research findings are now supporting a ‘proactive view’ of clients as co-constructors of positive therapy outcomes (Bohart & Wade, 2013). The two most often cited sources in support of the influence of client factors are Lambert (1992) and Wampold

(2001; 2010). Lambert ascribed 40% of the variance in outcome to the client and factors in the client's life. Lambert described these variables as being incidental to which treatment model is used and as idiosyncratic to the client. Wampold (2001; 2010) estimated a considerable 87% of variance with regard to outcome as due to variables related to the client. Additionally, after reviewing 50 years of research, Orlinsky, Ronnestad and Willutski (2004) identified the client's participation in therapy as the most critical determinant to outcome. Due to increasing evidence that the client makes the strongest contribution, over recent years there has been a growing recognition that it is the client's active participation that makes the largest difference to therapeutic change (Addis et al., 2006; Bohart & Wade, 2013).

It is argued that continuing to look for simple relationships between client demographics and outcome is unlikely to be fruitful (Bohart & Wade, 2013). Decades of research exploring the relationships between demographic variables (e.g., age, gender) and outcome have generally produced inconsistent results and only weak trends (Bohart & Wade, 2013). Clarkin and Levy (2004) suggest that one reason for this is that attitudes toward gender, race, and age change according to the cultural atmosphere of the time, and both therapists and clients are likely to be affected by this. Another obvious factor is that these demographic variables (age, gender) are 'conceptually coarse' and are less able to convey meaning about unique individuals. Analyses focussed upon demographic variables agglomerate large groups of people rather than understanding individual clients, and are not finely honed to the unique individual.

A variety of client variables in relation to therapy outcome have been investigated by researchers. A noted progression in this field of research has been the shift from an early focus on demographic variables toward a focus on what are understood to be 'personality traits' (Clarkin & Levy, 2004). Over the last decade, a number of studies have generally found positive correlations between outcome and the client variables of ego strength, attachment style, comorbidity, motivation (intrinsic), quality of object relations, perfectionism, and "openness to emotion and inner experiencing" (Bohart & Wade, 2013, p. 231; Clarkin & Levy, 2004). Interestingly, characteristics that have shown inconsistent results are 'readiness to change', 'psychological mindedness', and severity of symptoms (Bohart & Wade, 2013; Clarkin & Levy, 2004).

Notwithstanding that client variables are constructs and only represent lived experience, some client variables have been more well-defined than others. For example, clients' collaborative participation in therapy is often cited as a significant factor contributing to change. In a recent meta-analysis of 19 studies conducted by Tryon and Winograd (2011), a correlation was confirmed between 'client collaboration' and therapy change. However, Bohart and Wade (2013) note that in 13 of these studies, collaboration was measured through "some form of homework compliance and/or treatment adherence" (p. 241). The authors note that "collaboration implies more than just cooperation and much more than compliance" (p. 241), and that more elaboration is needed in terms of how clients engage in the process of a collaborative relationship (Bohart & Wade, 2013). In many studies, client collaboration is defined in terms of observable behaviour rather than being based on a client's understanding of their engagement in the therapy process. Client characteristics or variables may be based on constructs that are not defined with any breadth or depth of meaning.

One shortcoming of the 'trait model' is that the variables are 'static' characteristics and are conceptualised as relatively stable internal attributes of a person. This essentialising process obscures the influence of other factors such as the social and cultural conditions and discourse that might give rise to 'character traits'. This sole focus on the individual is a restricted view that reduces the potential for understanding the client as a 'social-individual', influenced by their cultural environment. The majority of studies investigating client variables and their influence on therapy outcome are correlational (Dobson & Dobson, 2009; Timulak, 2008), and do not provide any understanding about cause and effect. These static client variables are typically measured before - sometimes during - and after treatment, but the confounded results yield little if any information about the cause of therapy change. Clarkin and Levy (2004) note that "pretreatment client variables have a plausible impact on therapy, but as soon as therapy begins, the client variables are in a dynamic and ever changing context of therapist variables and behaviour" (p. 215). For example, positive change may be attributed to a constructive and harmonious therapy alliance. However, the coincidence of a positive therapeutic alliance and a desired outcome for the client does not necessarily imply that the alliance played a causal role; a client may have felt better (for other reasons) early on

in the treatment process and this may have contributed to the formation of a positive alliance (Kazdin, 2007). There is an unlimited number of confounding variables that may influence therapy outcome because human psychology and the therapy process are such complex areas of inquiry. And yet in most studies, the range of variables is significantly restricted, meaning there is increased difficulty showing a relationship between outcome and client factors (Dobson & Dobson, 2009). In summary, the limitations of the existing client perspective research are that it is founded upon static variables that are decontextualised, and which are based more on observed behaviour than on clients' subjective accounts of their own experience. Research has not adequately considered the subjective experience of the client but rather operationalises constructs like the therapeutic alliance, which then becomes the focus.

Duncan, Miller and Sparks (2004) argue that it would be beneficial for researchers to listen to clients' perspectives and to attend to clients' theories of change, to improve therapy outcomes. They note that clients can describe changes in the nature of their problems in their daily lives. Recent research has confirmed the importance to therapy outcome of the client's theory of change, their perceptions and views about the nature of their problems and their ideas about possible resolutions (Robinson, 2009). Gordon (2000) contends that our understanding of therapy and therapy outcome would be increased by a detailed exploration of clients' perspectives with the use of a more 'user friendly' methodology. One advantage of qualitative research is that it provides an alternative to "the more simplified, broad-brush general statements that are typically derived from quantitative studies" (McLeod, 2013, p. 73).

Qualitative studies that have explored clients' perspectives on therapy outcomes are still relatively rare (Valkonen, Hanninen, & Lindfors, 2011). However, these studies can elicit rich and detailed descriptions and explanations from clients about the process and outcome of therapy as they perceive it. Because qualitative research focuses on subjective perspectives, it is able to engage with the complexity of human experience (Gordon, 2000). The use of in-depth interview-based methods is suited to exploring clients' points of view (Timulak, 2008), and is particularly well suited to the exploration of the process of change in therapy (Elliott, Slatick, & Urman, 2001). These research approaches enable participants to give their own accounts of what

change, if any, has occurred, how it eventuated, and why it is meaningful to them. Rather than attempting to find answers to hypothesis-driven methods, qualitative research can produce unanticipated results (Hill, Chui, & Baumann, 2013). This is because these methods provide a discovery-oriented research approach (Maoine & Chenail, 1999). Prior qualitative research has evidenced that when given the opportunity, clients can provide nuanced and considered appraisals of their therapy experiences (McLeod, 2013).

Client agency has been a topic of interest for some qualitative researchers. Qualitative methods make visible the ways in which clients are reflexive agents who can relate to their therapy in a myriad of ways, because they are able to take account of human agency and context in their explanations (Gordon, 2000; Rennie, 2010). Duncan, Miller and Sparks (2004) note that the client is seldom recognised as the agent of change, however research into clients' perspectives "supports the idea of the client as someone who plays an active, agentic role in therapy" (p. 237). An understanding of client agency is based on the assumption that clients do not merely 'absorb' what therapists offer to them, but actively make and enact choices within therapy and generate change themselves (Bohart & Wade, 2013; Hoener et al., 2012). From this perspective, therapists' interventions do not cause change within clients, but rather it is the client's active engagement with interventions that leads to therapeutic change (Hoener et al., 2012). While studies that explore clients' agency in therapy are relatively few, research suggests a client's sense of well-being is associated with agential thoughts and narratives (Bohart & Wade, 2013).

Hoener, Stiles, Lukac and Gordon (2012) found that across different therapies, clients were strikingly similar in their expression of why they valued the therapy they received, citing feeling active in 'doing the work', feeling responsible for themselves and involved in the process, and gaining a sense of accomplishment and empowerment for their own self-healing. One area of interest has been clients' 'cross-contextual agency', which has explored how clients agentially transform everyday life based on what has been learned in therapy (Bohart & Wade, 2013). For example, Mackrill (2009) found that clients draw from extra-therapeutic sources to corroborate, test, and validate ideas across contexts and produce positive outcomes. In one study conducted by Levitt, Butler and Hill (2006), clients participated in activities such as allowing some time before a session to prepare, reading self-help

books, pondering dialogues with their therapist, and spending time reflecting and self-questioning. An advantage of interview-based studies is that they provide the scope wherein clients can explain their own input and how they combine extra-therapeutic resources with therapy to produce desired outcomes.

Another area in which the importance of client agency has been highlighted is the therapy relationship. When the therapy relationship is referred to it is often portrayed as something which is 'built' by therapists for the sake of the client (Bohart & Wade, 2013). However, research has evidenced that clients play an active role in managing the therapeutic relationship. Recent studies have supported the view that clients positively contribute to the relationship in unique ways (Knox & Cooper, 2011). In one study conducted by Rennie (2000), clients reported covertly steering the course of therapy for their own benefit. Rennie described this 'manoeuvring' of the client as a form of exerting control; a product of the client's ability to be reflexive and agential within the therapeutic relationship. In another, Knox and Cooper (2011) found that clients' experiences of relational depth with their therapists were preceded by their own 'state of readiness' and making a positive decision to be vulnerable within the relationship, which facilitated a potential moment of change. These studies illustrate how interview-based approaches can elicit causal accounts from clients that provide a greater understanding of how clients actively influence the course of therapy and use the therapy relationship to promote change.

Clients have pointed to the therapy relationship as an important and helpful aspect of therapy in over one hundred studies (Bohart & Wade, 2013; Norcross, 2010), and yet there is a dearth of CBT research into clients' perspectives on the therapy relationship. Dobson and Dobson (2009) note that research has focused more on the technical aspects of CBT rather than 'nonspecific' factors such as the therapy relationship. In addition to this limitation, over the last twenty years, research into the therapy relationship has been dominated by the concept of the 'therapeutic alliance' (McLeod, 2013). Safran and Muran (2006) argue that the sustained interest in the therapeutic alliance as a concept has largely been due to a paradigm shift that recognises the significance of relational factors in treatment. While this is a positive step, McLeod (2013) argues that the conceptualisation of the therapy relationship as an alliance has had the unintended effect of diverting researchers' attention away from other relational aspects that are clinically significant.

Norcross and Wampold (2011) argue that researchers should move beyond correlational designs that associate client outcomes with the frequency of relationship behaviours, toward methods capable of exploring the complex associations between clients, therapists, and treatment outcome. While relatively scarce, qualitative studies in this area have revealed the complexity involved in clients' perspectives on the therapy relationship. For example, although a client's perception of their therapists as caring is usually experienced as helpful (Bachelor, 1995; Levitt, Butler, & Hill, 2006), caring can be experienced as detrimental for some clients if it interferes with a client's agency (Levitt, Butler, & Hill, 2006). Clients have also reported deferring to their therapists for a variety of reasons, including feeling indebted, and worrying about the therapist's feelings (Grafanki & McLeod, 2002; Rennie, 1994b). McLeod (2011) notes that when clients are given space to talk at length, they tend to offer a more critical account of therapy that is less optimistic than the results conveyed through quantitative studies.

Qualitative research has shown some interesting outcomes that clients consider of value and which they directly attribute to the therapy relationship (Levitt, Butler, & Hill, 2006). Clients have expressed valuing the experience of exploring sadness in the presence of an empathic therapist, and having their determination, accomplishments and new emotional expression affirmed by the therapist (Timulak, 2010). A therapist's warmth and caring is valued by some clients, as is firm direction when there is a perceived need for it (Binder, Holgersen, & Nielsen, 2009; Levitt, Butler, & Hill, 2006). In a review of several qualitative studies, McLeod (2011) found that clients frequently formed internal representations of their therapists, thinking about what they had said or might say, and engaging in internal dialogues with the 'internalised therapist' after treatment was over. These findings reflect the subtleties involved in clients' perspectives on the therapy relationship. They illustrate how eliciting accounts from clients can deepen our understanding of how clients experience the relationship and how they maintain the effects of therapy by creatively using their memories of the relationship to influence their daily lives.

Qualitative studies researching CBT clients' views on the therapy relationship are very rare. However, in one study, Messari and Hallam (2003) interviewed clients who had received a course of CBT for psychosis, and found that clients positioned their therapists as 'healers', portraying therapy as a collaborative enterprise that

helped them explore alternative ways of viewing things within a respectful and trusting relationship. The authors note that although typically cognitive behaviour therapists tend to depict the therapeutic relationship as one of the ‘non-specifics’ of therapy, their study highlighted how crucial the relationship was in these instances. The researchers suggested that because CBT puts an emphasis on the collaboration between client and therapist, a greater understanding of clients’ experiences of the therapy relationship might contribute to greater effectiveness of techniques.

Studies investigating clients’ perspectives on valued outcomes have been illuminating. Clients value outcomes that may be unexpected and not anticipated by their therapists (McLeod, 2011). In a review of qualitative studies, McLeod (2013) found that clients evaluated therapy according to what they believed they needed at the time that they received it, such as providing a place of retreat from troubles or a difficult relationship, an opportunity to learn skills, gain insight or advice, or as an introduction to the therapy experience. Perhaps unsurprisingly, clients appreciated learning skills they can use but, less predictably, clients spoke of modifying these skills to fit their own needs. In one study conducted by Levitt, Butler and Hill (2006), clients reported they valued understanding themselves and others better, and improvements in how they felt about or related to themselves and others. Although clients in this study reported that the specific therapeutic interventions employed by the therapist were helpful, they did not associate these with the changes and newfound insight that they considered to be significant. Clients instead reported that they gained benefit from experiences that were not specific to the therapy. The researchers noted that the effects of therapy the clients valued had little to do with illness, but much to do with how they related to their social world. Similar findings were reported in a study conducted by Binder, Holgersen and Nielsen (2009). Clients cited insight, self-acceptance and learning to value themselves, improved ways of relating to others, changes in patterns of behaviour and better self-understanding as valued outcomes of therapy. Clients understand therapy as a way of making sense of themselves in the context of their own lives, and within therapy people are often intent on finding their ‘true identity’ (Rose, 1996).

Researchers have also explored clients’ evaluation of the aspects of therapy they found either helpful or ‘hindering’. These studies have yielded some interesting results, although it has been observed that most studies have focused on helpful

rather than hindering events (Timulak, 2010). Helpful events reported by clients include an elevated sense of empowerment, increased awareness and insight, reduction of a sense of personal shame, feeling empowered, improved emotional functioning, ‘mastery of problematic experience’, and improved interpersonal functioning (McElvaney & Timulak, 2013; Timulak, 2010; Timulak & Elliott, 2003). Hindering aspects have included feeling exposed in therapy, experiencing the practical material as incomprehensible, and interrupted ‘flow’ within sessions (Grafanki & McLeod, 1999; McElvaney & Timulak, 2013).

In one interesting study (Lillengren & Werbart, 2005), 22 young adults who had completed psychoanalytic psychotherapy were interviewed after the completion of therapy about their experiences of the ‘curative’ and ‘hindering’ aspects of treatment. Many of the participants identified simply talking and expressing themselves as curative. Particularly, they appreciated how talking had given them a chance to reflect and to ventilate their thoughts and feelings which brought them a sense of relief. Some participants reported they valued being able to ‘put their feelings into words’ and could ‘sort their feelings out’ when they had once felt overwhelmed by them. Storytelling was enjoyable because it provided an opportunity to revise and ‘work through’ their lives. In these cases, the therapist was characterised as a kind of ‘background figure’ and a witness to what they had to say. A typical representation of the therapist was that of the ‘listening other’; it felt good to talk to someone. Of great importance was feeling allowed to express emotion to an ‘outside person’ who was not involved in the clients’ problems. The reports indicated that therapy was a ‘special’ place as was the relationship with the therapist. Therapy was represented as having a special emotional atmosphere wherein they felt accepted, supported, and respected, and how therapy was a ‘neutral zone’ and a safe place to unwind. A sense of collaborative exploration was valued, as was having a new and positive relationship experience, and expanding self-awareness. Many of these participants portrayed themselves as initiators of activity and active agents in the therapy process, illustrating the influence clients have on the therapy process. What is striking about these results is how strongly they point to the highly social and relational nature of therapy. They also reveal how much of what clients find of benefit relates to the therapy relationship and positive, socially-oriented outcomes. Not so positively, hindering aspects included therapists who were reported to be too passive, and being

given no practical help or any ‘concrete advice’. Although expanding awareness was considered therapeutic by many of the participants, for others, gaining greater awareness was considered of no use because they hadn’t received any “actual help”. Some wanted “action-oriented” interventions they could practice between sessions that linked therapy to their ordinary lives, and they found they experienced no change in their problems. As practical interventions are a regular component of CBT, this area was of particular interest for the current study. CBT is commonly regarded as a ‘practical’ therapy. It provides a number of techniques and skills for the client’s assistance (Moorey, 2012).

The process of just thinking and talking in therapy was also identified by young people (16-21 yrs) as one of the most beneficial aspects of their experiences of psychoanalytic therapy (Bury, Raval, & Lyon, 2007). Some participants linked this process to being able to reflect and stand back, which they reported led to greater awareness about the causes of their behaviour. Again, participants spoke of the importance of being listened to, accepted, and in this study, liked by the therapist and liking their therapists in return.

It has been noted that the qualitative studies that have been conducted into clients’ experiences of therapy thus far have concentrated more on what clients found helpful in therapy as opposed to what they believe has changed about them (Nilsson et al., 2007). Although research on helpful events provides some understanding of how clients benefit from therapy, these findings do not speak specifically to the nature of change (Heatherington et al., 2012). One exception is a study conducted by Binder, Holgersen and Nielsen (2009), who interviewed ten clients that had completed a range of therapies, inquiring about their experiences of therapeutic change and their understanding of how change occurred. The researchers identified four themes around which the participants gave meaning to their change processes, one of which related to the social nature of therapy; being in a relationship with continuity when suffering from feelings of inner discontinuity with a wise, warm, and competent professional. This theme again points to the significance of the therapy relationship to clients. Clients also identified having their assumptions corrected about the self and their relational world and an increase in self-acceptance as facilitative of change, self-understanding (creating new meaning and being able to see new connections regarding life patterns) and symptom relief as ‘good outcomes’. The authors suggest

that researchers should broaden the assessment of outcome beyond symptom reduction as it appears that clients value other therapy outcomes.

One area that has had some attention is the investigation of how therapy ‘fits in’ to the client’s existing meaning-frames. A study conducted by Kuhnlein and colleagues (1999) set out to explore how the therapy experiences of forty-nine clients had been integrated into their autobiographical narratives two years post-treatment. Therapy had been based on a cognitive-behavioural model of treatment. The interviews were interpreted by looking into the narratives for the “interviewee’s implicit and explicit view concerning himself or herself and the (social) world” (p. 275). Kuhnlein found that, rather than therapy having the effect of clients reinterpreting their personal history, the “new experiences from psychotherapy are integrated, and thereby assimilated, into the previous person schemas” (p. 274). The researchers deduced that the clients conceptualised both their psychological problems and the effects of their therapy experiences differently depending on their personal schemas. They constructed four ‘types’ among the clients according to what they had wanted from therapy and how they felt therapy had been of benefit to them. These were first, the ‘overburden type’, who saw the origins of their difficulties as being due to difficult life events, and judged the effectiveness of therapy according to whether it prepared them to appreciate when their burden was becoming too hard to bear. The second type, the ‘deviation type’, tended to evaluate their experiences in relation to their idea of what was normal or abnormal. For these clients the goal of therapy was to recover and no longer need therapeutic assistance, as ongoing need would signal the continuation of the disorder. The third type, the ‘deficit type’, emphasised shortcomings they had acquired during their lives - how they interpreted events and their behaviour. For these clients the goal of therapy had been to gain a greater understanding of their problems and increase their competency. Lastly, the ‘developmental-disturbance type’, who regarded their life journey as a complex interrelationship between life events, personal characteristics, and family and social conditions. This group accepted the possibility their symptoms may reoccur and saw therapy as a means for personal growth and something they may need to engage in again at some point in the future. The researcher noted that the study showed that these clients actively accommodated and assimilated knowledge and evaluated the effectiveness of therapy according to the extent they could achieve ‘biographical

continuity'. This was achieved when the therapy outcomes could be integrated and assimilated into their meaning-structures or schema prior to their 'breakdown'. They note that the main conclusion of the study in regards to the effectiveness of therapy "is its *integrative potential* to relate what therapy offers to the meaning structures of the clients" (p. 286). Kuhnlein (1999) argued that "the new knowledge and the experiences in psychotherapy are integrated and assimilated into the knowledge and meaning structures that have grown throughout their lifetime: They determine the long-term positive development in everyday life *after* the treatment is finished" (p. 275).

Discussing Kuhnlein's study, Bohart and Wade (2013) note the congruence between the clients' narratives about their problems, what they thought was 'wrong', and how they perceived the path of change occurred. Although the therapy received was cognitive-behavioural, the clients' narratives displayed themes that went beyond CBT learning processes, and the clients' maintained their own explanations of the therapy process independent of those offered by their therapists (Bohart & Wade, 2013). These findings show that the clients held concepts about psychology and 'healing' prior to therapy, and that these ideas were instrumental in producing positive outcomes. They reveal how clients' own ideas about the sources of their problems and their theories of change may influence the way therapy is interpreted and used. Bohart and Tallman (2010) note that Kuhnlein's study showed that clients do not blindly adopt what is presented to them in therapy, but take what is useful and combine it with their own existing meaning-frames.

Another study conducted by researchers Valkonen, Hanninen and Lindfors (2011) also explored how therapy integrated with clients' meaning frames; their 'inner narratives'. Inner narrative was defined by the researchers as the "ongoing process that weaves together a person's past and anticipated future, taking into account the material realities present in the life situation and making use of the social stock of stories available to the person" (p. 228). The researchers analysed "the pre-therapy views and post-therapy experiences" of fourteen depressed clients. They identified three orientations among the participants toward their depression, and to their ideas about therapy prior to receiving it. The 'situational story' explained depression in terms of present life situations. Clients in this group expected therapy would help them either solve their current problems or develop their personal resources in order

to restore a sense of balance and empowerment in their lives. These problems involved the relationship between the individual and the situation. The 'moral story' described how clients were either dissatisfied with themselves or their life. They tended to feel incapable of meeting either the demands that they had placed on themselves or the demands the prevailing culture had imposed upon them. Clients in this group hoped that therapy would help them find meaning and purpose in their life, restore their sense of moral value and fill an existential vacuum, and perceived the problem as due to their relationship with the social and cultural milieu. The 'life historical story' connected depression to early childhood experiences. These clients expected therapy to explain these connections and work out the past in order to heal in the present. The problem was perceived as residing within the individual. These stories may reflect the influence of ideas that originated from psychoanalytic theory and which have now become common knowledge (Parker, 1994). The participants' inner narratives were identified as continuing in three ways after therapy: progressing, changing, or stagnant. The researchers found that in the majority of cases, the inner narratives of the participants progressed when the therapy was suited to their particular orientation. The inner narratives of those participants with a life-historical orientation progressed after receiving long-term, psychodynamic therapy, while the inner narratives based on situational factors progressed after receiving short-term solution-focused therapy. Interestingly, none of the participants with pre-therapy moral inner narratives had thought that therapy met their 'existential need' and original expectations. The authors concluded that the utility of a given therapy was connected with the way in which an individual interprets themselves and their problems, and "the ability of the therapy (or therapist) to assist the individual to progress in line with their inner narrative" (p. 238). They argue, "The findings suggest that a person's expectations, hopes and values are worth taking into account to ensure positive therapy outcomes" (p. 227).

McLeod (2013) notes "these studies [Kuhnlein, 1999; Valkonen et al., 2011] have shown that clients enter therapy with pre-existing ideas about the reasons for their distress, and the type of treatment experience that is necessary to help them" (p. 65). Clients have beliefs about how change is possible - and how it occurs - that can be capitalised upon for clients' benefit by researchers and practitioners. Duncan, Sparks and Miller (2006) argue that the client's theory of change is "the quintessential

element” (p. 230) in formulating a viable plan for assisting the client to resolve their problems. Due to the fact the majority of CBT research has approached researching therapy from the perspective of how CBT operates *on* clients, little is known about clients’ theories of change. More qualitative research into clients’ perspectives on CBT might inform how clients’ understandings of themselves, their problems, and what they need from therapy, influence the process and outcome of CBT.

Conversely, researchers have also found that the kind of therapy clients receive influences the kinds of outcomes they report to be valuable. One group of researchers interviewed participants about their experiences of change after having completed a course of either Psychodynamic Therapy or CBT (Nilsson et al., 2007). The quantitative analysis of the data revealed little difference between the two therapies in regards to the proportion of satisfied and dissatisfied clients. However, the qualitative analysis revealed interesting differences between the groups. The authors noted that the main conclusion of their study was that there were differences between the Psychodynamic client group and the CBT client group with respect to the content of their expressed satisfaction and dissatisfaction, with each group defining outcome in different ways depending upon which therapy they had received. The satisfied CBT clients appreciated how therapy helped them regain a feeling they were normal and that others had the same problem as they had. They also reported therapy helped them see there was something that could be done about their problems, by applying the techniques they had learned in therapy to cope with them. Gradual exposure to their fears was regarded as helpful, and they described their therapists as experts on their problem, and as active, directive and cooperative partners. Satisfied clients also recalled they enjoyed CBT as a well-structured, focused, and goal-directed therapy, whereas satisfied PDT clients spoke about open-ended and sometimes painful self-exploration in which the therapist was positioned at a distance providing connections and summaries, and defined positive outcome as relating to a wider range of post-therapy personality changes and increased self-reflection. One principal gain expressed by both the satisfied CBT and PDT clients was that therapy had helped them understand themselves better. Both groups of satisfied clients reported an increased awareness of both their personal agency and sense of responsibility as potentially active, agents of change. The researchers argued that among satisfied clients, the perspectives expressed by the participants suggested that the orientation

of the therapeutic approach had influenced the kinds of effects the clients valued. Dissatisfied CBT clients reported that although therapy helped at the time they received it and in the short-term, it had either not had lasting, positive effects, while others felt they were steered and restricted by their therapists. Clients in this group also indicated that some of the specific techniques were experienced as difficult to learn and were at times a distraction from the problems they really wanted to talk about. Dissatisfied PDT clients on the other hand reported feeling stuck, lost, unsupported, and that their therapists seemed disengaged or aloof. Interestingly, the researchers noted that the dissatisfied clients of each group gave accounts about how therapy ought to have been conducted that fitted well with the prototype of the therapy they did not receive. The study shows that while clients' existing 'inner narratives' or 'meaning-frames' influence how therapy is constructed, reciprocally the kind of therapy clients receive affects how they construct the outcomes of therapy.

Some researchers have shown that the way therapy is constructed by clients is also influenced by the social and cultural resources that are available for understanding it. Investigating the influence of morals on the therapy process, McLeod and Lynch (2000) analysed one client's experience of client-centred therapy. The researchers noted how the client had embedded her problem within cultural ideas about what 'goodness' is and what a 'good' life looks like (in the moral sense of the word). The research presented two ideas about morality that appeared to be influential in the client's construction of her problem: the client's perceived goodness in maintaining a relationship with another person that is intimate by nature (romantic/relational), and the perceived goodness in fulfilling obligation and duty to children and wider family members (Protestant/Calvinist). The analysts suggested the participant had not been able to reconcile the imperatives of these two morals. The researchers concluded that the therapist's response was to couch the problem in terms of a humanistic psychology perspective of what a 'good' life looks like, introducing another story - an alternative version of a moral self - 'into the mix'. The therapist's story included two aspects: the central importance of human expressiveness and "the notion of a deep 'personal interior' that requires exploration as a prerequisite for fulfilment" (p. 400). Interestingly, the researchers observed that in the narrative that was reworked and 'built up', morality was implicit; never explicitly referred to by either party. This

illustrates how certain ideas and discourse are culturally entrenched and accepted, and may provide a basis for shared understanding and the construction of new meaning. Issues concerning morality may be problematic for clients and an integral part of the solutions they construct. This is an example of how psychological practice can align (or seep into) popular cultural ideas about psychology, such as the value of human expressiveness. This kind of shared knowledge between client and therapist facilitates the therapy process and shapes the experiences and narratives of clients. Moral ideals are often deeply felt and may be powerful sources of both distress and potential for change. These findings are interesting in light of the aforementioned study (Valkonen, Hanninen, & Lindfors, 2011) wherein clients with ‘negative outcomes’ had pre-therapy moral inner narratives and therapy had not met their ‘existential need’.

McLeod and Lynch (2000) noted that the beginnings and endings of stories are vitally important. When therapists and clients co-construct the beginning of a client’s perceived problem, the trajectory of therapy and potential endings of the ‘problem narrative’ are shaped. Writing about an aspect of what has been termed a ‘contextual approach’ to understanding therapy, Imel and Wampold (2008) note that “The key issue is not whether a treatment’s rationale provides accurate diagnostic [sic] picture of a client’s problems, but the extent to which the rationale is experienced as a compelling framework for understanding the problem” (p. 259). They write that clients are likely to accept certain explanations for problems because to some extent they will share the same ‘worldview’ as their therapists, being immersed in the same culture. It is argued that in light of the trend towards language-based research in therapy processes, there is an increasing need to examine the narrative processes that enable the co-construction of meaning in the interpersonal context of therapy (Avdi & Georgaca, 2007).

An advantage of qualitative research into clients’ perspectives of therapy is that it gives clients a voice and allows clinicians to remain receptive to clients views (McLeod, 2013). These studies point to the usefulness of qualitative approaches to interview-based data for exploring clients’ perspectives and the potential benefit for theory and practice. However, more exploration of clients’ subjective perspectives is needed because of the paucity of research to date. Clients’ perspectives on positive outcome and their theory of change have not been privileged. Qualitative research

provides clients with the opportunity to speak freely about the aspects of the therapy experience that are most relevant to them. With the growth of qualitative research over the years there has been an increasing understanding of the great diversity among clients. These methods acknowledge the formative influence on clients of social and cultural ideas, which are made more visible when clients are given a longer turn to talk. Due to a number of factors, the majority of CBT outcome research has focused upon the reduction of symptoms, and little attention has been paid to clients' perspectives. This research is a response to the need for more qualitative research that explores clients' perspectives on the process and outcomes of their experiences of CBT.

Research Aims and Questions

The overarching aim of the study was to gain an in-depth understanding of clients' perspectives of CBT by examining the ways in which they gave meaning to their therapy experiences. With this aim in mind, the intention was to abstain from imposing constraints with respect to the areas the participants wished to speak about. It was hoped that the findings would be useful for informing practice and theory, and suggesting avenues for future research.

It has been argued that defining a research 'problem' or question tends to misinterpret the work narrative inquirers do, as narrative inquiry is more akin to a type of searching, re-searching, and continual reformulation, than it is to problem definition and solution-oriented research (Clandinin & Connelly (2000). However, in consideration of the research and literature that has been reviewed, and the epistemological framework for the research that follows, I have identified five central questions of interest:

- 1) What meaning do clients give to their experiences of CBT?
- 2) How do clients' understand change in CBT to occur?
- 3) What outcomes do clients value and why?
- 4) How do clients make sense of their identity?
- 5) From which cultural discourses have the clients drawn their ideas for their narratives about their experience of CBT?

Chapter 2

Theoretical Framework

This chapter provides a brief outline of the theoretical framework that underpinned the methodological approach to the research. The framework is based on social constructionist ideas and covers narrative theory, identity, and the cultural context of therapy. Social constructionism takes a critical stance toward the assumption that people's interpretation of their world corresponds to real or 'objective' entities; our perceptions and experiences of life are brought into existence and adopt the particular form they do, due to the language that we use to describe them (Burr, 2003). These topics are discussed separately for the sake of clarity but are clearly interconnected. First, I present some basic principles of narrative theory and argue that a narrative research approach is well-suited to exploring clients' perspectives of therapy. Second, I consider how the topic of personal identity is inextricably linked to the process of therapy. Third, I discuss how popular discourse about psychology in the wider cultural environment, and psychological discourse derived from the immediate context of the therapy experience, may shape how clients understand their experiences.

Narrative Theory

The foremost purpose of qualitative research is to attempt to understand the meaning of psychological phenomena as they occur naturally (Natasi & Schensul, 2005). At its most basic level, qualitative psychological research involves collecting and analysing non-numerical data to provide possible explanations and rich descriptions of how people experience and make meaning out of particular events (Lyons, 2007). Qualitative research approaches to therapy remain closer to clients' lived experience by enabling clients to offer their understanding of the meaning they attribute to various aspects of the therapy process (McLeod, 2013). As a particular form of qualitative research, narrative inquiry is an optimal way of gaining access to a client's inner world of meaning, because narrative provides a portal into the realm of human experience (Bamberg, 2014; Marecek, 2003). People's experiences are by nature storied, and the ways in which we sequentially order and impose structure on

our experiences and make them into temporal narratives is not only characteristic of us, but makes us human (Crossley, 2000a; Squire, 2008).

The ‘narrative turn’ in research began in the 1960s as a response to criticism that arose within the social sciences of positivist assumptions and methods of inquiry (Riessman, 2008). The analysis of narrative is now a cross-disciplinary movement that encompasses almost every social science discipline (Lieblich & Tuval-Mashiach, 1998; Riessman, 2008; Riessman & Speedy, 2007). Increasingly in the social sciences, narrative is considered both a core psychological and social process and a concept that can assist researchers to investigate the connections between experience, social structures and culture, and meaning (Avdi & Georgaca, 2007). The importance of narrative to the study of clients’ perspectives of therapy is paramount; the way clients draw from cultural discourse and use language to story their experience shapes and constructs their understanding. However, narrative research remains a largely underused and yet useful approach for studying the therapy process (Avdi & Georgaca, 2007).

While definitions abound of what a narrative is, Riessman (2008) argues that ‘everyday storytelling’ involves speakers selecting, organising, and connecting events that they consider to be important into a sequence that is evaluated as meaningful. Narratives arrive upon a conception of reality as temporal and continuous (Clandinin & Roseik, 2007). A narrator takes disordered experience and typically creates temporal plots that give reality and the past a sense of unity (Riessman, 2008). Narrative acts as an ordering principle that imparts meaning to that which may be otherwise meaningless, and functions as a structure that enables people to transcend the incoherence and discontinuity of everyday life by imposing a point of beginning and an orientation toward closure (Bamberg, Defina, & Schiffrin, 2007).

Sarbin (2004) argues that imagination plays a vital role in narrative construction. He posits that people’s constructions of reality are dependent upon the skill to function at levels of ‘hypotheticalness’, and that hypothesis-making skills can liberate people from the constraints of their immediate environment. Due to their creative potential, narratives afford their authors a significant amount of personal agency. This narrative creativity is in part what lends a narrative its ‘tone’. McAdams (1993) notes that the

tone of a narrative is conveyed by both the content of a story and the manner in which a story is told, and reflects the extent to which an individual believes that the world can be a good place. An optimistic story may be so because ‘good things’ happen, or because despite the occurrence of ‘bad things’, the narrator remains optimistic that things will improve. Conversely, a pessimistic tone may give ‘good things’ a negative cast.

Parker (2005) notes that a narrative is already a cultural narrative, individuals reworking available ideas into a specific shape which produces something distinctive and captures and represents their experience. Moreover, as Sarbin (2004) explains, people can fashion narratives that reflect an imagined past or future. However, while people retain the agency to imagine what they wish, the nature of the ‘intended goals’ of clients when they narrate their therapy experiences is likely to be influenced by the cultural context, which strongly shapes how people narrate their experiences. We are surrounded by narratives from the time we are born, and growing up as children we begin to notice which narratives are favoured in our culture (Nelson, 2003). These frequent narrative patterns are established through their repetition and have been conceptualised as types of ‘genres’ (Elliott, 2005). They have distinctive content and structure and are socially and culturally constructed forms (Squire, 2004). Therapy narratives themselves may fall into recognisable genres, such as those that influence a person to narrate their experience as a journey of ‘self-discovery’ or experience of catharsis.

While it is true that people have the capacity to construct narratives about themselves that are to some extent original, narratives take the template of existing narratives that all individuals have learned and internalised (Elliott, 2005). The therapy experience may be assimilated into a given narrative framework. As referred to previously, narrative researchers have found that clients may have ‘inner narratives’, such as a ‘life historical story’, and see their distress as connected to experiences that had taken place in their childhood. These types of stories may be generated by popular cultural ideas that recognise that difficult childhood experiences can have a negative impact upon an individual (Williams, 2011). Such clients may emphasise the need for understanding the past, which provides a particular context from which therapy outcome is evaluated (Valkonen, Hanninen, & Lindfors, 2011). Clients are likely to narrate stories about therapy that in some way feel known to them;

recognisable plotlines, ideas, characterisations, and morals that resonate due to their familiarity.

A narrative perspective offers a useful means for approaching moral engagement through psychotherapy (McLeod & Lynch, 2000). The majority of psychological research supposes that therapy occurs outside the realm of subjectivity, as if in a value-free environment without meaning or morality (Slife, 2004). However morality is something that reverberates throughout all stories of experience, including narratives about therapy. Narrators speak from a moral stance and either explicitly or implicitly their stories contain a form of evaluative orientation (Salmon & Riessman, 2008). McLeod and Lynch (2000) argue that that narrative inquiry is suited to gaining an understanding of how themes or stories involving morality are co-constructed between clients and therapists. Morality may be reflected in clients' understanding of their problem and in their ideas about what a 'self' should be. A moral understanding may also be implicit in a client's ability to grasp an alternative perspective, perhaps provided by the therapist, based on their familiarity with the cultural discourse that informs it. Therapy can be an experience in which client and therapist draw from alternative discourse to construct moral counterpoints to moral dilemmas. Narrative analyses can take account of the points that are emphasised in the story, the morals that are drawn, and whether there appears to be some significance that is beyond the teller's awareness (Hollway & Jefferson, 2000).

Gergen and Gergen (1986) argue that an essential ingredient of narrative is that it structures events in a way that demonstrates movement or direction through time. In order for a narrative to be successful the account must begin with establishment of a goal or a valued endpoint, and once created, the narrator selects and arranges events in a way that makes the goal more (or less) probable. The authors argue that the 'directionality' of the narrative may be *stable*, wherein no change occurs, *progressive*, wherein the narrative progresses toward the desired endpoint, or *regressive*, wherein the direction of the narrative moves away from the established goal. Robinson (1990) notes that analyses that are informed by this understanding of narrative "seek to chart the overarching framework of a narrative, and to draw out its major form and content" (p. 1176). These types of analyses can yield unexpected results. After exploring the narratives of people living with multiple sclerosis, Robinson (1990) found that despite the influence of social stigma and the biomedical

perceptions of the disease, the majority of narratives were not regressive, but progressive, noting the positive and vigorous approach people took in attempting to gain personal control over the effects of their illness. Robinson concluded that the narratives showed a personal quest for meaning and mastery, and that stories were assessed and deployed so that appropriate responses to the disease might be reinforced. He contends that progressive and positive narratives may be far more common than anticipated because people do not just passively respond to illness but are active in storying their experience through narrative. This active, functional characteristic of narrative is particularly pertinent when researching the therapy process as, similarly, clients may seek to make meaning out of and gain mastery over difficult life experiences, constructing change through their narratives of therapy. Understanding the nature of change is the primary issue of interest in psychological research and is at the heart of the narrative perspective (Adler, 2013; Laurenceau, Hayes, & Feldman, 2007).

Squire (2008) notes 'experience-centred narrative analysis' is the dominant conceptual framework within social science research, and is one that is most often related to the work of Ricoeur (1991). She describes this approach as being distinguished by its attention to how themes in the data are sequenced and progress, transform and resolve. The development of one theme that is of particular relevance to clients' narratives of therapy is that of agency, which concerns the individual's autonomy, mastery, and ability to affect the course of life, and which is strongly connected to a person's ability to find a sense of meaning and purpose in life (Adler, 2012). When clients begin therapy they typically have a diminished sense of agency, and studies of clients' retrospective accounts of therapy have linked the development of this theme to successful treatment and psychological well-being (Adler, 2012; Adler, 2013; Adler, Skalina, & McAdams, 2008). Many researchers who are interested in the social and cultural influences on narrative are also concerned with the effective agency of personal stories (Squire, Andrews, & Tamboukou, 2008). Riessman (2008) argues that a good narrative analysis moves beyond the surface of text toward a broader commentary, and investigates language and intention - how and why experiences are storied. Narrative research into clients' perspectives on therapy is well placed to explore the interplay between cultural influences and the agency afforded to clients through their imaginative ability and narrative

construction of experience. People take more ‘ownership’ of a story, choose how they want to develop it and use it to convey their ideas about cause and effect, making them well-suited to providing their perspectives and investigating how the nature of change is perceived.

Identity

Over the past 30 years, social constructionists have emphasised that identity is established linguistically and culturally, theorising identity as an implicitly social concept (Burr, 2003; Crossley, 2000a). Identity is not a ‘thing’ that exists (Parker, 2007), but is relational; people construct their identities culturally and socially through their communication with others (Elliott, 2005; Speedy, 2008). Identity is imagined and constructed. People gain their identities by virtue of the resources available to them in the cultural and social environment, their own agency, choice, and narrative ability. The importance of narrative to identity is total; “the story *is* one's identity, a narrative created, told, revised and retold throughout life. We know or discover ourselves, and reveal ourselves to others, through the stories that we tell” (Tuval-Maschiach, 2006, p. 250).

In an increasingly complex world, many people carry distinct, often conflicting identities (Josselson & Harway, 2012). Raggatt (2006) argues that identity does not emerge from a single narrative voice, but is more like a ‘war of historians in one’s head’ and a ‘conversation of narrators’. However, it is argued that “while we may be positioned in a non-unitary way, the normative practices that fix us produce for us a model of a whole mature ‘individual’ with an identity. Much is therefore invested in our recognising ourselves as unitary, whole, non-contradictory” (Henriques et al., 1984, p. 225). There is a Western, cultural imperative to establish a firm sense of personal identity (Rose, 1996; Bauman, 2009). Due to these influences, clients are likely to believe in the idea of an evolving and crystallising identity, and may seek therapy to assist its development or establishment. In society in general, and particularly within the therapy environment, individuals are committed to finding their ‘true’ identity and enhancing their authentic expression in their lifestyles (Rose, 1996).

The ‘cultural meta-narrative contextual sphere’ is the substance from which clients construct a sense of identity (Zilber, Tuval-Mashiach, & Leiblich, 2008). From an

individual's narrative account emerges a personal identity that may be understood as a "figure against the 'ground' of culturally-given images of the self" (p. 71), evidenced by the fact that the form of the 'self' differs from culture to culture (Parker, 2005). Various socio-cultural factors such as gender, age, occupation, class, sexual orientation, ethnicity, race and religious beliefs are critical to the shaping of narratives about the self (Bamberg, 2006; Singer, 2004). These become aspects of identity, and people may find themselves positioned unfavourably by cultural discourse and others' prejudices. People may either embrace or resist definitions, but because identity is socially constructed, they are not simply free to just declare their identity and have it accepted by others; labels may become fixed to people (Josselson & Harway, 2012).

Gergen and Gergen (1997) understand identity as being formed through self-narrative and a person's account of how he or she understands the relationships between self-relevant events over time. They contend that rather than seeing things haphazardly and without meaning and direction, people attempt to understand the events in their lives as systematically related; identity is not a mysterious and sudden event, but is a sensible result of the individual's life story. Narrative provides a means by which people can understand themselves as a person with a past, a present, and a future (Elliott, 2005). This connection between time and identity (Crossley, 2000a) enables people to narrate how the self has changed or developed. For example, Polkinghorne (1996) argues that the plots of narratives used to construct identity may be transformed by narrators from 'victimic', wherein the narrator is passive and depicts their life as out of control, to agentic, wherein they are persistent, show purpose and commitment, and are clear about what it is they want to accomplish and how they can attain their goals. Identity consists of a self-narrative that integrates one's past into a coherent story, and constructs a future story which continues the "I" (Polkinghorne, 1988). Within therapy, clients may reorder and reconstruct the meaning of 'self-relevant events', enabling them to conceive of a different self in the present and project that self-image into the future.

Narrative research is a useful approach for exploring how clients understand change over time, due to the sequential and explicative nature of narrative data and the level and richness of the detail it consists of. Frank (1993) investigated 'self-change' in the narratives of people with a variety of forms of illness. He argued that at the core of

an illness narrative there is an epiphany, defining epiphany as “moments that are privileged in their possibility for changing your life” (p. 42). Frank identified four types of narratives, three of which he concluded contained different forms of epiphany: discovery of a ‘new self’, but one that was perceived as “fundamental to the self that always was” (p. 43), discovery of a ‘wholly new self’ who was different to the person prior to illness, the oxymoronic ‘cumulative epiphany’ wherein over a long period of time the ill person realises that the self has become ‘formed’ through illness, and the ‘reluctant phoenixes’ who claimed there had been little or no self-change following illness. This study highlights the ever present possibility for people to re-author identity through self-narrative, and how self-change may be achieved through narrative in a variety of ways. These acts of narration illustrate two dilemmas that Bamberg (2011) argues must be negotiated in order for an individual’s identity to be established: navigating the sense of self over time when experiencing constant change, and constructing personal agency despite the constitutive forces that are beyond the individual’s control. Frank (1993) notes there is a long-standing cultural rhetoric that formulates the self as a project for change, and that particular experiences and events are understood as occasions for changing the self. Therapy is a prime example of such an occasion. Clients who seek personal change are likely to incorporate the therapy experience into their meaning-structures, narrate a process of change and re-author self-narratives, based on their hopes and expectations.

Linde (1993) argues that narrative is crucially involved in the evaluation of the self and one’s actions, and whether they are incorrect or proper. She argues that one of the most important functions of reflexivity is the establishment of the self’s moral value, and that individuals do not simply want any objectifiable self, but a good self, and one that is seen as such by others. Similarly, Taylor (1989) contends that the concept of morality and the self are inextricably intertwined, and that identity is defined by the way things have significance for people. This connection, he argues, is evident in our basic aspirations to feel connected with what is seen as ‘good’, what life is considered worth living and what constitutes a rich and meaningful life as opposed to an empty and meaningless one. Clients may construct narratives about therapy to assist them to construct an image of the self that conforms to popular notions of what it means to be a ‘good person’ leading a ‘good life’. Bruner (2002) also contends that the ‘self-making’ that occurs through the act of narration is guided

by unspoken but implicit cultural models concerning what a self should be, might be, or shouldn't be. For example, researching identity through the analysis of narrative, Tuval-Maschiach (2006) compared the narratives of middle-class Israeli men and women, and found that men's stories focused on their professional development, intention, ambition, decisiveness and competitiveness, whereas women's narratives had multiple plots; the 'professional narrative' playing a central role, along with relationships and social networks, ambition, purpose, dedication, patience, flexibility, and improvisation. She concluded that although agency and invention are evident in the subjective experience of telling a narrative so too is conformance to cultural conventions and social norms.

Tuval-Mashiach (2006) notes that most narrative analyses of identity construction focus on the content of narratives rather than on their form. She contends that although the analysis of content informs researchers about narrators' values and ideas, the analysis of form highlights the individual's subjective experience of the development of the plot. She describes the different approaches in terms of 'perpendicular mapping', referring to the identification of topics and themes, and 'horizontal mapping', which refers to how these topics and themes change and develop over time. The analysis of form involves two specified activities: identifying the narrator's primary plot and following the development of the plot throughout the narrative. While in the construction of identity narrators are typically aware of the content of their narratives and thus retain some degree of control, she argues, they are usually limited in their awareness of the form or structure of their narratives. As such, "analyses of form may touch on more unconscious and less manipulated levels of identity" (p. 250). Tuval-Maschiach (2006) questions where the story is going, the number of plots in the narrative, the nature of change in the plot, and whether the narrator is the active agent of change or is "passively reacting to uncontrollable changes" (p. 253).

The way in which clients narrate the therapy experience and its relationship to identity will reflect cultural discourses in the wider environment. Narrative approaches to the self and identity as topics of study emphasise the inextricable interconnection between social structures, language, and the self (Crossley, 2000a). Clients engage in therapy in a spirit of negotiation with the intent of working on the project of self-transformation, and may understand the therapy process as that which

assists them to reflect on and remake aspects of themselves. Clients may use therapy agentically as an occasion for deconstructing unwanted identities or constructing desired alternatives through the narrative reordering and resignification of experience. Therapy is a forum wherein clients and therapists collaboratively co-construct 'new and improved' self-narratives and identities that clients prefer. A client's story of therapy is incorporated into their identity, and when therapy is successful, it represents the experience of discontinuity and personal turning points; the retrospective stories that emerge after treatment completion support the client's ongoing sense of self (Adler, 2013).

The Cultural Context of Therapy

Rose (1996) posits that psychology has played a major role in inventing ourselves by making visible certain aspects of people. He argues that the 'regime of the self' values personal identity, self-esteem, autonomy, individuality and choice. The value of loving yourself and having a positive self-esteem are easily recognisable and prevalent in modern day culture (Blyth, 2008). Research has evidenced that particularly over the last two decades, the idea that loving yourself, being self-confident and believing in yourself are the keys to success, are commonly accepted (Adewunmi, 2013). Cultural ideas about the self are not usually capricious and fleeting but are relatively stable and enduring, and may influence the kinds of problems that clients construct and the solutions they seek from therapy. People may seek assistance when they feel their self-narratives don't reflect these culturally constructed aspects of the 'ideal self'.

Rose (1996) argues that "contemporary individuals are incited to live as if making a project of themselves: they are to work on their emotional world" (p. 157). The modern self is a reflexive project for which the individual assumes authorship and responsibility; the 'I' may be seen more like a verb, that is, 'selfing' (McAdams, 1996). Ways in which people know how to 'work' on themselves arise from popular notions about psychology circulating in the wider culture, conceptualised as the 'psy-complex' (Rose, 1996). Examples are the perceived need to be in touch with one's emotions, the value of emotional expressivity, and the belief the present can be understood in relationship to the past. These ideas may be imprinted upon narratives about therapy, and consist in part of widely accepted assumptions about what it is to

be psychologically healthy or unhealthy. They influence how clients perceive themselves and their problems, and their theories about what they need from therapy. The permeation of popular ideas about psychology encourages people to ‘deal’ with the past and work on their ‘issues’.

One observation of the discipline of psychology is that it is accompanied by ‘confession’, the assumption that the more a person speaks the freer they will become (Parker, 2007). Clients come to therapy prepared to speak about themselves and expect that by bringing things to the surface psychologists will be able to explain to them why they do the things they do (Parker, 2005). Describing the typical position clients adopt in relationship with their therapist, Rose (1996) notes that “their relation to authority is a matter neither of subordination of will nor of rational persuasion. Rather, it has to do with a kind of discipleship. The relationship between therapists as ‘experts’ and their clients is structured by a hierarchy of wisdom; it is held in place by the wish for truth and certainty and offers the disciple the promise of self-understanding and self-improvement” (p. 93). As clients often come to therapy seeking advice and look to their therapists for answers to their problems, therapy narratives may be constructed around ideas about the giving and receiving of advice and direction.

It has been noted that the swing towards medicalisation in psychiatry and psychology has implications for clients’ identities as their difficulties become associated with words such as disease, disorder, and dysfunction (Duncan, 2010). Clients’ perspectives on the issue of diagnosis have been varied, with some clients reporting it is helpful when it brings a sense of order to a subjective experience of chaos and hopelessness, while others report feeling overpowered by the definitional nature of diagnosis and feeling as if their unique personhood had been obscured (Binder, Moltu, Sagen, Hummelsund, & Holgersen, 2013). Fee (2000) notes that “depression and other diagnostic categories are now *social objects* - points of personal and collective significance. Thus, ‘depression’ is something that increasing numbers of people know about - often in some degree of sophistication - and hence might invoke in a variety of ways to make sense of the trajectory of their lives” (p. 75). He argues that the way depression is storied is of great significance and needs to be taken seriously, because stories influence how people act and perceive their futures. In Robinson’s study (1990), people’s personal narratives took precedence over social or

medical discourses about illness, and experience was transformed through narrative to create positive meaning and provide a sense of mastery.

Narratives are embedded within the sphere of ‘cultural meta-narratives’; meaning-systems that give local stories their legitimacy (Zilber & Tuval-Mashiach, 2008). In the same way that cultural discourse shapes a person’s view of themselves, so too does the language peculiar to psychological practices. People’s access to the real world is moderated by the ‘linguistic practices’ of the context in which they are immersed (Eatough, 2012). Research has shown that the kind of therapy a client receives can shape how the client interprets the outcomes of therapy (Nilsson et al., 2007). CBT practitioners, for example, typically focus on a client’s presenting problems and do not delve into deeper issues and the past (Beck, 2005; Mansell & Taylor, 2012). CBT clients have been found to evaluate CBT accordingly, evaluating therapy as a means by which they can focus on present problems and acquire methods in therapy to deal with them (Nilsson et al., 2007). Concepts peculiar to CBT may become assimilated into a client’s narrative framework, influencing how they construct their problems, interpret the process of change, and the kinds of outcomes they seek and produce. Narrative research based on social constructionist ideas is attuned to the way language is used to author and maintain certain versions of reality, and how psychology is produced through interactions and practices that take place in particular social and cultural contexts (Avdi & Georgaca, 2007).

In summary, exploring how clients make meaning of their therapy experiences through narrative privileges the voices of clients and can offer significant contributions to research and practice (Adler, 2013). A narrative approach to researching clients’ perspectives on therapy offers clients the flexibility and means by which they can convey to researchers in rich detail the meanings they ascribe to their experiences. Clients can articulate their own theory of change and understanding about cause and effect, and provide researchers with the context they view is important for a comprehensive understanding of how they perceive the therapy experience relates to their lived experience. Researchers can explore clients’ narratives, tracking the sequencing and development of ideas in the story to understand the ways in which clients construct change. Narrative research into the therapy experience allows researchers to examine how clients are imaginative and

agential in the construction of their experiences, while drawing from cultural discourses to evaluate therapy and to re-author the self.

Chapter 3

Methodology

One common criticism levelled at retrospective research has been that an absence of detail or lack of accuracy when participants remember therapy after the event makes it difficult to confidently connect clients' accounts to aspects of the therapy (Elliot and James, 1989). Clients' recollections and understandings of their therapy experiences are both susceptible and likely to change and develop over time. As time progresses, clients will change the meaning of their experiences, because narratives are not static but are fluid and dynamic, and change both developmentally and situationally (Crossley, 2007; Fivush & Buckner, 2003). One feature of stories is that they are always changing. However, clients' narratives about therapy are what they keep after the 'real' experience is over, and it is the knowledge and meaning that is active in the narratives that is of most significance. The 'accuracy' of the narratives is less important than the meaning imbued upon the therapy experience. Eliciting narratives after a period of time has elapsed allows the therapy experience to 'settle' and mingle with participants' lives, personal narratives, and cultural and social influences post-therapy.

It has been noted that "the central issue of interest in the study of psychotherapy is that of change over time" (Laurenceau, Hayes, & Feldman, 2007, p. 682). This sits well with narrative research, which is not only interested in life as it is experienced in the past or present, but also how it is experienced on a continuum (Clandinin & Connelly, 2000). Unlike more traditional methods of inquiry, this kind of research is in a prime position to take account of the time 'back then' when the participants had therapy, and to explore the meaning participants have attributed to their experiences in the time that has elapsed since therapy (Bamberg, 2006).

Method

Participants and Recruitment

Twelve participants were sourced from two private CBT clinics that each had several CBT practitioners. The clinics were situated in two suburbs of Auckland, New

Zealand. The inclusion criteria for the study were that participants were adults (over 18 years of age) and that the treatment they received was CBT, received no longer than two years prior to interviewing. All but two of the participants informed the researcher during their interviews that they had entered therapy due to either depression or anxiety, or both. One participant had sought assistance for coping with workplace pressure, and another for help with the effects of chronic illness. Some of the participants stated they had received formal diagnoses from other professionals, others not. The ages of the participants were fairly evenly spread among younger to middle age groups (between 18 to 60 years approximately), as was gender; seven of the participants were female and five were male. A range of ages was also distributed among the gender groups. All participants were New Zealand Europeans bar one female participant who was of Maori and Pacific Island descent. Most of the participants had received between six and twelve sessions of CBT, while two of the participants had spent six months and two years in therapy.

Participants received a letter of invitation to participate in the study (Appendix A), an information sheet that detailed the purposes of the study (Appendix B), including issues regarding confidentiality. Participants were informed that their privacy would be protected through the use of pseudonyms and that no potentially identifying information would be used. Included was a consent form for signing, indicating the participants felt comfortable that they had been given the opportunity to ask any questions they wished or to contact my supervisors should they require further clarification. The signed forms the participants returned indicated they felt sufficiently informed about the study and that they understood and agreed to the terms of the research (Appendix C).

Data Collection

At the start of each interview the overall purpose of the study was briefly reiterated for the participants. It was explained to each participant that I was interested to hear their story about therapy and I mentioned that they need not feel constrained to tell their story ‘in a particular way’ or paint their experience of therapy in a certain light. The participants may have assumed that as a psychology student/researcher I would want to hear only ‘good things’ about their experiences of therapy and that the therapy had produced effective, positive results. I told the participants I was not hoping or looking for particular ideas or accounts to emerge and they needn’t feel

obliged to present a positive picture. After this brief introduction, I suggested to participants that if they chose to, they could begin with an account of what they felt had led them to seek therapy. All of the participants chose to do this, some offering very brief accounts and others up to 5-10 minutes in length. This was considered a worthwhile suggestion to make to participants as it was possible they may have inferred that prefacing their story with a history the ‘problem(s)’ they brought to therapy - as they saw them - might not have been considered relevant to their therapy experiences. Offering the participants an opportunity to provide some context to the meaning of their experiences drew indications of significant cultural discourses from which participants constructed their problems, and which influenced the progression of the narrative toward probable ‘solutions’.

It has been noted that the primary means of eliciting narrative accounts is simply by asking for them and encouraging such accounts wherever possible (Murray, 2003). While the word ‘interviewing’ connotes the idea of formality, the intent during the interviews was to adopt a position of curiosity and a sense of informality when interacting with the participants. Nestor and Schutt (2012) note that, unlike the structured interviewing typical of survey research, qualitative interviewing relies on open-ended questions. For example:

- Joe:** *Acceptance of good and bad instead of forgiveness. Another thing was forgiving.*
Interviewer: *What was that about?*
Joe: *Basically I don't really forgive people to cut a long story short.*

The interview process was also loosely guided by Hollway and Jefferson’s (2000) four principles designed to elicit the interviewees’ meaning-frames: (1) Use open-ended questions; (2) Elicit stories. “Turn questions about given topics into story-telling invitations” (p. 35), for example asking participants “Tell me how your experience of therapy all began”; (3) Avoid ‘why’ questions. ‘Why’ questions elicit an intellectualisation of actions or feelings, but such talk is abstracted and disconnected from the participants’ actual lives; (4) Use follow up questions that use the respondents’ ordering and phrasing. This is recommended so that the interviewees’ meaning-frames are respected as much as possible. These questions should also be designed to elicit further narratives (e.g. “You say that you opened-up to your therapist after you began to trust him/her, can you tell me more about that?”)

At times, I would reflect back to the participants what they had said to prompt them further:

Interviewer: *So when you came...*
John: *Yep*
Interviewer: *You...you feel like you only had one word for it, and that was 'depressed?'*
John: *That was my one feeling.*
Interviewer: *Yeah*
John: *Yep*
Interviewer: *...and the...the process of therapy helped you identify your feelings...*
John: *Yes*
Interviewer: *...and how...*
John: *...and get control of them...*

Because less structured interviews encourage research participants to give narrative accounts of their experience (Hiles & Cermak, 2008) I used a free-flowing 'interview method' that attempted to reconstruct or resemble something more like a conversation. I introduced a small number of topics as stimulation at points in the interviews when I felt there was significant pause and it seemed the participant had exhausted all they had to say on a previous point. The questions were not rehearsed, but the 'thread starters' were on the topics of cognitive behavioural techniques, the therapy as a whole, and the therapeutic relationship. During the majority of the interviews I asked the participants about their experiences of the therapy relationship. I did not bring up the topics of identity or 'how the participants viewed themselves'. I did not inquire directly about social or cultural influences the participants perceived had affected their therapy experience with the exception of inquiring about 'spiritual or religious beliefs', or 'philosophies about life' they might have considered relevant. The decision was made to include this topic after it spontaneously appeared in the second interview.

As suggested by Rapley (2004), one aim was to follow the interviewees' talk and to work with them rather than being rigid and restricting the participants' talk according to the aims and questions of the research. I did not linger on topics that I sensed from responses were of no interest to the participants. A particular strength of narrative research that is conducted through the use of interviews is that it gives research participants more control in shaping the agenda (Murray, 2003). Although the nature of the interviews could be described as conversational, the majority of my speech consisted of 'minimal encouragers'. However, at times, decisions were made about

which aspects of the participants' talk to pursue and investigate further. I tried in the interviews to follow the participants' lead:

Joe: *Then that goes downhill from there into self-esteem issues, 'you're useless', and I still do have a self-esteem issue, which I know I have to deal with at some point. My self-esteem still isn't brilliant.*

Interviewer: *Did that come up in therapy?*

Joe: *Probably did but I thought the therapy was more aimed at dealing with the situations I was faced at in a work environment. It was more focused around that.*

Interviewer: *And did you drive that focus cos that's what you wanted?*

Joe: *I suppose to some extent I did.*

Clare: *It was good, but just in the back of my mind I was sort of thinking 'I wanna get going. I wanna get going, you know? I want to start doing something rather than hearing about how we're going to.*

Interviewer: *Right*

Clare: *Yeah, cos I was just at the point of it, you know.*

Interviewer: *That's interesting.*

Clare: *'Let's get going and let's get working' (laughs). Yeah.*

Interviewer: *And what would have...what would have 'got going' looked like for you? You know what I mean?*

Parker (2002) notes that the first rule to break as a researcher is "don't talk about yourself" (p. 2) because much psychological research has a blank space where the reflections of the researcher's moral-political standpoint should be. However, I leaned more toward approaching the interviews based on Hollway and Jefferson's (2000) perspective who regard good interview practice as that which aspires to transform the researcher from one that is the 'visible asker of questions' to an invisible facilitator, acting as a catalyst to elicit the participants' stories. While I did not talk about myself per se, there were many times when I responded empathetically as one who 'knows what it is like' to go through something similar. This was achieved through 'minimal encouragers', my tone of voice and body language, in an attempt to convey I understood what the participants were saying.

Clients' narratives are dynamic and likely to change and develop over time. Due to this ever-changing nature of narrative it was decided to accept the narratives exactly as they were formed in the interview at first hearing, rather than have them reviewed by participants with a view to making amendments. Due to the fact that narratives are interpretive and constantly evolving, attempts to render a more 'accurate' reflection seemed counterintuitive. Participants' subsequent reflections and possible alterations

might have had the inadvertent effect of stripping the data of its vital dynamic and meanings that emerged within the interactive context from which the data was obtained. Participants were, however, asked before the end of the interview if they wished to clarify or explain anything or add to the data they had already provided.

Eight of the interviews were transcribed by myself, and the remaining four were transcribed by a professional transcriber due to time constraints. Willig (2001) notes that making the choice of what kind of transcription is made of the interviews is dependent upon the research aims and questions of the researcher and the chosen method for analysing the data. Because I intended to conduct a narrative analysis of the data, 'intelligent transcript' was chosen as the form of transcription, which omitted 'non-meaningful utterances like 'ums' and 'ahs'. No words or phrases were omitted from the transcript and pauses are indicated. This kind of transcription was preferable because the intention was to gain an overall perspective of the narratives rather than focusing on finer aspects of speech. That said, there is discussion about particular words and phrases within the narratives, but this is contextualised in the analysis by their place, function, and meaning within the narrative as a whole.

Ethical considerations

Approval for this study was gained from the Ministry of Health, Health and Disability Research Ethics Committee. Participants were assured their anonymity would be preserved through the use of pseudonyms and the removal of any information that could potentially be identifying.

The ethics application for the research stated that if a participant became obviously distressed due to the nature of the material being discussed, a clinician would be provided free of charge to ameliorate any negative effects should they wish to receive assistance. Throughout all of the interviews I remained sensitive to any signs of participants' distress. On only one occasion did a participant become upset during an interview. The interview as such, was subsequently called to a halt and I spoke with the participant for the remaining length of time to assist her comfort. The participant accepted the researcher's offer to receive one free therapy session with a clinician who was one of my supervisors for this study. The researcher was informed by the clinician that the participant felt satisfied she had received assistance and help in identifying available options as to how she might solicit further support if needed.

Participants were given the option of being interviewed in an office provided by the researcher, or at their homes, their workplace, or another place of their choosing. The aim was to make the interview process for participants as comfortable and convenient as possible. One participant chose to be interviewed at his workplace, two in their own homes, and nine in a location provided by the researcher. The participants had previously been advised in the information sheet that the interview could last up to one hour in length. The reason for suggesting a ‘cap’ on the length of the interviews was considered advisable to minimise any possible negative effects due to the participants ‘reliving’ emotionally distressing periods in their lives. The content of the narratives was of a highly personal nature and had been at one time for the participants, if not still, associated with difficult and strong emotion.

Participants were informed at the start of the interviews that they were free to decline answering any questions should they wish to. They were again assured that their confidentiality would be maintained through the use of pseudonyms and the removal of any information that might be identifying.

Analysis

Shortly after each interview, I listened to the recorded interviews so as not to lose the inflections, tone, and emphases of the participants’ speech. Going through this exercise soon after the interviews consolidated these impressions in my memory and consequently I found that when I came to read the interviews the voices of the interviewees were more than just the printed words on the pages. Listening to the interviews shortly after they occur privileges the participants’ meaning-making by paying attention to how the text had been spoken in the context of each interview (Emerson & Frosh, 2004). Once all of the interviews had been transcribed, I followed Crossley’s (2007) suggestion and read through each interview several times to familiarise myself with the data. Each interviewee was allocated a pseudonym, and I made notes during the repeated readings about ideas as they occurred to me.

During my first readings of the interviews, I focused primarily on the content of each narrative. As stated, all the participants to greater or lesser extents chose to contextualise their experience with a history of the problem they presented with in therapy. It became clear during early readings that the participants’ narrations of the therapy experience had definite ‘beginnings’. The participants mingled their personal

and social histories, psychological concepts, and cultural ideas into a ‘micro-narrative’ of the problem, which provided a foundation from which their narratives of therapy unfolded. How the participants constructed their problems bore a significant influence on the meaning they extracted from their therapy experience and contextualised the narratives the participants told. In the majority of cases these constructions appeared to direct the story in a certain direction and shaped the kinds of solutions that were sought and constructed. ‘Constructing the Problem’ was identified as a narrative theme. Once this theme was identified it then became apparent that the remainder of the data consisted largely of participants’ perspectives on the process of change. ‘The Process of Change’ was identified as a second theme, and subsumes a number of ideas the participants expressed about how they perceived their experience of therapy contributed to change, including their perspectives on the influence of the therapy relationship.

The analysis, therefore, is divided into two parts: ‘Constructing the Problem’ and ‘The Process of Change’. While comparisons are drawn across the narratives, I was mindful of Riessman’s (2008) instruction to refrain from fracturing the data by focusing on theorising across cases, as is the case in ‘thematic analyses’, but rather kept the analysis case-centred and concentrated on how the themes developed within each narrative. I attempted to maintain the integrity of each narrative as a whole by referring back to how participants constructed their problems when analysing their depiction of the process of change, tracking the overall progression of the narrative. Under the two broad thematic headings, the participants’ narratives are divided further into ‘sub-categories’ that reflect the content of the problems the participants conceptualised.

As I investigated the narratives further I dwelt upon the following questions:

- How do the participants narrate change and what do they ascribe it to?
- What outcomes do the participants value?
- How much agency does the story afford its narrator?
- Why might the participant be narrating their experience this way?
- How do the participants negotiate identity with their narratives?
- What social and cultural discourses are evident in the data?

- What might the findings derived from the above questions mean for the theory and practice of CBT?

I studied the narratives to see how the participants used CBT concepts to understand their problems, and the process and outcome of therapy. At times it was clear that CBT concepts were being explicitly referred to and used by the participants (e.g. ‘core beliefs’), but at other times it was not so clear. I was careful not to make assumptions about what the participants were referring to. When in doubt, I suggest in the analysis the possibility of the influence of CBT concepts and practice rather than assuming this was the origin of the ideas.

Many of the participants provided a generous amount of information about their lives prior to therapy and how they perceived their problems had arisen, and I looked to see whether the participants’ perspectives on their problems had remained the same or whether therapy had catalysed a shift. Riessman (1993) notes that she discourages students from specifying questions too tightly, suggesting instead an inductive approach. However, after completing the analysis and reflecting on the process, I realise that much of the time I was looking for evidence of change. This probably stems from my perspective as a student looking to practice someday, and an idea that therapy should, or can, change people, and an understanding that people often engage in therapy seeking personal change. I explored the progression of themes within accounts, tracking their transformation and resolution (Squire, 2008), and looked in the stories for pivotal turning points. I attempted to understand the participants’ theory of change and how they perceived change developed, and whether the narrative progressed toward the stipulated goal.

As stated, I did not bring up the topic of identity or how the participants’ viewed themselves, however issues pertaining to personal identity were frequently referred to by participants. As suggested by Schachter (2011), I considered the values, morals, and ideas the narrative appeared to be based on, and explored the narrators’ implicit and explicit intentions as they narrated identity, and the constraints and goals that guided how the participants storied their identity. I asked myself what kind of ‘self’ the narrator was presenting, exploring the narratives to understand the participants’ objectives in their narration of identity, and what cultural ideas and values there may have been that were guiding these constructions.

Hollway and Jefferson (2000) note that people may offer accounts of their experiences which emphasise consistency and suppress contradiction, with the intent of producing a coherent, rational self, and that there is a danger that analyses may be “driven by the rationalising self-descriptions of informants” (p. 57). They advise that summaries should not iron out inconsistencies, puzzles and contradictions; grasping a person through the ‘whole’ of what is known about them need not imply that they are consistent, rational, or coherent. Similarly, Riessman (2001) notes that narrators do not ‘reveal’ an essential self, they perform a preferred self that they select from the multiplicity of selves which they switch between. This was an issue of particular relevance to this topic as it was not assumed that therapy had been a ‘miracle cure’ for the participants. I considered that the participants may still be grappling with some of the issues they took to therapy, and that there may be oscillation or tension between problematic and evolving or ‘healthier’ self-narratives.

I took note of Morrow’s advice (2005) who argues that credibility is lent to analyses that provide ‘thick descriptions’, which involve rich and detailed descriptions of participants’ experiences and of the multiple layers of context and culture in which these experiences occur. Morrow (2005) views validity in constructionist research as requiring attentiveness to culture and re-contextualising interview-based data “by examining the contextual issues that may impact on the data” (p. 253). She argues this attention to the cultural context must be clearly defined as the lens through which the research is investigated. Using narrative analysis from a social constructionist perspective required me to be attentive to the influence of cultural discourse as it appeared to thread through the participants’ narratives. The data was viewed as a manifestation of the available discursive resources the participants drew from to construct a certain version of events (Willig, 2001). This included CBT discourse, cultural ideas about psychology, identity, values and morals. I looked for the emergence of narrative genres as evidenced by my familiarity with the sequencing of ideas, the suggested meaning of events, and the recognisability of the ideas and ‘lessons’ of the narratives. I also kept in mind that although there are cultural ideas and genres of storytelling that are shared and accepted as ‘valid’ narratives to tell, the participants might resist these conventions. The influence of cultural discourse appeared to be prominent in the clients’ narratives, particularly in

their construction of their problems, and I have endeavoured to present and discuss the clients' narratives in a way that reflect the emphasis they gave to these ideas.

Approaching the analysis from a social constructionist perspective meant that I ought not to assume there was a relationship between the research data and the actual experiences of which the participants spoke (Lyons, 2007). I found adopting a social constructionist 'mind-set' a rigorous and uncompromising discipline. For example, as a clinical psychology student I have been learning about the validity of diagnoses for several years. I had to keep pulling myself up in this regard by revisiting the analysis many times over and qualifying the surety of the participants' statements as being concepts they had come to believe in rather than truisms. It wasn't so much that I had difficulty wrestling with the idea that diagnoses are constructs, but more that I am accustomed to the use of these references. It took me a while and some persistence to become accustomed to the social constructionist frame of thinking, and not to slip into realist interpretations when analysing the texts.

There is an acknowledgement amongst narrative researchers that stories are also shaped by those who listen to them, making the narratives that emerge a co-constructed product (Squire, Andrews, & Tamboukou, 2008). This is as true of the analytic process as it is of the interviews that generated the participants' stories. In a sense, this can be a strength, because the cultural ideas the participants spoke about were interpretable and 'made sense' to me. On the other hand, it meant there was a temptation to settle upon one interpretation too quickly, and not to look for alternative interpretations. Over the course of the analysis, I reflected on the interpretations I made and occasionally altered or discarded some versions for alternatives that I felt were a closer reflection of the participants' stories, or that represented the elements of ambiguity I saw in the text.

Slife (2004) argues that any perceived objectivity of a method cannot assume an absence of values and biases, and yet values are often left unexamined or ignored in clinical research. Researchers must by necessity encounter the world from one perspective or another; it is not possible to step outside of one's humanity and observe the world from no perspective at all (Burr, 2003). Similarly, Willig (2001) notes researchers cannot position themselves outside of the topic because they will inevitably have a relationship with the phenomenon under investigation. Moreover,

researchers do not have direct access into participants' experiences; "Narratives are interpretive and, in turn, require interpretation" (Riessman, 1993, p. 22). An interpretive approach is unavoidable due to the complexity of the subjects the researcher seeks to understand (Hollway & Jefferson, 2000). The participants' narratives are 'presented' in the analysis, but they are a subjective interpretation of an already interpreted experience. Bold (2012) argues that critical reflection requires a researcher to challenge what is assumed to be true, and think about alternative interpretations and analyses while reflecting upon their own values, assumptions, and beliefs, and how they are evident in the handling of the research. While I was familiar with the cultural ideas expressed by the participants, I am immersed in the cultures of clinical psychology and CBT, which meant there was an inclination to make interpretations from these discriminative perspectives, rather than privileging the participants' voices. Realising this, I became careful to remind myself of this inclination and to reflect the participants' perspectives as well as I could. In the analysis I tried to keep to a social constructionist stance and remain critical of the ideas of the disciplines I am a student of.

Chapter 4

Analysis and Discussion

As outlined in the previous chapter, the analysis has a two-part structure: ‘Constructing the Problem’ and ‘The Process of Change’. ‘Constructing the Problem’ familiarises the reader with an understanding of the problem(s) each participant constructs, and contextualises the narratives of therapy the participants tell. This provides a framework for understanding the meaning the participants attribute to their experiences. As the data is analysed, comparisons are occasionally drawn across the accounts and some of the participants’ accounts appear in more than one sub-category heading, as appropriate. In the majority of cases, the narration of the process of change reflected a development of the same ideas that were evident in the participants’ conceptualisations of their problems, and these ideas progressed toward the participants’ intended goals.

Constructing the Problem

Under ‘Constructing the Problem’, the twelve narratives appear under five subcategories (outlined below). The participants’ narratives unfolded from a broad range of the participants’ life experiences and challenges. For some of the narrators, the problems they faced revolved primarily around one central concern, such as ‘identity loss’. Other participants expressed a number of life stressors as producing cumulative effects of stress that they had felt overwhelmed by. Many of the narrators provided a detailed account of the problems constructed in (and prior to) therapy, while others were more succinct, or their problems were more difficult to conceptualise. One of the participants, ‘Judy’, did not have a positive therapy experience. Judy’s narrative only appears in this section, ‘Constructing the Problem’, wherein she expresses her view that her problem was wrongly conceptualised by her therapist. The ‘Constructing the Problem’ section has five sub-categories that appear in the following order: ‘The Effects of Childhood Experiences’, ‘Emotional Repression’, ‘Concerns about Mental Health’, ‘Coping with Life Stress’, and ‘Identity Issues’. As with the development of the two broad themes of the data, these

sub-categories were arrived at as emphases became apparent after several readings of the text. However, as may be expected there is overlap between the sub-categories, and within the sub-categories themselves related ideas emerge that contextualise how the clients understand their problems.

The Effects of Childhood Experiences

Some participants constructed their problems around popular psychological ideas about how negative childhood experiences may affect an individual, which they understood through the CBT conceptualisation of ‘core beliefs’. Participants described how they perceived these beliefs were formed during their childhood and how they had influenced their sense of self.

Peter began a course of CBT for what he describes as a severe depression. At the outset of the interview, Peter described his childhood as “*hard*” and his mother as “*a very, very strange and extremely difficult person*”. He recounted how he spent several months working with another therapist prior to his CBT experience, and how the majority of sessions were spent focusing upon “*psychotherapy sort of work around my mother, particularly, and that’s been an issue, or was quite an issue for some time*”. In the passage below, Peter describes how CBT was instrumental in helping him to understand his problem, despite his low expectations:

Peter: *So I didn’t really feel CBT would do that much for me. You know, I’d done all this work before and I was quite clever, or so I believed, so CBT, well I thought I’d give it a go, but I don’t really see how I’m really going to change that much. You know, surely by my age...I’m over 60...[age], I would have worked some of these things out. You know, that was how I thought about it. So it was quite a shock to me when the CBT started to uncover what was for me some quite dramatic realizations about core beliefs, that I didn’t realize that I still believed...that I was such an awful, bad person.... inside....how deep it was buried in there. I thought I’d got over most of that stuff.*

By beginning his account with a description of his “*extremely difficult*” mother and “*hard*” childhood, Peter implies that his early childhood experiences led to the development of his ‘core beliefs’. His depiction aligns with and is likely influenced by a CBT conceptualisation that posits that ‘negative core beliefs’, which are relatively enduring and fundamental cognitive structures, develop due to early, negative experiences during childhood (Beck, 2011; Grant et al., 2008). Peter may have been quick to understand the concept of negative core beliefs because of the

wide availability of cultural ideas about the negative sense of self one can develop as a result of difficult childhood experiences and maltreatment (Williams, 2011).

Peter uses the CBT concept of ‘core beliefs’ to understand the influence of his childhood experiences on his sense of self. The ‘deeply buried’ metaphor conveys the entrenched nature and intractability of his ‘core beliefs’ as well as their obscurity to him. Although at one time Peter had been aware of these beliefs, he thought he had “*got over most of that stuff*”, and he depicts himself prior to therapy as being unaware of them; the realisations were “*dramatic*” and he was shocked when they were uncovered. His narrative may serve to construct the illuminative quality he perceived was necessary to make therapy an experience that catalysed some kind of change for him. By expressing his surprise that at his age he had not “*worked some of these things out*”, his narrative is persuasive about the significance and potential benefit of the conceptualisation. Similarly, in telling how he did not find the idea of engaging in CBT overly compelling because he did not feel he would “*change that much*”, Peter implies that ultimately, he was pleasantly surprised.

Another participant, Aroha, in her late forties, when questioned about how CBT helped with the problems she described experiencing prior to therapy (“*depression*”, substance abuse, and an “*immense amount of social anxiety*”), also pointed to ‘core beliefs’ as being the primary cause of her problems. Aroha had finished her course of CBT six months prior to the interview. One of several siblings and the only daughter in her family, Aroha prefaced her narrative of therapy with a description of some of her early childhood experiences. She described how as a female child she was given the customary, “*care-giving role*” in the family:

Aroha: *The boys got a lot of attention, and like, our family was Maori and Pacific Island - my mother's Pacific Island - and females in families tend to do sort of like the cooking and cleaning and care-giving role and the boys just do whatever the boys do. I suppose in a way I had a lot of resentment towards my father for...and probably towards both my parents for my upbringing, but I sort of think that at the end of the day in a lot of respects it sort of made me feel like a stronger person. In terms of the household and sort of like running...within the family now, it's pretty much like my brothers even leave a lot of stuff to me now...I think, to decide and make decisions about sort of like, family stuff, without feeling like...I dunno. I was always feeling like I was being dominated by males.*

Although Aroha subsequently conceptualises herself as having negative core beliefs emerging from her childhood, her story of personal identity is a narrative genre of

survival and triumph over adversity. She depicts herself as a “*stronger person*” despite her childhood experiences. It is a culturally familiar idea that hardship can breed a kind of strength or resilience in people who are determined to make something good of the cards life has dealt them (Adewunmi, 2013). By using a narrative genre about strength and resilience, overcoming the odds and ‘making the best of things’, Aroha constructs an alternative narrative about the significance of her experiences and how they have influenced her. She capitalises on this genre as a discursive resource, characterising herself as empowered by her past. This story positions her as a capable person, worthy of respect. Similar to Peter, Aroha spoke about her core beliefs as having originated from difficult childhood experiences:

Interviewer: *So how did the...how did the CBT kind of help with that? And the gaining more confidence and you know, the [substance] and stuff, like how did it work?*

Aroha: *My core be....and a lot of my core beliefs had come really from when I was young and growing up with my father...and my father was highly critical and so I sort of like grew up with these beliefs about myself, and also I'm the only female of [xx] boys, like I have [xx] brothers. And so, you know, like my father's real mean to me and so (laughs).*

Aroha points to her relationship with her father whom she recalls as being “*highly critical*” and “*mean*”, and some disadvantage in being female in the culture she grew up in, as being where “*a lot*” of her ‘core beliefs’ had come from. The narrative is similar to Peter’s in that the experiences of Aroha’s childhood and family relationships are represented as the source of the ‘core beliefs’; Aroha says that she “*grew up with*” them. Like Peter’s story, her narrative aligns with a cognitive conceptualisation about how an individual develops: “children learn to construct reality through early experience in their social and material environment, especially with significant others” (Grant et al., 2008, p. 50). Again, it is likely that Aroha’s familiarity with cultural discourse about the negative effects of difficult childhood experiences on one’s sense of self (Williams, 2011), trussed the validity of the cognitive conceptualisation. However, unlike Peter, although Aroha constructs herself as a person who developed negative core beliefs due to childhood experiences, she inserts this into a different narrative, suggesting not so much that these held her back but rather that she is “*a stronger person for it*”.

These stories appear to align with the ‘life historical story’ of depression that was identified by researchers Valkonen, Hanninen and Lindfors (2011), wherein clients were found to connect depression to early childhood experiences. Therapy was expected by these clients to explain these connections and to enable them to work out the past in order to heal in the present. Each narrator goes on to depict both similar and different ways in which the problem of the influence of the past (in the form of ‘core beliefs’) was perceived to be addressed by CBT.

Identity Issues

Identity narratives vivify and integrate life, and make meaning out of the therapy experience (Angus & McLeod, 2004). Reciprocally, narratives about therapy are frequently cited as a source of identity development (Lieblich, 2004). Therapy is regarded as a place of self-discovery wherein we determine ‘who we really are’. When effective, therapy can be a transformative process that capitalises on a distinctly human trait and strength - the ability to author new identities by suffusing events and experiences with different meanings. Clients may seek therapy to address a negative self-image due to a disruption to their sense of identity, and perceive a need for some kind of personal transformation. Identity disruption may be due to a number of factors, including trauma, illness, or the rupture of personal relationships. At times like these a sense of identity can be an Achilles’ heel, as the trauma of the original events or circumstances may be exacerbated by the loss of an identity that no longer fits. Many of the participants expressed having held particular views of themselves, but the narratives that appear in this section all contain direct references to identity: identity loss, having the development of an identity forestalled, or a sense of conflict and confusion about identity.

Matthew, a young adult, was referred for a course of CBT for ‘social anxiety’ and associated ‘panic attacks’. Over the years prior to therapy Matthew described himself as having become increasingly withdrawn socially and “*completely demotivated*”. He described how his “*social anxiety*” became more and more severe until it got to the point where he remembered thinking, “*I need to stop work. I need to get therapy and I need some help with this*”. In the extract below, Matthew speaks about the events leading up to this development that he believes were the source of his emotional difficulties:

- Matthew:** *I had quite a lot of social anxiety as well. We worked on that, and that in particular was a big concern for me. I think that's probably the thing we made a huge amount of progress with quite quickly actually, yeah.*
- Interviewer:** *And what...what do you attribute that to now? You know, obviously it was a big problem at that time, but it sort of.....*
- Matthew:** *I think a lot of it...I'll just give you a bit of history on it as well. I actually had a head injury when I was in 7th form at high school playing [a sport]. And at the time it was quite...it was just a concussion....nothing more was, you know, I had one doctor's appointment. No follow up was done regarding that but I actually failed my bursary exams very badly. I'd normally been an 'A' student up until that point...no, you know, real reason... I couldn't think of any real reason. I just had a lot of trouble studying. I had headaches from the head injury, so it seemed looking back it was a lot more severe than...than I realised at the time, and I failed my 7th form exams. I then got provisional entrance to university. So I always intended to go to university straight after high school anyway. So [I] ended up going to university. Struggled quite a lot with studying there, and yeah, so ended up leaving university... getting sort of very simple sort of café/hospitality-type jobs and yeah, it was...I'd always had a feeling I was underachieving a lot, considering I'd basically...up until that point I'd defined myself by my intelligence, my academic ability...that was who I was. And I wasn't using, you know, that. I couldn't...I couldn't do it anymore. So that seems to be sort of where the...all the anxiety and feelings of sort of worthlessness and all that sort of thing...sort of started, and yeah, from there I guess leading to(laughs) I can't remember the question. Oh social anxiety stuff, that...yeah that kind of started just I guess a lot of the worrying about what...a lot of it seemed to be how people perceived me.*

Matthew recalls how he had perceived that achievement and self-worth at that time would be evidenced by his intelligence, academic attainment, and the type of employment he gained. He remembers how he “*struggled quite a lot*” for some time before he gave up trying to achieve academically, conveying his level of commitment to maintain (or regain) the identity he had once had. Matthew depicts how his experiences left him uncertain about who he was as a person:

- Matthew:** *I was still defining myself as 'the academic'. I mean, or maybe not so much defining myself, but I'd lost my identity.*

In the construction of a life story, narrators tell of their personal development by providing explanations about how or why they reached a given point, and the factors that drove them from one point to the next (Lieblich, Tuval-Mashiach, & Zilber, 1998; Lieblich, Zilber, & Tuval-Mashiach, 2008). In Matthew's account, he points to the effects of his brain injury, his subsequent loss of identity and perception he was a 'worthless underachiever' as the factors that led to the development of his social anxiety. He explains how he came to think about himself in unfavourable terms

because prior to his injury, he had defined himself by his intelligence and his academic ability; that was ‘who he was’. Matthew explained the impact of these experiences further:

Matthew: *Yeah, the focus on the worrying and I'd tend to worry that...what other people thought of me, and I'd overly worry about it for no reason at all. I'd get very self-conscious about...I guess it probably tied in with the panic attacks. Something that used to drive them and get them really going was, can people tell that I'm having a panic attack, you know? I don't like being the centre of attention anytime, especially when I think there's something...when I'm having problems or you know, if I'm in the middle of a panic attack in a public place sort of thing and it really got down to not sort of letting myself worry about what everyone else was doing really. You know, it seemed even at the time, before I started having therapy, I knew it was irrational. I knew that people weren't thinking about...weren't looking at me, judging me, whatever I thought they were doing at the time. But I just couldn't get my head round it.*

Although Matthew said he was aware his fear was unfounded, he could not be rational about it and his fear that people were judging him persisted. This conveys the persuasiveness of his thoughts at the time, despite what he knew to be really occurring (the probable indifference of others). A CBT assessment would conceptualise Matthew's problem similarly: maladaptive social self-schemas about others' disapproval and social performance standards, leading to 'situationally bound' panic attacks (Clark & Beck, 2010). This may have shaped his understanding of his experiences and how he constructs the problem in his narrative.

Matthew's narrative illustrates how a person's sense of identity is a relational process wherein the self is defined in interaction with other people and their perceptions of us (Elliott, 2005; Lax, 1992). His view of himself as an underachiever illustrates how identity is tied to the culture we live in, and from our positions we reflect upon what makes us different to others (Parker, 2007). Matthew may have perceived himself as he did because compared to other people, his options had become relatively limited. The loss of his identity is depicted as the cause of his distress and the narrative evokes ideas about an anticipated end to the story, wherein therapy assists him to regain a sense of identity, achievement, and self-worth.

Matthew's story illustrates how the experience of living with disability may cause a person to feel inferior (Garland-Thomson & Bailey, 2010). The sudden onset of his disability precluded him from maintaining a preferred identity and invoked feelings

of abnormality. These ideas are linked to perceptions of being judged or appraised by others as being somehow deficient or inadequate, precipitating his emotional distress. The feel from the narrative is that the social impact upon Matthew - his sense of identity loss and position in society - was of great concern to him, as were his physical symptoms of 'panic'. In subsequent sections the idea of the interconnectedness of personal identity, social anxiety and panic continue to thread through his narrative of therapy and the process of change.

Another participant, 'Stephen', in his late teens, recounted a problem that was in some ways similar to Matthew's. Stephen had been diagnosed with a chronic disease in his early teens. This was then compounded by a rare, adverse reaction to a medication he had been given, which led to cognitive difficulties that he was told would probably remain with him his entire life. Stephen was referred to a cognitive-behaviour therapist to assist him to cope. He recounted that at that time he did not think therapy could help him, and that he "*simply didn't think it was possible to reintegrate me back into a normal life*". The narrative of the problem conveys the idea that because of health problems, Stephen experienced himself as being somehow on the 'outside' of society. In the extract below, he describes the impact of a second blow to his health:

Stephen: *So, school work had been something that I'd hung onto all that time through high school because it was something that I was able to thrive in despite of that [his first illness]. I wasn't able to do sports and social situations had become a bit difficult because of lack of energy that school work was something that I seemed to be able to maintain. So, now all of a sudden having this new set of symptoms that was potentially going to detrimentally affect my ability to be able to get good grades and to do what I wanted to do - it was overwhelming.*

The loss of a former positive self-image becomes most marked for chronic illness sufferers when they define their former lives, actions, and selves as having become precluded by illness; the loss of autonomy and choice due to the restrictions imposed by chronic illness can undermine the actions upon which a client's ideas about the self may be built (Charmaz, 1983; 1991; 2002). This sense of loss can be seen in Stephen's narrative as he makes several references to being unable to do the things he used to do, and would like to do in the future. Stephen remembers experiencing

the hardship he was facing at the time as “*overwhelming*”. He spoke further about his experiences:

Interviewer: *What about emotions? How did they fit into the picture? Or did they fit into the picture?*

Stephen: *Looking back on it now I think I was very much depressed. All this happened in my final year of high school, because of it I had to miss out on my final exams that I'd been working for so long, so it meant that university was potentially gonna be effected as well. The prospect of being able to go to university was fading away quite quickly and on top of this, I now had this new set of symptoms and I just wasn't in a particularly wonderful place. I'm no expert on it but I believe that that emotional loss during that time would all merge together, so I felt very mute emotionally.*

The feel from the story is that Stephen managed to adapt to his first illness by focusing on an area of his life that had been relatively unaffected by his health. When his second illness developed and threatened this ‘avenue of hope’, he felt overwhelmed and defeated and “*very mute emotionally*”. Stephen uses ‘depression’ as a concept to understand and describe his emotional experiences at the time. In the passage below, he speaks about how the physical limitations placed on him by his illness curtailed his ability to try new things and find out what he liked doing:

Stephen: *I think that I'd withdrawn a lot since the time of the disease because I didn't have the energy to be able to go out and do things. So, really, in those years I guess your development from [‘age’ to ‘age’] when I was sick you'd be experiencing whole new things, wouldn't you? That's normally when you've got this get up and go and you're out there, you're trying new things, you're trying to figure out what you'd like, and I simply hadn't done that so life was school, go home, study, sleep - a lot of sleeping because of the exhaustion and then back to school.*

Stephen said that although he enjoyed the company of his friends, by the time he engaged in therapy he was often so ill he found going out too much like “*hard work*”. He describes how keenly he felt his difference to his peers:

Stephen: *That was a period where everyone else was out there going and discovering what they liked, what things they wanna get into, they were out there seeing the world etcetera and it's something that I didn't get to.*

Because a person's sense of self is situated within social relationships, the restricted lifestyle and social isolation caused by chronic illness can foster a loss of a sense of self (Charmaz, 1983). Withdrawal from social activity can precipitate a sense of isolation and difference. As Stephen puts it, he did not think it was possible for

therapy to “reintegrate” him “back into a normal life”. Looking back, he reflects how he had been deprived of the opportunity to engage in what are commonly perceived to be normal, developmental experiences of adolescence. Similar to Matthew’s story, the tone in Stephen’s narrative is one of disadvantage in comparison to others. His withdrawal from social activity during his adolescent years left him with the sense that he emerged from this period of his life with his identity underdeveloped or undifferentiated. Stephen conceptualised the problem as a need to define his ‘self-identity’ and self-awareness:

Stephen: *Self-identity... and trying to figure out, like I say, what I liked. Not necessarily what I liked, what I’d like to try to see if I liked. What things I would like to give a go and try and develop some type of self-awareness.*

Activity is intrinsically bound to identity, and when activity is curtailed or impaired there can be a corresponding effect upon an individual’s sense of self. Stephen’s inability to explore the world and discover what he liked doing may have been particularly difficult, because in Western societies, adolescence is the time that the emergence of identity is expected to and does occur (Binder et al., 2013; Giddens, 1991).

Stephen’s and Matthew’s stories depict how they felt disadvantaged and robbed by their illness and injury. They describe how they used to compare themselves to others and consequently experienced their sense of identity as distressing. As has been noted, some life experiences and events are relatively easy to incorporate into a narrative and sit nicely within a person’s continuing story of the self, while others pose a significant challenge (Adler, Wagner, & McAdams, 2007). Writing about the strains on the contemporary self, Kidron (2009) notes that there is ongoing uncertainty for people about where they stand, because “in our worlds, activities may have purpose, but life no longer has” (p. 233). He argues “the widening gap between ever-more demanding standards of achievement and improving....between ‘achievers’ and others, is teeming with illness and unhappiness” (p. 237). These kinds of pressures are likely to be felt more sorely by individuals who suddenly have their avenues for achieving constricted. Through these narrators’ conceptualisations of their problems the idea of identity change becomes one of the intended goals for therapy and integrated into their narratives about their experiences of CBT. These participants did not explicitly use CBT concepts in their conceptualisation of their

difficulties but as they continued their narratives, they each describe using CBT in different ways to resolve these issues.

A third participant, 'John', in his mid-thirties, also constructed his problem around the theme of identity loss, which occurred after the dissolution of his marriage. John had been married for several years and shared two young children with his ex-wife. John stated that he came close to taking his life on two occasions prior to therapy. He attended a course of CBT for a diagnosed depression that developed shortly after his marriage break-up. At the outset of his narrative, John paints a picture of himself as a person who from an early age sensed that he lacked direction and purpose:

John: *I was one of those people...sort of ups and downs a lot you know? Probably first talked to a counsellor when I was 14, and I was just feeling real...like many times in my life, "Why am I here? What am I doing?" ...feeling directionless. Yeah I was...yeah...found myself crying in class and, like when I was in fourth form sort of thing, like no motivation to do stuff, you know?*

John recounted how he had married and begun a family as a young man, and how he adopted the role of "house-dad":

John: *I was never sort of a big fan of having kids in care so I went and became a house-dad and she went and worked at [an occupation] and shortly after became a [job title]. So she was [working], this and that, and I was home with the kids. It was a challenge, stepping into that more traditional female role. But I did relish it. It gave me focus. It gave me...so that was quite good for me really, to keep, you know, chipper. I was busy with the kids, there was always something happening with the kids, you know?*

The challenge John speaks of concerning his step into the role of house-dad does not appear to be due to the fact he didn't enjoy being one, as he describes relishing the focus and sense of well-being it gave him. The nature of the challenge John refers to is evident in his use of the word 'traditional', and his awareness of cultural ideas about what kinds of identities men ought not to or don't commonly have. His story illustrates how some men are doing gender differently, or 'undoing gender', and in doing so the individual is finding the self 'out of kilter' with a particular set of requirements (Robinson & Hockey 2011). John's narrative continues as he outlines the pivotal point in the development of his problem as he perceived it:

John: *So when that was taken away from me.....well...it wasn't taken away, you know, I choose to.....you know, I'd given up trying to stay with my*

wife....when that was no longer with me, I just lost all sort of focus and reasoning.

In the extract above, John corrects his initial statement that his role as caregiver was ‘taken away’, stating instead that in fact he did have a choice in the matter. This correction may denote some fleeting resistance to how he was repositioned after the breakup of his marriage in relationship to his children. John may not have contested the loss of his role because cultural narratives communicated to him what the more suitable or obvious choice was for a man to make (‘children should be with their mother’). He may have been influenced by cultural discourse to understand that a separation from his wife necessitated that he forfeit the day-to-day care of his children. It has been noted that “social regulation can function, not only in a sense through overt oppression, but rather through defining the parameters and content of choice, fixing how we come to want what we want” (Henriques et al., 1984, p. 219). John’s narrative here may be functioning to maintain an illusion of agency and control in a situation he felt he could not change. He went on to tell how the effects of the loss of his caregiving role and breakup of his marriage were profoundly powerful:

John: *“Who’s John? Where’s John?” You know, I didn’t know who John was. And for a long while I didn’t feel like a part of the family.*

Although John had felt ‘challenged’ when he occupied the role of house-dad, the loss of this role after his separation left him bereft of any sense of himself. When John’s identity as house-dad was disrupted, he no longer perceived he had anything he could grasp on to and assert, ‘this is who I am’. The narrative conveys that this was a confusing and disorientating experience for him, perhaps because “our lived sense of time and identity is one of implicit connection and coherence” (Crossley, 2000a, p. 541). Ruptures to personal relationships, such as divorce, can disrupt a formerly secure sense of self that has been founded upon everyday interpersonal communication and activities. Clients may feel as if they no longer know ‘who they are’ because they can no longer moor their identities to the old narratives. John had also been thrust into the social category of singleness, which is associated with discourse about exclusion, lack, and disadvantage (Reynolds, Wetherell, & Taylor, 2007). John went on to recount how it was his response to the loss of “*rhythm*” in his

life - the daily activities of life with his family - that when gone, had caused him to experience life as an unfulfilling and lonely experience:

John: *I was finding it hard to get motivated to go to work... because that rhythm of life that you have when you're in a relationship with children and what-have-you, I found it hard. But anyway, sort of kept pushing it to one side and doing other stuff. I finished that trail walker and I was sort of mucking around. I started going out on a few dates and what-have-you, and was feeling a bit...finding it hard, I was finding it hard to be alone, because of the fact I'd been looking after the kids and what-have-you.*

The connections John once had with his family and the daily life he had enjoyed and was accustomed to, were suddenly gone. Crossley (2000b) notes that in forms of loss such as relationship breakdown “the loss of ‘grounding’, of things making sense, highlights the way in which we routinely take for granted the sense of implicit connections between events, people, plans, aims, objectives, values and beliefs” (p. 56). The idea that life had become nonsensical in some way was evident in John’s narrative, as he metaphorically describes the experience as a loss of “*rhythm*”, “*focus and reasoning*”. Hetherington and Kelly (2002) note that for many people, separating from a spouse involves substantial emotional challenges, including grieving, managing feelings of loneliness, and revising one’s self identity. The profound loss of relationships is compounded by the rupture of former self-narratives that no longer represent lived experience.

John’s narrative depicts how the human capacity and proclivity for meaning-making had exhibited itself by bringing about a state of doubt and confusion in John, who from an early age had been troubled by the questions: “*Why am I here? What am I doing?*” This existential angst was relieved for John when he embodied the role of house-dad, illustrating how identities provide people with a sense of purpose and meaning (McAdams & McLean, 2013). His construction of the problem aligns with the ‘situational story’ of depression identified by researchers Valkonen, Hanninen and Lindfors (2011), wherein the client’s problem involves the relationship between the individual and the situation. The researchers found that these clients expected therapy would develop their personal resources in order to restore a sense of balance and empowerment in their lives. These ideas emerged in John’s narrative as he went on to narrate the process of change.

Peter, who had spoken of his ‘core belief’ about being a ‘bad, awful person’, also spoke of a second ‘core belief’ that he associated with ideas about his identity. Peter had stated at the beginning of the interview: *“I’d managed my career quite well. I did post-graduate diploma papers. So I was functioning reasonably well, but I knew that I had a depression then”*. He described how his depression became “severe” and that he had had to take six months off work. He described how at the time: *“I still wasn’t right at work. I dragged on. I struggled to function, which is quite hard in my type of job, really. Really, desperately hard.”* In the passage below, Peter speaks about the second core belief that he recognised:

Peter: *I spent a lot of time denying I was depressed because one of my core beliefs that I’ve recognised is my need to be quite perfect. Maybe not perfect externally, but feel that I’m perfect in myself and so I couldn’t be this high, spiritual person and be depressed. How can you be ‘mad’ and a wise man at the same time? (laughs)*

Both: *(laughter)*

Peter: *So I struggled with that for a long time. And trying to be this very spiritual person and not functioning very well in the real world, and not seeming to be able to come to some conclusion one way or another.*

Because historically, mental illness has been associated with dysfunction and abnormality (Parker, 2007), Peter may have associated depression with imperfection and ‘madness’. This discourse may have influenced Peter to deny his depression in order to preserve his preferred identity of that as a wise, spiritual person, who on some level he had thought, had to be perfect. He constructs the dilemma he faced prior to therapy as having sprung from his inference that he needed to “*come to some conclusion one way or another*” about who he really was. As noted by Mishler (1999), identity may be understood as a collective term that refers to the organisation of sub-identities that may either align with or conflict with each other. Negative cultural connotations associated with ‘mental illness’ or emotional distress might seem to a client to be antithetical to the idea of an identity constructed around positive images of the self. Cultural discourse persuades people to think of their identities in a unitary and non-contradictory way (Henriques et al., 1984), making the integration of ‘anxious’, ‘depressed’ or even ‘sad’ as aspects of identity difficult when it conflicts with those of a preferred identity. Implicit in the narrative is that Peter uses the CBT concept of ‘core beliefs’ to encapsulate assumptions he once made about the required attributes of a spiritual person, that he now understands were unrealistic and unhelpful.

For these four narrators, all men, unexpected life events disrupted the continuity of their self-narratives and they were forced to re-evaluate their claims to identity. Notably, the two younger men, Matthew and Stephen, both speak of their concern about limited career options, and Peter and John (in 'The Process of Change' section) both refer to their impaired performances at work. There is a particular constrictive form of identity construction that is imposed upon the masculine gender, which remains narrowly defined around career, professional development, and supporting one's family financially (Tuval-Mashiach, 2006). Sussman (2012) argues that at the turn of the eighteenth and nineteenth centuries there emerged "a new form of manliness - middle-class economic man" (p. 82), and contends that the "masculine identity of the warrior" was "displaced into commercial activity" (p. 88). Similarly, Brooks (2010) contends that "all explications of the male role cite "work" as a central component of how men define themselves" (p. 19). Consequently, in the event that a man's performance of his work is compromised or his future plans are interrupted, as was the case for these narrators, he may temporarily experience feelings of inadequacy and sense that an aspect of his identity is under threat.

Additionally, men are incited by cultural discourse to develop a façade of emotional strength and invulnerability that can grossly interfere with their ability to acknowledge sadness or depression and cope with 'negative' emotions (Rabinowitz & Cochran, 2002). Showing emotional restraint is one aspect of the 'male code', and men who are openly expressive can risk censure not only from others, but also from themselves (Brooks, 2010). Masculinity embodies rationality and the ability to prevent one's emotions from impinging on reasoning (Burr, 1995). It is possible that because a man's level of competence in stereotypically masculine behaviour shapes his masculine identity (De Visser & McDonnell, 2013), these participants may have felt less masculine due to their distress, further compounding the sense that their identities had been challenged.

In these men's narratives the social formation of identity is evident as they form their identities in relationship to others as inferior, disadvantaged, estranged, and 'unwise'. The stories also illustrate two dilemmas of claims of identity, those being the requirement to maintain a 'sameness' in regards to one's sense of self across time, and constructing a sense of personal agency when circumstances are prohibitive (Bamberg, 2011). Because symptom change is a focus for cognitive-behavioural

therapists, it is significant that these participants seem to associate their distress and symptoms with a sense of compromised identity. Although ‘identity issues’ are not a specified part of the CBT lexicon, clients may present in therapy with problems that do not always align with standard CBT conceptualisations, and may seek to use CBT to address these issues.

Emotional Repression

Like all narratives, narratives of therapy are embedded within the sphere of ‘cultural meta-narratives’ (Zilber, Tuval-Mashiach, & Leiblich, 2008). Many Westerners are familiar with ideas about the ways in which the unconscious is understood to be defended (Parker, 1994). Most people understand what is meant by being ‘*in denial*’, or ‘he’s taking it out in his work’, or ‘she’s angry because she’s hurting’. It is a culturally accepted truism that bottling up emotions instead of releasing them is potentially damaging for people (Rime, Hervette, & Corsini, 2004). This kind of repression is commonly understood as unhealthy, and being in touch with and expressing your emotions is perceived as a better alternative. It is probable that because psychoanalytic ideas such as emotional repression are so entrenched in popular culture they frequently emerge in other forms of therapy such as CBT. One participant in this study, ‘Jane’, constructed her problem around the concept of emotional repression.

Jane, a young adult, had a younger sister who passed away five years prior to her experience of CBT. Jane stated that she had what she described as a “*bit of a breakdown*” because she had “*never really dealt with it*”. She recounted how therapy was “*...very helpful because it kind of gave me an opportunity to talk about things that I couldn’t talk about with my family*”. She described how in her family it was typical for family members not to express their emotions:

Jane: *...because yeah, in my family you don’t really express emotions and if you do you kind of get...shut down a little bit, and so yeah, it was....that was kind of great to have that person there [the therapist] to be like “no, you can be like this, you can express your emotions, you can do that, and so yeah it was good. It was very helpful.*

Jane tells how she typically didn’t express her emotions due to the instilment of familial patterns of acceptable behaviour, and how she found her therapist’s

encouragement to do so “*very helpful*”. It has been suggested that the idea of stifling emotion became more prevalent in Western culture during the world wars, but since the 1960s, stoicism has been increasingly regarded as pathological, and with the popularisation of psychoanalysis, keeping a stiff upper lip is now viewed by many as uptight and repressed, and potentially harmful to people (Evans, 2013). In addition, it is argued that because of the contemporary emphasis on personal independence in Western, individualistic culture, authentically expressing emotions is now viewed as an ideal goal; “emotions are seen as important personal experiences, and their expression is the individual’s right” (Safdar et al., 2009, p. 2). These ideas are not discordant with psychodynamic ideas about unconsciously repressing emotion, and may have influenced Jane to designate ‘emotional expression’ as the desired endpoint she intended her narrative to progress toward. She went on to speak about the effects of hiding and ‘bottling-up’ her emotions:

Jane: *....after her death because like I said I just bottle....like if I start talking about it with someone I will hide my emotions and start talking about it in such a...like.....*

Interviewer: *Intellectual way?*

Jane: *Yeah, yeah, instead of...and then people kind of think that ‘Oh, because she’s talking about it like this she’s okay’, but in reality I wasn’t. I would just go off by myself and have a cry or something like that. Yeah, that’s when you start breaking down because there’s only so much you can bottle in before it comes out. Yeah, and it usually comes out in the worst places and people that are around you don’t get it and are like, ‘why is she acting so crazy?’ It’s because of this.*

Jane portrays herself prior to therapy as a person who had a tendency to repress and ‘convert’ her emotions due to her childhood conditioning. It is not clear what Jane means by “*acting so crazy*”, but she may be obliquely referring to a type of ego defence mechanism. Her narrative would make sense to most readers, because the idea of repressing emotions or “*holding it in*” as she subsequently describes it, which originates from psychoanalytic theory, has become part of people’s everyday talk (Parker, 1994). Jane’s narrative continues as she goes on to describe the negative effects that are liable to be evoked when a person does not express their emotions. These defensive actions are commonly viewed as liable to produce negative consequences, such as those Jane alludes to:

Jane: *Because it is quite detrimental sometimes, that if you don’t open up and say things that are on your mind, that in the end it’s gonna come out, but it’s*

gonna come out in such a bad way that it's gonna cause more problems than if you just get it out when the situation's happening and deal with it then.

The idea of the potential harm that may be caused when emotions are repressed is reflected in Jane's narrative. She depicts her repressed emotion as coming out "*in a bad way*", "*detrimental*", and causing her to 'act crazy' in social situations. The narrative conveys the sense that thoughts and associated emotions do not typically just subside. If they are not expressed some 'conversion' may take place and the repressed material may end up exhibiting itself in other ways and "*cause more problems*". In the passage below, Jane talks about how she came to understand her pattern of repressing emotion:

Interviewer: *And how did you guys get to that realisation that that was what was going on?*

Jane: *She told me.*

Interviewer: *She told you?*

Jane: *Yeah. She said that I....well cos the first session was pretty much just talking about myself and why I was there and my family and that sort of stuff and....she...the next session she kind of told me that I really don't deal with emotions or I just kind of shut down.*

Jane explains how the conceptualisation that she was shutting down or not dealing with her emotions did not 'take' on first hearing:

Jane: *Like it was...I think it was like the second session that we had, she told me this after our introduction sort of thing...and she told me it, and we had to go over it again the next session just to reiterate it because I don't think I really got it the first time. It was kind of 'denial', sort of thing.*

Similar to Peter's narrative, Jane's story depicts the problem as having arisen from the influence of family relationships. Referring specifically to psychoanalytic ideas, she describes being in a state of "*denial*" about her problem. Her narrative is consistent in that she describes how due to her lack of consciousness concerning the nature of her problem, she needed to be directly informed by the therapist that she "*shuts down*" emotions as opposed to fully experiencing them.

Peter's, Aroha's, and Jane's narratives depict problems that originated from childhood experiences and imply that in some sense, therapy was required to rectify the damage that they incurred when they were children. Jane's familiarity with psychological ideas about the effects of childhood experiences, repressing emotion,

the cultural value that is attached to emotional expressivity, and her understanding that she was ‘in denial’, may have facilitated her understanding of the problem. She recalls how it was “*great to have that person there*” who could tell her that expressing emotions was “*okay*”. Although this conceptualisation of the problem does not align with standard CBT practice, Jane uses these ideas and steers her narrative of the therapy process and outcome toward the releasing of emotion and learning to become an emotionally expressive person who can “*deal with emotions*”.

Concerns about Mental Health

Six of the twelve participants in this study mentioned a mental health diagnosis in their accounts of their problem. However, the narrators that appear in this section construct their problems with a primary focus on clinical diagnoses as their cause of concern. ‘Anne’, in her early thirties, had been receiving an unspecified form of psychotherapy over a period of “*three or four years*” to cope with “*generalised anxiety*”. Anne and her therapist both agreed that complimenting her ongoing psychotherapy with a course of CBT might be a useful adjunct, after which she would return to her long-term therapist. In the extract below, Anne describes how at the time she was “*struggling with off the radar anxiety*”:

Anne: *I’ve probably struggled with anxiety and depression for a number of years. I had a depressive incident at 19 first, when I first left school and then I have had, again, probably been clinically depressed once before, in between struggling with off the radar anxiety. Depression’s actually not my biggest issue - anxiety. I’m what they call generalised anxiety. It’s more of an issue for me than depression.*

Anne constructs her problem in terms of the effects of her clinically diagnosed ‘depression’ and ‘generalised anxiety disorder’. Her striking statement, “*I’m what they call generalised anxiety*” conveys the extent to which she identifies with her diagnosis. Anne depicts how although she had been receiving an alternative, unspecified form of psychotherapy for some time, she approached CBT from a different perspective and with a different aim in mind:

Anne: *I discussed it with my psychotherapist, she agreed it was a good idea and it’s a little bit different to the approach that she takes. I think the work we’re doing there is valuable, it may be the root causes of why I maybe suffer with some issues. There’s some big issues that maybe I need to deal with but, I*

think for the day to day, I really struggle with work and it drives me a bit insane, the thought that I can't handle work.

Anne identifies her need for a therapy that will provide her with practical help in managing her anxiety “*for the day to day*”, and contrasts this with three or four years of trying to get to the “*root causes*” of the “*big issues*” that may be behind it. This sits well with a CBT approach wherein quick, efficient and practical solutions are provided to assist clients to overcome their problems (Dobson & Dobson, 2009). Anne went on to speak about the impact of her anxiety on her personal relationships:

Anne: *There's quite a few other things like that I don't wanna not be able to do. I guess, wanting to be a good sister, daughter, partner – I really struggle with anxiety around my relationships and things. A big motivation for me was to be a better person and be able to deal with my day to day life.*

Anne describes how her “*struggle with anxiety*” precluded her from being the “*better person*” she would like to be for her family. She expresses her personal morality about the importance of being able to function well in her relationships with her family, and her frustration about not being able to interact with them in a way that she would like to. Anne recalls that a “*big motivation*” for engaging in CBT was to receive assistance with her anxiety with the aim of improving her familial relationships. She also spoke further of being motivated by not wanting her problems to detrimentally affect her partner:

Anne: *My partner, for example, a lot of it even came from wanting to be better. If you're anxious and have a lot of repetitive thoughts and needing to seek reassurance about a lot of things, well, your partner's the one who suffers a bit and has to hear all that crap all the time. It was a big motivation to not have that in our relationship. I've always tried, that's why I was seeing a psychotherapist, to keep it out of our relationship, and it's been a huge motivation to be less of a crazy person for my partner.*

Anne's wish for engaging in CBT to improve her interpersonal relationships aligns with the perspectives of clients interviewed in previous studies who reported improved interpersonal functioning and styles of relating to others as valuable outcomes of therapy (Binder, Holgersen, & Nielsen, 2009; Levitt, Butler, & Hill, 2006; McElvaney & Timulak, 2013). Anne describes having “*repetitive thoughts and needing to seek assurance*” from her partner. This aspect of her description of the problem aligns with (and may be influenced by) a cognitive conceptualisation of

‘generalised anxiety disorder’, which theorises that a client’s worry and recurrent, unintended, unwanted, ‘intrusive thoughts’ provoke a search for safety and problem solving (Clark & Beck, 2010). Anne’s construction of her problem is medically-oriented; she remembers “*wanting to be better*” for others. Similar to other participants in this study, she associates her problems with negative cultural discourse about emotional distress as evidence of ‘craziness’. In the extract below, Anne summarises what it was she hoped to gain from therapy:

Anne: *It’s been at least 10 years now since I first struggled with anxiety and for me, a big thing this year has been wanting to deal with it, and long-term strategies for dealing with it, and it not just cropping up over and over, but actually changing myself somewhat.*

Anne’s narrative conveys the sense of personal hardship she experienced after enduring ten years of what she described as ‘suffering’ and ‘struggling’ with anxiety. While she tells how she hoped therapy would change her, she also implies she did not expect to be ‘cured’ by therapy, as she recalls how she was seeking “*long-term strategies for dealing with it*”. This perspective reflects a theme McLeod (2011) saw emerging from a number of qualitative outcome studies, that being that clients often perceive their problems as ongoing and something they need to learn to cope with indefinitely. As CBT offers a variety of techniques for coping with anxiety symptoms, the strategic approach that Anne describes envisaging as the best means to effect change in her life, constructs CBT as a potentially effective form of treatment.

Another of the narrators, ‘Jill’, also in her early thirties, similarly constructed her problem with a focus on mental health concerns. Jill described deterioration in her mental health that she perceived was precipitated by experiencing the devastating earthquakes that hit Christchurch, New Zealand in 2010 and 2011:

Jill: *I came because I had been experiencing quite a lot of anxiety and a bit of low mood. Probably it started off when I was in Christchurch through the earthquakes. So, then when we moved to Auckland I lost my support network cos it was just me and my husband that moved up here, and we didn’t know anyone else and that just made it worse. Then I felt like I was slipping further and further down into depression and my anxiety was getting quite bad and I was having problems going to the supermarket or to the movies and normal stuff that I had done before that I didn’t have problems with.*

Jill recounted how since the quakes, she had walked down the aisles of the supermarket judging whether the stacked items might kill her should an earthquake hit while she was shopping. She also describes the indirect repercussions of her anxiety, when after moving to Auckland she sensed that she had ‘lost her support network’, and implies that this further added to the strain on her husband and relationship. Jill went on to describe how over the course of the year prior to beginning CBT, she describes how she began to “*get unwell*”:

Jill: *Last year when I was getting more anxious, starting to get unwell, I didn't really know what it was but I was getting sick quite often. But one of my anxiety symptoms was nausea and diarrhoea. I was getting that more and more often and so I was having to take more time off work and more time off uni. We'd go away on holiday and it would get worse and then it would gradually get better. If I didn't go to work it would get better. I didn't really know what the problem was at that time.*

Interviewer: *Did you actually think it could've been a physical ...*

Jill: *I'd been to the doctors and they said, “Oh, yeah, it's some sort of virus,” and I'd had blood tests and all sorts of stuff, all sorts of medications and potions. They were thinking it was some kind of a virus but nothing ever showed up on any of my results or anything.*

Interviewer: *That's quite amazing, isn't it?*

Jill: *Yeah. And that went on for maybe six or seven months. I don't know what made me think about it, really, but I think maybe it was because having done some of the psych stuff I thought about it a bit more and kind of self-diagnosing myself, reading the symptoms as you do in your text books. I thought, I have all of this problem. I went to my doctor and I explained – this was a different doctor then cos we were up in Auckland, at uni. So, I explained to them what was going on and they said, “Oh, have you thought about maybe that you're having a bit of depression and anxiety problems?” I was, “Oh, yeah, maybe.” And then that's when I went to see the counsellor at uni, and that made it really clear then that it was actually not a physical sickness. I was actually having emotional issues.*

Jill's use of the word “*unwell*” to describe herself at the time indicates the medical orientation of her construction of the problem, as being indicative of a diagnosable illness rather than a ‘normal’ response to stress. She depicts herself as showing the kind of ‘cross-contextual agency’ that Mackrill (2009) identified in clients, drawing from alternative sources of information to validate her ideas, corroborating across contexts, in this case to confirm her ‘self-diagnosis’. Jill recounts how she developed her own theory of the problem from her university textbooks, and implies she was active in explaining this to her doctors, seeking and obtaining from them a confirmation or perhaps an ‘official diagnosis’ of ‘anxiety’. Reinforced again by her university counsellor, Jill tells how accumulatively, this “*made it really clear*”. She

depicts understanding with certainty that her physical experiences were “*anxiety symptoms*”, and both speakers in the extract allude to the idea there was/is a definitive mental health problem - that ‘*amazingly*’, I add - had not been diagnosed. Jill’s narrative aligns with McLeod’s (2013) observation of clients in previous studies (Kuhnlein, 1999; Valkonen et al., 2011) that he contends showed that “clients enter therapy with pre-existing ideas about the reasons for their distress” (p. 65). There is also a slight tone of relief in her narrative that bears some similarity to findings from a prior study (Binder et al., 2013), wherein diagnosis was experienced by clients as bringing a sense of order to a subjective experience of chaos. Jill elaborated further on the nature of the problem:

Jill: *If people invited me out somewhere, I didn’t really want to go unless I had been there before. For instance, when I go anywhere I needed to know where the bathroom was in particular because if I was feeling really panicky and starting to get like I was getting a panic attack, I needed to get to the bathroom so I could sit in there and then no one would see me having a panic attack so I wasn’t embarrassed if I could go in there and get away. I wouldn’t go anywhere unless I had been there before and knew where the toilets were.*

Jill’s description of her experiences as ‘*anxiety*’ and ‘*panic attacks*’ may indicate the influence of a cognitive-behavioural conceptualisation, that is, her experiences might be deemed to be evidence of ‘*Panic Disorder*’, wherein discrete occurrences of intense fear due to situational triggers and a perceived lack of controllability induce abdominal distress or nausea and “*safety-seeking behaviour (escape, avoidance etc.)*” (Clark & Beck, 2010. p. 277).

In both Anne’s and Jill’s narratives, the mental health constructs ‘*anxiety*’ and ‘*depression*’ are actualised with metaphors: Anne “*struggled with anxiety and depression*” and Jill depicts herself as “*slipping further and further down into depression and anxiety.*” The narratives convey a sense that to some extent Anne and Jill perceived themselves prior to therapy as people who were ‘*losing the battle*’ against the mental illnesses that they - and their loved ones - had been afflicted with. These narratives coincide well with the way that CBT has been conceptualised by theorists and practitioners. The narrators’ problems are medically oriented in their constructions, and in the process of change that was narrated by these participants, appeared to guide them toward narrating CBT as a medically-oriented form of treatment. These participants expected therapy to provide them with skills and

techniques to cope with their symptoms. The CBT experience was incorporated into a narrative about regaining a sense of relative wellness through receiving treatment in the form of practical strategies that assisted them to manage the symptoms of these ‘disorders’.

Coping with Life Stress

Some participants spoke of either prolonged stress from a single source of difficulty or experiencing a number of stressors that accumulated and brought them to a kind of ‘breaking point’. These participants sought therapy primarily to gain assistance coping with their personal response to difficult life events.

Joe, in his early fifties, attended a course of CBT in order to cope with the distress he was feeling due to a difficult relationship with his boss and a stressful workplace environment. Joe gave a detailed account of the circumstances that led toward his engagement with CBT. In the passage below, the context of the problem as Joe perceives it focuses initially on the external situation, but then moves toward what was happening for him “*internally*”:

Interviewer: *Was there just one problem that you wanted to address or were there ...*

Joe: *Probably quite a few things, really. Part of it was, I guess, dealing with him in a work situation and a lot of it was actually about what actually was going on with me internally. So, when situations happen – and it wasn’t just about him, there were other things as well. Basically what had happened is cos I had started a new job four years ago, I’d got to the point where I was under this stress that had accumulated and the accumulation of stress had just got to a point where I couldn’t really handle the different scenarios that were going on at work – the work pressures. Became over sensitive to things and, I suppose, I didn’t really react badly at work, it was just internally I was more in turmoil and, of course, I had less tolerance to things internally. So, I couldn’t deal with those things inside.*

As with many of the narratives, in Joe’s narrative social factors are strongly implicated in how the problem is narrativised initially, but the story culminates with a focus upon how he is going to understand, manage, and respond to his ‘internal processes’. Joe describes how he was both “*in turmoil*” and had “*less tolerance to things internally*”. Joe speaks about how the “*work pressures*” had accumulated to a point where he “*couldn’t really handle*” some situations at work. Although the problem is depicted as social in its origin, Joe’s narrative then emphasises a need for

management and a change in his behavioural responses to the inner “*turmoil*” he was feeling as a response to this context. The construction of the problem in these terms constructs the task of therapy, as Joe put it, to “*deal with those things inside*”. Joe elaborated further on the nature of the problem:

Joe: *Basically, I had a situation at work where I was effectively being bullied, really, I suppose, and I found that really hard to deal with. Just got to a point where I had a ... my manager...was quite a domineering type and very condescending and very controlling, I suppose would be one word. But it was more about the feelings that I was left with during conversations and the manner that he went about it. What happened was one day we had a bit of a blow up because of my personality type, I'm not the type to gradually let off steam. I bottled it all up and one day let him have it. It didn't become physical but it was pretty verbal and I took him into a room and basically gave him both barrels, really.*

Joe described how he had quite a high-pressured job and held a position of responsibility over a team of people. He came prepared with much of the CBT paperwork he had worked on both in and out of therapy to assist with the interview process:

Joe: *I've got my notes here if you want to know what those were and I can tell you. It's just things I had cos I'd written...a whole lot of notes, like he was patronising, belittling, undermining behaviour, and he said things like, "Read my lips, this is what you should do, Get on with it." That type of stuff. It's very domineering and not what you'd expect from a supportive manager.*

Interviewer: *I think that's a pretty fair assessment.*

Joe: *I told him, I said, "You're the worst manager I've ever had - ever." And I've had some really good managers over the years, it's not I don't like being managed – I do. I don't have a problem with that.*

In part, Joe attributes the ‘blow up’ that happened at work to his ‘personality type’, that being the kind of person who does not “*gradually let off steam*”. Joe paints an image of himself as someone who had bottled up so much anger that it was inevitable that ‘something was going to give’. Running alongside this conceptualisation, Joe contextualises the problem as having arisen within a particular set of social circumstances. This thread characterises Joe as a person who was being bullied at work by another, who exploited his position of authority. Read this way, Joe’s ultimate angry outburst might be construed as a healthy, perhaps long-overdue, ‘morally justified’ response in the given social circumstances. This layer of meaning is evident in Joe’s negative portrayal of his boss’ personality and in his choice of the

expression “*I let him have it*”; his boss deserved it or ‘asked for it’, so to speak. Joe constructs a persuasive story of the righteousness of his anger. The narrative defends the idea of Joe’s blamelessness by informing the listener/reader that over the years he had had some really good managers and that it wasn’t because he didn’t like being managed or had a “*problem with that*”. The extent of his anger is portrayed as an effect of the prolonged stress of coping with his boss’ behaviour within the dynamics of their working relationship. Getting off-side with his boss may have had negative consequences for him. Joe’s narrative continues as he speaks about other workplace pressures related to his problem:

Joe: *So, I guess the conflicting thing is there’s the cost thing, there’s the expectation, there’s also the relationship angle where you wanna obviously have a good relationship with the customer. You don’t wanna piss them off to the point where they don’t wanna deal with you anymore. I could say I’ve lost some customers like that, but sometimes they get annoyed. They don’t really rant and rave but you can tell by some of the language they’re not happy.*

Joe’s story describes how his responses are modified by the imperative to avoid his customers becoming ‘pissed off’ with him, refusing to deal with him anymore. Here, it is evident that Joe’s ability to ‘disconnect’ (as he subsequently puts it) from worrying about the problems that are out of his control is contingent upon or significantly limited by his position as an employee of a company and the nature of his relationships with his customers and his boss. Part of his problem as he depicts it is trying to negotiate the tension between his employer’s and his customers’ expectations. Joe is aware he may need to be ‘flexible’ and stifle his emotions at times, and maintain a measure of freedom in his personal expression. While on one hand the narrative depicts the problem as social in its origin, Joe says that he sought therapy to assist him to “*deal with those things inside*”. His construction of the problem in this way is suited to a CBT approach in that the modification of responses to situations is said to be achieved by gaining an understanding of the client’s ‘internal world’; clients can become more functional and adaptive by understanding how their thoughts mediate their ‘emotional and behavioural reactions’ (Dobson & Dosbon, 2009, p. 5).

Clare, a participant in her early thirties also spoke about the cumulative effects of a number of stressful events that had occurred in her life prior to receiving CBT:

Clare: *Well what brought me was a really tumultuous three years...like everything had happened. Lots of life changing events, you know, I'd had a baby, and luckily everything did work out okay but the birth was very tricky, and then my Mum died three weeks later, and then my father collapsed, so the funeral had to be put.....just everything happened, like in-laws came, we had housing issues, it was just one thing after another after another so, and yeah, and the latest one, or the one that really sent me here [therapy] was we'd just got settled in a lovely rental house and then they decided to sell! (laughs), and gave us sort of several weeks to get out, and our in-laws were coming from England at that time and we said "could we have a couple of extra weeks?" No, we've got to sell.*

Interviewer: *Major stress.*

Clare: *It was right at that rental crisis time and I just thought, okay, I can deal with this but if one more thing happens, no, I can't. (laughs). Yeah, so I thought, no, I need some help.*

Clare narrates how over a three year period of her life she had been subject to a number of “*life-changing events*” that I conceptualise as “*major stress*”. The way her narrative of the problem portrays the events in her life it is as if at the time she faced her stressors simultaneously, rather than individually, even though the events may not have coincided. She describes how she perceived at the time that the number of difficult events exceeded her coping abilities; “*if one more thing*” happened, she wouldn’t be able to cope. Clare recounts that this is the reason she needed “*help*” from therapy. She went on to explain that part of the reason she sought therapy was to get “*a third person’s perspective that wasn’t involved in the situation*”, indicating a possible perception that she needed advice and/or support from another person outside her circle of family and friends. Notably, like Joe, Clare did not mention any ‘mood disorders’ (anxious or depressive disorders), and focused on the cumulative effects of difficult life events.

Unlike Joe and Clare, Ruth conceptualises ‘depression’ as part of her problem, but similarly and with more emphasis, she recalls how “*the stress really got on top of me*”. A young woman in her early twenties, Ruth began CBT after she had what she described as a “*breakdown*” due to high stress levels at work. At the beginning of her narrative Ruth provided a succinct précis of the multiple stressors that were occurring in her life at the time:

Ruth: *I have had depression for years as well and a lot of health issues and I started a new job at the [xxxxx]. The stress just really got on top of me, the high demands and things like that. I was going through some real bad health issues at the time and it just got on top of me and I had a mental breakdown almost. I ran out of there crying and I couldn’t even go back. Being*

unemployed, when you have a breakdown they advise that you have a few months off before you go back but those months off brought me deeper and deeper and deeper because I wasn't doing anything. I wasn't being active, I wasn't using my brain so I just got into such a deep, deep place and I also had a boyfriend at the time who was really abusive and rude - not physically - just an awful person but I didn't see it at the time because I was so low. I said to my doctor, "I'm really struggling to get out of it" and she suggested coming here.

Ruth describes a number of events and circumstances, and her narrative conveys the sense of being overwhelmed by the collective strain. It is notable that even after discontinuing her employment, she experienced further decline, though the workplace stressors (*"the high demands and things like that"*) were no longer active. She explains this by attributing her continued decline *"deeper and deeper and deeper"* to the inactivity of unemployment. It is also likely that Ruth would have had internalised self-standards derived from cultural discourse about being unemployed that may have affected her self-image. An additional social factor Ruth points to as having contributed to her deterioration is her poor relationship with her boyfriend. Implicit in Ruth's narrative is the sense that she had little - but needed - social support:

Ruth: *Yeah, when you've got so much going on... I've only got my Mum and Dad, I don't have brothers or sisters so I don't wanna tell them everything and tell them how low I'm feeling because that really brings my parents down.*

Similar to Anne and Jill, Ruth implies that she does not want to burden her parents with her problems and that to some extent, she engaged in CBT to garner the personal support that she felt she could not obtain from her own social circle.

'Judy', a participant in her late forties, also pointed to *"stress levels"* as the cause of her problem. Judy had begun a course of CBT two years prior to the interview to cope with the stress associated with her adult son's severe and chronic anxiety. Judy was the only one of the twelve participants interviewed in this study who considered that her therapy experience had been 'unhelpful'. She was diagnosed with depression but thought this diagnosis was the *"wrong focus"* as she perceived her problem primarily to be her concern about her son's health and circumstances. She did not find CBT *"a helpful or positive experience"*.

- Judy:** *It seemed to me that a lot of other stuff was coming up that I didn't think was particularly relevant and, you know, that was my impression as a lay person.*
- Interviewer:** *She...she was bringing up stuff that you didn't think was relevant?*
- Judy:** *Yeah, or repeating stuff and she probably saw things that I didn't and needed to do that, so I'm not saying that... that....that was wrong. But for me, I just felt sometimes like saying "let's get on with it. Let's get on with it. We seem to be stuck here. I want some....." I suppose I was wanting some progress.*
- Interviewer:** *So what sorts of things did you feel were coming up that you didn't feel a need to dwell on?*
- Judy:** *(Judy begins to cry) The situation is not resolved, in fact if anything it's worse. My son, he had a complete breakdown about 15 years ago, and as his sole caregiver, I just watched him go down and down. Basically watching him die in front of my eyes, to the point now where he just lies in bed in this awful little cabin....doesn't eat....it's just the most terrible situation a mother could possibly....he wants to die.*
- Interviewer:** *That's so hard.*
- Judy:** *He has no life, nothing to look forward to. He has nothing left...and ... multiple other problems of course as a result of that, including being addicted to prescription drugs and too much alcohol when he can go out and get it, which isn't that often now. And it's sort of come to crunch time where I'm trying to find a boarding situation now but I have to be honest and tell people what he's like and they immediately say, "no, I'm sorry." My health over the years has gone down. The stress levels have sort of been....and everyone's saying "you can't have him back with you" [living with Judy], but what do you do? What do you do when your son's dying?*
- Interviewer:** *Yes. It's such a hard situation.*
- Judy:** *(Crying) I didn't expect this. I'm so sorry.*
- Interviewer:** *No, it's fine. It's absolutely fine. You really don't need to be sorry at all.*
- Judy:** *So anyway, to go back to the topic...you know, maybe no-one could really have helped. It just got too bad. I don't know if anyone could have been of help, although I was...part of the deal was that I was kind of assessed. I had an assessment, and I was seen by one girl who was looking for her study... someone with anxiety I think, and she classed me as being more depressed than anxious or something like that. Anyway, I didn't fit with her needs of her study. And so I kind of questioned that; that my main problem was depression, because I think for me it's just huge stress levels caused by anxiety about my son. There probably is depression in there too as well but to me, the depression will go when I've lost the anxiety. So to me it seemed the wrong focus. However, you know, that was what was decided so....but in the finish – and I don't know how many sessions it came to...was it about 8 or 10 or something like that(?) – I decided to stop. Christmas came along so there was kind of a natural break anyway. I think the therapist wanted me to come back after the holidays, and I decided not to, and that was more because I just didn't feel comfortable anymore. I probably needed to...and [son's name] was with me at that time – he's not actually with me at the moment – but he was living with me, and she was sort of helping me to see how manipulative his behaviour was...*

Judy explained during the interview that she perceived it was the lack of support in the community available for her son and her “anxiety” and “stress levels” as sole caregiver of a person with chronic and severe mental illness that were the primary

causes of her distress. She went on to describe how she had explained in therapy that she had been unable to find appropriate accommodation for her son and had exhausted the public mental health provisions for him to no positive effect. Judy was then in a position where she had been hamstrung by financial constraints and unable to garner any more therapeutic assistance for him, or a suitable place for him to live. In the extract above, Judy states the diagnosis of depression was the “*wrong focus*”, and that she questioned the diagnosis. Instead, she points to what she describes as “*huge stress levels due to anxiety about [her son]*”, and believes that these problems were wrongly overlooked. She states that from an early point in the therapy process, the diagnosed depression became the focus of treatment.

A typical cognitive-behavioural assessment would likely conceptualise Judy’s stress about her son’s situation as ‘precipitating’ and ‘maintaining’ factors in the development of the depression she was diagnosed with (Carr, 2006). Extra-psychic, environmental factors are regarded as an integral part of the development of a case conceptualisation (Dobson & Dobson, 2009), and it has been acknowledged that in some circumstances it is particularly difficult for clients to adopt positive perspectives in certain situations (Dryden, 2012). However, Judy depicts the focus in therapy as misdirected and not addressing the primary problem as she saw it, that being the frustration of there being no more therapeutic assistance available for her son, a lack of appropriate housing, and “*huge stress levels*”.

It is notable in the extract that although Judy says she questioned the diagnosis, she defers to the therapist, and the authority of a clinical diagnosis when she says “*I’m not saying that... that....that was wrong*” (the focus on depression), but as a “*layperson*” Judy could not, and still cannot, feel she could/can argue with it. Judy’s report of the experience of being diagnosed with depression is somewhat similar to the experience of clients in a previous study (Binder et al., 2013) who felt that they had been defined by a diagnosis and that their uniqueness as a person had been obscured. It has been noted that although clients often come to therapy complaining of ‘anxiety’ or ‘depression’, “typically, there are real-life problems these private events are being used to explain” (Hayes, Strosahl, & Wilson, 1999, p. 54). Because the therapeutic focus was on depression, the problems Judy faced at the time and the impact they were having upon her emotionally, were not recognised by the therapist and consequently not addressed.

In all of these participants' constructions of their problems the idea is conveyed that they were overwhelmed by their respective situations at the time. They all depict a build up to a tipping point; Joe doesn't gradually let off steam and has a "*blow up*", Clare states, "*if one more thing happens...*" Ruth describes having a "*mental breakdown, almost*", and Judy recalls how things had "*come to crunch time*". The narrators' constructions are similar to the 'overburden type' of client that Kuhnlein (1999) saw emerging as one of four 'types' of clients. These clients tended to see the cause of their problems as being due to difficult life events and not knowing how to deal with them, and made connection between these life events and the distress they were experiencing. These narratives tended to be focused on clients' failure or success in coping with difficult life events. A number of previous qualitative outcome studies have found that like these participants, clients evaluate therapy according to what they believe they needed at the time that they received it, such as providing a place of retreat from troubles, or an opportunity to learn skills, gain insight or advice (McLeod, 2011). Joes, Clare's, Ruth's and Judy's narratives all illustrate how therapy is more often concerned with coping with life than it is with the elimination of symptoms (Kazdin, 2008).

The variety of ways in which participants conceptualised their problems reflected the influence of discourses available in the broader social environment, and their own attempts to understand and make meaning of their experiences. The problems clients conceptualise are likely to reflect the ideas of the culture they live in, and the outcomes of therapy are not produced in a vacuum but are always, in a variety of ways, related to the client's previous life and thoughts (Valkonen et al., 2011). However, as previous studies have reported (Nilsson et al., 2007), there was evidence to suggest that among the participants, to different degrees, therapy experiences were shaped by the discourse and practice of CBT. The participants' agency was evident both in how they conceptualised their problems and in their expectation that they would be able to extract from the therapy experience what they perceived they needed. In conceptualising their problems the participants identified desired endpoints to their narratives, and established expectations about pathways of change and frameworks within which they could evaluate the success of the therapy.

The Process of Change

In the majority of cases, participants narrated a process of change which reflected a development of the ideas they established in their conceptualisations of their problems, and their narratives progressed toward the ‘endpoints’ or intended goals they had constructed. There are four subcategories in ‘The Process of Change’ section. The first two categories are ‘Making Sense of Internal Processes’ followed by ‘CBT Techniques’. This order was chosen because many of the participants first described coming to understand their internal processes before applying therapy techniques in combination with their increased self-awareness. ‘Emotional Expression’ is the next subcategory, followed by ‘Reconstructing Identity’, which includes a discussion about how identity issues relate to the participants generally, and then focuses on those narrators who had constructed identity issues as a primary area of concern. The last subcategory in this section is ‘The Therapy Relationship’.

Making Sense of Internal Processes

When Peter spoke of his problem, he relayed how the identification of his negative core beliefs was like a kind of epiphany. He described having been shocked and that they were “*dramatic realisations*”. As he continued his narrative, he reiterated the importance of the revelatory aspect of the CBT conceptualisation:

Peter: *I didn't realize that so much was driving me from inside. And I could look at that and begin to explore how I did things or how I went from core beliefs, to thoughts, to feeling depressed. Or acting depressed if you like. Feeling depressed and acting depressed.*

Peter speaks about becoming conscious and aware of how his core beliefs were productive and ‘driving’ how he thought, felt, and acted. This conceptualisation mirrors a cognitive-behavioural model of depression wherein a client’s thoughts, feelings, and behaviour are conceptualised as being generated from their core beliefs (De Terte, Becker, & Stephens, 2009; Grant et al., 2008). The sense from the narrative is that Peter has acquired the capacity to ‘step back’, see things from a broader perspective, and perceive patterns in his thoughts, emotions, and behaviour. Additionally, it is possible that by conceptualising ‘core beliefs’ in terms of absolute, categorical statements (‘I’m bad’ and ‘I have to be perfect’), the error of such thinking was made obvious to him, as it is commonly understood that nobody is

‘perfect’ or ‘bad’. These more compassionate views about the nature of people - which stem from contemporary, humanistic discourse - may have facilitated his ability to counter what he came to understand were his ‘core beliefs’. Peter speaks metaphorically about what it meant to him to be able to perceive patterns in his thoughts, feelings, and behaviour, and view them as derivative of his “*deeply buried*” core beliefs:

Peter: *Immediately I could recognize some of the things I was doing, the ways I was thinking. I’d got most of it. It was like I’d got the foundations.*

Just as his realisations about core beliefs had been “*dramatic*”, Peter tells how his recognition of his thinking and behaviour was immediate. His awareness and understanding marks a definitive end to his ‘not knowing’ period, and he implies a ‘new beginning’ when he imagines he has “*got the foundations*”. The conceptualisation of Peter as a ‘self’ conditioned by difficult childhood experiences discredits ideas about ‘goodness’ and ‘badness’ and reframes who Peter was in the past in value-free terms of ‘cause and effect’. This may have assisted Peter to view himself more compassionately. His narrative positions him as advantaged by the self-understanding he derived from therapy. The idea of discarding a negative view of the ‘self’ did not appear unfamiliar to Matthew, and neither does it seem so for Peter, perhaps in part because it is culturally ingrained that a high sense of self-esteem is valuable to a person (Blyth, 2008). The development of self-understanding continues to thread through Peter’s narrative:

Extract 1:

Peter: *But it was a psychological...well not psychological issues on their own, but more a behavioural...rooted in a.....in a core beliefs about what I cannot do and what I’m not allowed to do and what I shouldn’t do.*

Extract 2:

Peter: *All those kind of ‘shoulds and woulds’, ‘can and can’t’....I’ve found I can just go and do the things I’ve planned to do for so many years. Yeah, it’s been a relief.*

Peter tells how the beliefs had inhibited his personal expression, producing thoughts that monitored, judged, and restricted his behaviour. He understands his behaviour as being “*rooted*” in his core beliefs. These kinds of thoughts (‘shoulds’ and ‘can’ts’) are conceptualised in CBT as ‘intermediate beliefs’ or ‘assumptions’ that are said to

stem from the individual's more fundamental core beliefs (Beck, 2011), and these may have been identified in therapy. With this conceptualisation, Peter understands that in the past he kept thinking he should not, could not, or wasn't "*allowed*" to do something because of the influence of his core beliefs. In the narrative there is a shift from a position of ignorance to one wherein he then understood where his thoughts were 'leading' him:

Peter: *By understanding some very basic concepts about where my thinking is starting from and where it's leading me, and by having that knowledge I've found I've been able to move on.*

Peter depicts how the therapeutic conceptualisation brought his beliefs out into the light and open to critique, and there is an emphasis in his narrative on the transformative and liberating aspect of self-understanding or "*knowledge*". This appears to have been an appreciable and clear turning point from which Peter could then "*just go and do the things I've planned to do for so many years.*" This repositions him as able to break free from the restrictions he unconsciously imposed upon himself prior to therapy and "*move on*"; a positive outcome from CBT that he had not expected.

Peter is unique among the twelve narrators in that he is the only participant who makes no mention of the social, interactive element of the therapy. He does not refer to any direct communications, nor does he depict the nature of either the therapist or the therapy relationship at all. Typically, in CBT practice, "Alternative core beliefs are considered and the advantages and disadvantages of each are evaluated...the client is encouraged to come up with alternative attributions and to consider the evidence for and against each of these competing hypotheses" (Laird & Metalsky, 2008, p. 36, 38). However, as was the case in Aroha's narrative, there is no sense in Peter's account of the cognitive thought-challenging that typifies most second-wave CBT approaches to dispute unhelpful thoughts (Cooper, 2004). It seems from his narrative that the identification of his core beliefs, appreciating from whence they had originated, and understanding the effect they were having on him, were the factors that facilitated change. The emphasis in Peter's narrative is on the self-understanding that was provided by cognitive-behavioural conceptualisations.

When constructing his problem, Matthew explained that after a head injury he received at secondary school rendered him academically unable, he felt worthless and like an ‘underachiever’. He recalled that although at the time he had been aware that people weren’t judging him, he ‘couldn’t get his head around it’. Matthew attributed “*half of the benefits*” of therapy to aspects of the therapy relationship, however the importance of self-understanding also emerged as the other crucial aspect of the process of change:

Matthew: *A big thing with me, and I explained this to my therapist at the time, is...is I have to have understanding of something to be able to deal with it - like a really deep understanding and I always...with anything in my life, if I understand how it works then I can deal with it much better. It’s something I’ve always done. I’ve always...I don’t just accept things at face value. I always have to dig quite deep and you know, figure out how things work basically.*

Matthew relays how he explained to his therapist that a ‘big thing with him’ was that he had always needed “*a really deep understanding*” of something in order to be able to ‘deal’ with it. The narrative conveys how Matthew exercised agency in therapy, assisting his therapist to understand his theory of change, based upon his needs. Clients in prior studies have shown their agency in covertly steering the course of therapy for their own benefit (Rennie, 2000), but here Matthew recalls being explicit with his therapist about what he needs from the therapy experience. In stating that he needs to ‘figure out’ and understand “*how things work*” rather than accepting things at “*face value*”, he reiterates the importance of self-understanding. He constructs the therapy as useful in that it satisfied a fundamental need that was characteristic of his personality. The story suggests the influence of cultural ideas about how, as clients, we might engage in therapy already prepared to speak about ourselves with the idea that by bringing things up to the surface, or ‘digging deep’ as Matthew puts it, psychologists will be able to explain to us why we do the things we do (Parker, 2005).

Matthew: *After a few sessions we realised that it seemed to be that worrying was my...my biggest issue with anxiety and we went into a lot of detail about what worry is, what it can lead to, whether it’s helpful to you and various things.*

Matthew tells how after a few sessions he and his therapist lingered for some time on the topic of what worry is, and whether or not it is helpful. This idea may reflect a cognitive-behavioural approach on the part of the therapist to ‘unproductive’ or pathological worry, wherein therapists assist their clients to discern between helpful and unproductive worry, and adopt a constructive attitude and response to their concerns (Clark & Beck, 2010). Cognitive-therapists help clients to step back and identify their ‘meta-cognitions’, such as the belief that worrying may be useful, and assess the consequences of their worrying (Dobson & Dobson, 2009; Dunkley, Blainstein & Segal, 2010). In any case, implicit in the narrative is that Matthew needed to accept that worrying about what people thought of him was a futile activity and was of no help to him. In order for therapists to successfully broach such an idea with a client they might first need to establish a sound rapport, as Matthew depicted he had developed with his therapist. They were on the “*same wave length*”, he said; he felt “*comfortable*” and “*happy to open up*”. Notably too, he had been able to “*rant*” and ‘get things off his chest’, and perhaps this facilitated his readiness to accept the conceptualisation, rather than infer invalidation or dismissal of his legitimate concerns. Matthew goes on to tell how, effectively, he accepted the idea that worrying was not helpful, and implies adopting a philosophical stance:

- Matthew:** *These people that have absolutelythey shouldn't have any effect on you. Just let it go. And again, that small sentence: Just let it go, has been sort of one of my mantras, I guess. Let it go, it doesn't matter. Yeah, and it's just something that I worked out in my own head to help me deal with those things, now that I have the understanding.*
- Interviewer:** *Yeah...yeah. And was there something about the techniques or the process of the therapy helpful in that way?*
- Matthew:** *I'm not so sure. I think more just once I'd got all the information about it.*

‘Let it go’ is a popular cultural maxim that conveys the idea that one should (and can) change one’s mind to decide that the issue will no longer be of the same significance, and need no longer be dwelt upon. There are implicit ideas about choice, liberty, and autonomy, which are recycling popular concepts about the ideal self that Rose (1996) posits psychology has played a major role in inventing. Therapy may be regarded by people as a place wherein they may be assisted to achieve choice, liberty, and autonomy. The phrase also presupposes ‘the time has come’ to let go of the issue. It implies that there is a relative amount of ease to the process and to achieving the potential freedom that had not been obtained, and which

perhaps should have been. Peter seems to chide himself when he says, “*I thought I’d got over most of that stuff*”, and Matthew implies self-blame when he states, “*they shouldn’t have any effect on you*”. There is an implication of some kind of failure on Matthew’s part. Aroha uses the idea of ‘letting go’ when she discusses the benefits of simply talking with her therapist: “*I felt that it was therapeutic. The therapy itself; just kind of talking about it, letting it go.*” Aroha refers to the act of just talking about it (and letting go) as “*the therapy itself*”. In the extract above, Matthew associates his ability to let go with therapy having afforded him ‘the understanding’. Below, Matthew again speaks of self-understanding as pivotal to being able to ‘deal’ with the problem:

Matthew: *But just going into the thought processes and all that behind the worry... really helped me understand what was happening to me and be able to deal with it.*

‘Deal with it’ is another colloquialism that several of the participants used with reference to the process of change. Generally speaking, ‘deal with it’ implies more than just coping, it also involves working on ‘sorting it out once and for all’. The expression is often used in connection with emotions, as Jane says, “*I really don’t deal with emotions*”. Her narrative explains that habitually, prior to therapy, she didn’t “*go through a process*” of really feeling the emotion and letting it out or, by implication, ‘sorting it out’. Jane goes on to narrate how the therapeutic experience involved expressing her grief to her therapist in an emotional encounter. Ann told how in long-term psychotherapy she still had “*some big issues that maybe I need to deal with*”, possibly with reference to her past and some unresolved issues that needed exploration and work. Similarly, Joe stated that he had “*less tolerance to things internally, so I couldn’t deal with those things inside*”, with respect to needing therapy to help him manage the anger and ‘inner turmoil’ he experienced at work. The narratives suggest the influence of the ‘therapeutic culture of the self’, which Rose (1996) argues incites people to make a project of themselves and work on their emotional world. The participants’ stories indicate they went to therapy prepared to work on or deal with the emotions they had been unable to resolve.

As previously discussed, Joe had described his problem as entailing a stressful workplace environment wherein he was under considerable pressure to perform as a

project manager whilst at the same time being “*bullied*” by his boss. He recounted how the cumulative stress finally culminated in an explosive outburst directed at his manager. Consequently, he had engaged in CBT for the management of his emotion. Although Joe represented the external circumstances as a significant factor in the development of his problem, he tells how it was only coming to understand his internal processes that produced change. As Joe’s narrative continues he describes how becoming aware of his internal processes was the first step toward addressing the problem:

Joe: *The brain side and all that...what I’d call theoretical stuff. It was useful for me to know, though. I can’t remember half it but it was useful to understand because one of the problems I had was when I’m put on the spot I couldn’t make a decision and I couldn’t think clearly because I was under stress. So, then I understood, okay, she said it’s just a standard reaction to how the body and the mind is protecting itself from the stress. There’s a big animal coming; gets some adrenalin into your system.*

Interviewer: *Flight or fight, yeah.*

Joe: *Protect yourself. And obviously I was under so much stress I was going into that really basic mode... rather than ... I understand there’s three levels and I can’t remember what they are now, but I was going into that real basic mode of protection rather than being on the other levels and being able to respond. I found that quite useful.*

The ‘fight or flight’ theory is often explained to anxious clients by CBT practitioners to help them understand how their physical symptoms arise from their sense of perceived threat as a biological organism (Clark & Beck, 2010). Drawing on this conceptualisation, Joe represents his inability to respond in stressful situations as a form of protectionism and escape, and can normalise it as a “*standard reaction*”. Joe tells how when he was in that “*basic mode of protection*” he was unable to respond. He notes that “*all that theoretical stuff*” was useful for him to know, and had brought with him to the interview many worksheets with examples of when he had applied the model to specific situations at work. Joe went on to describe how CBT assisted him to develop increased awareness of his internal processes:

Joe: *I had a chest tension. I could feel my mood changing to being defensive and from mildly defensive to really defensive, the more the conversation progressed. I guess this situation; thoughts, body, physical sensation, moods. This model here, or whatever it is ...*

Interviewer: *It’s the classic CBT model; five-part model.*

Joe: *This model was useful to separate out all the different things that are going on; otherwise you see this blob as a problem blob. How do you chop it up into all these bits? And this was a really useful model to do that. I’d been to*

some sessions; otherwise I wouldn't have the sheet. So, this was all part of the... therapist got me to fill these in. So, I'd fill these in. That's why I've got so many. My analysis of whys and what I should have done - that was my behaviour. I spoke defensively and I wasn't making any sense because I was stressed and I couldn't think clearly and therefore my responses were disconnected.

Interviewer: *How did that help? Has that helped since? That process, and delineating what's going on?*

Joe: *It's a little more automatic now. I don't think in those terms necessarily. I don't think, oh, what's my body reaction? What's my mood? I don't think in those terms but I'm still learning, obviously. I recognise now when I'm getting defensive. I think, oh, yeah, okay, I'm stressed. I'm getting a bit defensive.*

The CBT model Joe referred to is used by therapists to separate out the 'five parts': thoughts, physical sensations, behaviour, emotions, and the situational context. This is said to assist clients to gain greater awareness of their internal processes and how they are situationally specific, that is, how they manifest within a given context (Grant et al., 2008). Joe provides an example of how he applied the model to a specific situation at work: "*I spoke defensively, and I wasn't making any sense because I was stressed and I couldn't think clearly, and therefore my responses were disconnected.*" Joe separates out the parts: his behaviour (speaking defensively), his mood (feeling stressed), and his thoughts ('muddled'). Joe depicts the deconstruction of the problem by 'chopping it up into bits'. The information he gleans from the model is detailed and suggests that he is presently and sensitively aware of his internal processes as they relate to specific situations at work: "*I could feel my mood changing to being defensive, and from mildly defensive to really defensive the more the conversation progressed.*" Joe tells how the method for developing awareness has become "*a little more automatic now*". He depicts how he no longer has to consciously engage in the process but can just recognise when he's getting defensive. Goldfried (2012) argues that the change process in therapy involves the development of "cognitive-emotional-behavioural patterns that are less effortful and more automatic" (p. 18). Joe's depiction of change reflects such a process. The theory he learned in therapy appears to have been well assimilated and he is using it successfully to effect the kind of change he sought from therapy. His narrative also reflects perspectives of CBT clients in prior studies (Nilsson et al., 2007) who similarly reported that the application of techniques became automatic and natural parts of their lives and integrated into their habitual behaviour. As in Peter's story,

the feeling from the narrative is that internal processes are perceived as less chaotic and more understandable (breaking down the “*problem blob*”). Both narrators imply that their increased awareness and understanding were (and are) implicated in the process of change. However, unlike Peter, Joe uses the conceptualisation with the express purpose of monitoring, regulating or ‘managing’ his emotion.

Similarly, Jill, who had suffered severe anxiety after experiencing the Christchurch earthquakes, also spoke about the benefit of gaining greater awareness of her internal processes:

Jill: *I wasn't really aware of what I was thinking and...because now I notice that if I'm thinking about something then a little bit later I start to get anxious. Before that, I didn't really connect the two together. It was just out of the blue, you're having a panic attack kind of feeling. I didn't really connect the two together.*

Jill recalls how she had not been aware of her thinking and how it was connected to her anxiety, and how prior to therapy, her ‘panic attacks’ seemed to come “*out of the blue*”. Jill’s account is similar to Joe’s in that he too spoke of the benefit of making connections between thoughts and emotions.

The process of developing awareness of thought and emotion was also integral to John’s account of the process of change. John had described how he became depressed and lost his sense of identity after separating from his wife and losing the role of ‘house-dad’ and full-time care-giver of his children. John referred back to the topic of identity right at the end of the interview:

John: *You know, I didn't know who John was, and for a long while I didn't feel like a part of the family, but now I do. Even though we live apart, I really feel like a part of the family.*

However, when discussing the process of change, John’s narrative focuses on making sense of his internal processes. He explained why he found the CBT approach particularly suitable for him:

John: *I tried a couple of different types of counselling, and I sort of felt, for me as a man it worked the best... sort of an analytical approach to.....yeah, an analytical approach to feelings. And I've always been a feelings person, you know? Half the reason my wife and I fell apart was she was always a 'facts' person. She would say the facts and I would say “well I feel...” And she*

would say “well that’s not real, it’s not the facts.” And I’d go “well it doesn’t matter, I feel that way,” you know? “This is how I feel,” you know?

In the extract above, John explains that his appreciation or ‘good fit’ with the cognitive-behavioural method stemmed from his understanding of it as “*an analytical approach to feelings*”, an approach which he perceives worked best for him as a man. Here, John uses a familiar cultural discourse that associates masculinity with analytical thinking to explain an aspect of the therapy’s success, which aligns with his perception of therapy as being treated by his therapist “*like a science*”. However, in his narrative, the idea of his typically male, analytical thinking is juxtaposed in an uncustomary fashion with his additional appraisal of himself as a ‘feeling male’. This reveals how masculinity “can be seen as a practice which men recognise and, moreover, are able to engage with agentically, at times, whether in pursuit, subversion, or adaptation of its characteristics” (Robinson & Hockey, 2011, p.73). The more common stereotype is that of an *unfeeling* and analytical male. John resists this gender stereotype by claiming an unusual mix of characteristics as integral parts of his identity. However, by identifying with the analytical male discourse, John constructs CBT as a particularly useful and applicable approach for him. At the same time, he found the approach valuable for getting in touch with his feeling self, which he had become alienated from:

John: *But I’d really lost touch with the language of emotion....and I found the CBT quite good for that. She sort of said “how do you feel?” I said “I feel depressed.” And that was my only feeling. I didn’t have any other feelings that was, that was it...the one word was “I feel depressed...”and I couldn’t even, you know, I didn’t have ‘sad’ or ‘glum’ or ‘despondent’ or nothing like that it was, I was just lacking focus and that was it, the only, you know, word I could describe myself...and so we, we worked on that, identifying feelings you know?*

Burr (2003) argues that a person’s experience of the world, particularly of their own internal states, is intangible and undifferentiated without the framework of language which gives it structure and meaning, and that the way in which language is structured determines how experience is structured. It may be that the emotional confusion John experienced at the time reflected the disorder of his self-narrative, which came apart as his marriage had done, and was unable to explain the real and painful loss of his daily life with his family. John tells how prior to therapy, he could

not describe the breadth and depth of his emotional experiences other than to say “*I feel depressed*”, revealing the extent to which language can shape how we come to understand our experiences and, by extension, limitations in our ability to articulate experience also limit our understanding. Language mirrors our experience of emotion and acts as a representational device (Mehl-Madrona, 2010), but some experiences are easier to describe than others. It may be that for John, representing the complexity and intensity of his emotions felt too enormous a task. Being able to convey his emotion using a commonly understood term meant that he could communicate the magnitude of his distress, and expect that his therapist would understand and might know how to help him. However, the narrative suggests that he perceived that his inability to express his emotions with any articulacy was problematic, and he appears to ascribe part of the cause and maintenance of his distress as being due to having “*lost touch with the language of emotion.*” He uses the metaphor “*lacking focus*”, conveying a need for greater definition and the idea that expanding his vocabulary provided him with a clearer picture of his internal world. John’s narrative continues as he describes how this process developed:

John: *And she got me to track levels of depression, you know? How do I feel and was there any sort of, what took me there? What took me through this...why I felt depressed, you know, what was affecting me, you know, what event happened that week, that time, or that day that made me feel depressed....and once we sort of got a handle on the levels we started addressing more feeling words, and you know, she got me charting during the week.*

It is argued that in order to regulate and cope with emotional responses clients need to be able to differentiate their emotions, and that undifferentiated states of high emotional intensity are usually experienced as chaotic and distressing for clients (Angus & Greenberg, 2011). John depicts learning to differentiate emotions, starting out gently, tracking the fluctuation of the levels of the emotion he could identify (depression) over the week, and making connections between feeling depressed and the situations associated with this feeling. His statement “*once we got a handle on the levels*” suggests he viewed the practice as collaborative, and one wherein he began to develop his understanding and some sense of mastery with respect to his feelings. The story describes a gradual step-by-step progression that afforded John a sense of competency and confidence to explore his feelings further before

“addressing more feeling words”. He went on to tell how this then positioned him to be able to judge whether his emotional responses were appropriate given the circumstances:

Interviewer: *And the...the process of therapy helped you identify your feelings(?)*

John: *Yes, and get control of them. Not control of them, but an awareness of them, and I can choose to take that path. Am I feeling elated? Am I overly elated? Am I...you know, am I, you know, am I not looking balanced enough? Am I just excited about something and maybe I should just step back and go “you’re being over excited” and also vice versa, you know? I mean, yes, the guy said he wasn’t going to take your deal but you don’t have to go and slit your wrists over it. It’s just like, okay, go and do something else.*

Interviewer: *So once you were able to identify your feelings...*

John: *Yep.*

Interviewer: *....that helped you.....*

John: *Just helped me.....handle them. Yeah, I was getting ruled by my feelings, and I was just running with my feelings rather than, you know, my feelings were taking control. Rather than, you know, I’m not saying we have to be robots, you know, I’m certainly not a robot, but I was getting control of my feelings.... and so I was, you know, letting them rule me, and it helped me sort of step back a little bit and go, hang on here, I’ve got this feeling of emotion, you know? Where has it come from? Why have I got it? What’s, you know, what...what was I expecting from this situation that didn’t come about, you know, and do I need to be as low or as high about it?*

John seems slightly troubled that he might come across as ‘unfeeling’, but there is no sense in the narrative that emotions should not be felt. Although recent research has shown that among men the commitment to regulating emotion still persists (Robinson & Hockey, 2011), John dissociates himself from discourse about ‘men controlling their feelings’; he is not a ‘robot’, and he describes himself as ‘a feelings person’. He talks of ‘getting control’, but the ‘awareness’ he subsequently refers to is a better reflection of the process he goes on to depict. The process John depicts resembles how thought records are commonly applied in CBT practice. He notes the situational context, judges the intensity of the emotion, notes his associated thoughts, and counters the thought with a more positive, alternative response (DeRubeis, Webb, Tang, & Beck, 2010). He describes intense emotional mood swings, yet recognises that registering, in the moment, that feelings are present is important (“hang on here, I’ve got this feeling of emotion”).

Like Matthew, John says he has been helped to “step back a little bit”, conveying how his increased awareness and consciousness has enabled an amount of detachment and a broader perspective he did not have previously. John describes this

process as preventing him from being ‘ruled by his feelings’ and ‘running with his emotions’. The aware and discerning new position is contrasted with one wherein control was perceived as being exerted upon John by the feeling state. As in the narratives of Matthew, Peter, and Joe, gaining awareness of the content of his thoughts is significant, specifically, John’s “*expectations*” of a given situation, and the analysis of whether the intensity of his emotional response was warranted. Like Joe, John uses the technique to assist him to “*handle*” his emotional responses in the workplace environment, and implies that although feelings will continue to arise he still has agency to respond in a number of ways, or as John previously put it, “*choose to take that path*”.

Although within contemporary society being ‘in touch’ with one’s feelings is considered important, even more crucial is the ability to manage emotions effectively to prevent them from causing problems in everyday life (Robinson & Hockey, 2011). John goes on to speak about the necessity of being “*mentally tough*”:

John: *So you’re sort of trying to gauge...it was just really interesting studying my moods and feelings..... and what was triggering, I mean this job of [job title] is up and down, in and out, you know, you go into a meeting, you think it’s going to go this way and it goes that way, you know, you think you’re going to close some deal that’s worth 20,000 dollars and you don’t, so it can be real...you know?*

Interviewer: *I can imagine.*

John: *Knocks you around a bit. So you’ve got to be fairly mentally tough, and I found it very hard to work because at the time I was very mentally fragile. So the CBT was good.*

John contextualises his emotional distress as ‘part and parcel’ of the unpredictable nature of his work, making the management of his emotions particularly useful. John speaks of “*studying*” his feelings, carrying through the theme of CBT as “*an analytical approach to feelings*”. He alludes again to judging the ‘appropriateness’ of the intensity of his emotional responses by ‘gauging’ his moods and his feelings, exploring the thoughts that were “*triggering*” them. John uses imagery to convey his experience of therapy:

John: *What it did for me.....it got me standing back on my own feet and feeling in control. I didn’t feel like...I no longer felt like I was just getting blown willy nilly around the world. I was actually.....I could stop and I felt like I had a sail, you know? Instead of just launching my boat out in the Hauraki Gulf and seeing where the wind blew me, I was actually, you know, taking a path and yes, if the wind blew me I fed my sail out a bit or tightened it up.*

The metaphor of sailing that John uses connotes a feeling of freedom and a sense of mastery. It reiterates the importance of awareness and an acceptance of ‘what is’ (the winds, signifying stress). John conveys with this image his appreciation of the skill he gained to ‘take a path’ and exert an influence on his environment. The image suggests a more aware, deliberate, and agential actor. “*Standing back on my own feet*” conveys the idea of stability and a kind of centeredness. There is no suggestion that feelings should be controlled in the actual sense of the word. Rather the emphasis is upon awareness and comparative understanding, and a *feeling* of being in control. ‘Control’ is depicted as a measured response to external conditions. Recent research has evidenced that “emotional control need not be due to concerns about maintaining a macho image, but might be concerned with attending to the ‘climbing tasks at hand’ or avoiding danger” (Robinson & Hockey, 2011, p. 155-156). This idea is reflected in both Joe’s and John’s narratives as they describe using their therapy experiences to assist them to maintain their emotional equilibrium when faced with workplace stress.

In these participants’ narratives, self-awareness and self-understanding are emphasised and pointed to as greatly contributing to the difference between the ‘self’ prior to and after therapy. The narratives depict increases in self-awareness and self-understanding as having enabled the participants to stand back and observe their habitual thoughts, feelings, physical sensations, and behaviour as they relate to a given situation, from a broader perspective. In this regard, the narratives depict the fulfilment of what has been posited as CBT’s objective; “the aim of CBT is to understand both the client’s personal domains and their idiosyncratic way of appraising events” (Wills & Sanders, 2013, p. 6). While the newly acquired skill of self-awareness is depicted as assisting the management of emotion over the long-term, self-understanding is represented as revelatory and transformative, and facilitative of enabling participants to let go of old patterns and the past and ‘move on’.

Drawing on CBT Techniques

Some of the narratives suggested that participants sought practical strategies to cope with their emotional distress. This sits well with the CBT approach as it provides a number of techniques and skills for the client’s assistance (Moorey, 2012; Wills,

2012). Previous post-treatment accounts from CBT clients have reported that they valued the feeling that something could be done about their problems by applying the techniques they had learned in therapy (Nilsson et al., 2007). Similarly, these participants expressed that they valued the practicality of CBT and the sense that they had received something tangible and useful from their experiences. The participants speak about a variety of CBT techniques that they use to assist them to change and to cope with their internal responses, and modify their behaviour.

Joe spoke about how his awareness of his internal processes had increased since therapy. He went on to describe how he combined his newly acquired awareness with therapy “tools” to cope with the stress he was experiencing. The following extract is taken from Joe’s narrative as he explains that ‘tools’ were precisely what he had hoped to gain from his experience of CBT, and compares this with prior counselling he had received:

Joe: *As I say, it was like night and day between the two styles cos the guy that I saw pre-the blow up, I went round to his house and he’s obviously a counsellor. That’s what he does for a living. But it’s like he didn’t give any tools of how to deal with what was on my mind. “Okay, I want some tools. I wanna go away with something that I can practically use rather than just talking about stuff”. He goes “Yes, yes, well, you might wanna think about this or do that.”*

The idea of therapists or counsellors just talking and not really giving anything, and therapy being a waste of money, also appeared in John’s narrative. John told how he had had other forms of therapy in the past and the reasons why he preferred the CBT approach:

John: *....and it really worked well for me [CBT], cos I’d tried a few other counsellors and stuff over the years and it just was....like I went to one guy and after two sessions I said “mate....I think you’re just sitting there and charging me two hundred bucks an hour. I might as well talk to a wall! You’re not really...you know, trying to help me you’re just trying to drag me down further so you can spend longer getting me out. And he didn’t take that approach very well. He thought I was being a real prick. We had a bit of an argument and I refused to pay his bill.....but anyway.... (laughs) yeah, but anyway, I just sort of felt, yeah, it was you know, I can’t remember how long it was. It was like 8 weeks or 12 weeks. For me, it was, it was...I wanted it to be more supportive and less combative, and all the rest of it.*

The sense from the narratives is that Joe and John believed that CBT was a preferable approach because it focused on what could be done about a problem,

rather than ‘just sitting around and talking about it.’ The latter is an often held popular perception of therapy, but Joe and John recall that CBT gave them the sense that they were taking away something substantial and useful. John implies that he found the CBT approach supportive in comparison to his previous counselling experience which he described as “*combative*”. It is possible that John found CBT supportive by comparison because the majority of CBT approaches aim to be collaborative, and therapists share the therapeutic model with clients so that in the event of relapse the client has the skills to address the problem themselves (Dobson & Dozois, 2010). John alludes to this educative aspect of CBT when speaking about his therapist’s approach:

John: *We didn’t just sit there and yak, yeah? She almost treated like a science. It was quite.....yeah....at that time it was what I needed.*

Joe referred to ‘automatic thought records’ that he had brought with him to the interview. He discussed the effectiveness of using these records as a prompt to question the validity of his thoughts by putting them into one of two categories:

Joe: *Helpful versus unhelpful thoughts, identifying the situations and thoughts are related to helpful or unhelpful thought analysis. So, unhelpful things might be delving into why did you do that, and you should’ve thought of that, and you should’ve done that better. Then that goes downhill from there into self-esteem issues, you’re useless and I still do have a self-esteem issue, which I know I have to deal with at some point. My self-esteem still isn’t brilliant.*

Interviewer: *Did that come up in therapy?*

Joe: *Probably did but I thought the therapy was more aimed at dealing with the situations I was faced at in a work environment. It was more focused around that.*

Interviewer: *And did you drive that focus cos that’s what you wanted?*

Joe: *I suppose to some extent I did.*

Joe uses CBT to explain how by conceptualising his thoughts as either ‘helpful’ or ‘unhelpful’, he could quickly assess the usefulness of his thoughts in a stressful situation. The implication in the narrative is that before therapy, Joe was immediately identifying with his negative automatic thoughts. By conceptualising his thoughts this way he gains agency by being able to step back and take a critical view of his thoughts, questioning their validity rather than simply accepting them as true. The theme of his unhelpful thoughts seems centred upon responsibility (“*should’ve*

thought of that and you should have done that better”), perhaps reflecting the unrealistic expectations Joe perceives his manager had of him.

Although Joe seems unsure about how much of the focus upon work-related problems came from him or his therapist, the prioritising of present problems is common among CBT practitioners, who in general, only ‘delve’ into deeper issues if and when required (Beck, 2005; Mansell & Taylor, 2012). Joe refers to self-esteem as a problem that remains unaddressed, indicating his identification with cultural discourse about the value of high self-esteem (Blyth, 2008; Rose, 1996). It was his understanding that there would be opportunities for him to address his problem with self-esteem in the future. Joe went on to tell how after becoming more sensitively attuned to what was occurring for him internally, and adept at breaking down the ‘problem blob’, he was given “*catch phrases*” (which he subsequently refers to as tools), questions, and “*little realisations*” by his therapist, that were useful for reducing the intensity of unwanted emotional responses. In the extract below, he tells how he uses such a ‘tool’ to anticipate stressful moments:

Joe: *But when I came here I did get little phrases and the person I was with, she gave me little catch phrases like and questions as well and little realisations like, “If I say no then it creates internal conflict or guilt.”*

In the following extract Joe blends the use of the five-part model with catch phrases that he uses as ‘tools’:

Joe: *So, then I feel I hadn’t foreseen the problem. I hadn’t taken any action, basically. So, then what was I feeling? I had a tightening and nervousness. I had moderate stress of 50%, feelings of uselessness. I should not feel this as it is okay to ask questions and to take actions if required. That was my moods and emotions. My behaviour... I realised I was getting defensive and tried to self-talk myself; “listen and don’t get defensive”, that’s what I was saying. “If things are wrong they may not be my problem.”*

Joe uses the five-part model to assist him to respond differently in given situations at work, and to become aware of problematic internal responses which he counters with “*self-talk*”. Joe had initially appropriated responsibility for the problem, leading to defensiveness and an inability to ask for help or take action. The conceptualisation is depicted as providing the understanding and clarity he required to appreciate how the problem had been generated and was being maintained. In turn, this opened up some

space for Joe to ‘insert’ more helpful thoughts into the cycle and thereby produce different outcomes (“*I should not feel this as it is okay to ask questions and to take actions if required*”). By conceptually separating the problem from his own feelings of culpability he depicts himself as overcoming his defensiveness and approaching the situation constructively and methodically. Joe’s method of using the five-part model in combination with catch phrases as ‘tools’ is a creative use of the skills he learned in therapy. Clients modifying the skills they have learned in therapy to suit their own needs is a theme that had been observed emerging in a number of qualitative outcome studies (McLeod, 2011).

Interviewer: *It sounds like therapy here enabled you to anticipate how you were going to react when something happened so you weren’t caught off guard by your response.*

Joe: *Yeah, pretty much. Cos I had these phrases. I don’t remember them all but they obviously soaked in. Another one is, “I can’t control everything,” which sounds pretty simple. You might think, that’s pretty obvious, but I was taking everything on board and thinking that when something went wrong it was my responsibility and I was wearing the guilt and the responsibility for all of that. Just having that phrase, “I can’t control everything,” and I still use that. I use that phrase every day pretty much because there’s always things you can’t control. There’s always things that are out of your control and even though you’re a manager [pause]*

Interviewer: *And you’re supposed to be in control.*

Joe: *Supposed to be in control, but there’s some things you can’t control. You can’t control what everyone does for a start. You can put processes and ask questions and do all those mechanical things but there are still things that you don’t anticipate. Other things which were quite specific about, like I was taking work home as well so just having demarcation for work to say, well, when I leave work I can do it tomorrow so I have another phrase, “I can do it tomorrow. I’ve done a fair day’s work, there’s always more to do.” That was very useful and one of the tools. She said to write everything down before I left work, that unloads the brain and you leave stuff at work. That’s a last activity. I don’t do that every day by the way, but sometimes when I’m really busy I realise, hey, I’ve got a lot swimming round in my head, the best way to disconnect from work is to actually write everything down. I found that a valuable tool. Little practical things like that. So, what I got out of this place here, I think, was in the approach, just those phrases, I guess, realisations and the consolidation of chat and coming down to realisation of sound bites, if you like. Those were good.*

In the extracts above, Joe tells how ‘tools’ in the form of phrases assisted him to combat the effects of his emotional distress. He constructs the therapy ‘tools’ as quick, pithy, ‘don’t think like that’ phrases and affirmations of sorts, that help him when he’s under pressure in work-related situations. It is apparent in the narrative that Joe’s sense of responsibility extended beyond his sphere of influence. His catch

phrase “*I can’t control everything*” is a tool specifically designed to avert stressful responses to implicit workplace pressures or situations that can’t be controlled or anticipated. By relinquishing the desire to control, Joe is able to successfully reduce the problem to manageable proportions. The narrative portrays him as a stressed project manager, having to ‘take things on board’. If something went wrong it was his responsibility and he “*was wearing the guilt*”. There is something telling about the number and content of Joe’s ‘sound bites’: “*I can do it tomorrow*”, “*I’ve done a fair day’s work*”, “*there’s always more to do*”. These phrases constitute counter-rhetoric to combat a sense of being over-burdened with responsibility and the guilt he experienced. Joe subsequently states that there is “*no point in feeling guilty because I’m only a part of the chain.*” His narrative continues as he discusses the benefits of using these tools:

Joe: *But I don’t hook into the actual problem and I think that’s the difference. I haven’t hooked onto it and been towed along by the problem and I think it’s getting that disconnection – there’s a problem there but how much it troubled me was up to me. I could let it trouble me a lot by letting it tow me along or else like a trailer I could disconnect myself and wait to connect myself back up when I wanted to be connected up. It’s still a problem, it’s not saying it’s not a problem, it’s not being in denial, it’s not denying there’s a problem, it’s just that ...*

Interviewer: *How you’re going to respond to it.*

Joe: *How you’re gonna respond to it...I’m part of the solution and need more info from others. So, knowing that I’m part of the solution and not **the** solution, I think, that’s where a lot of the problems I deal with I’m only part of the solution. I’m not **the** solution, it’s really easy for me to get into that trap – I’m the solution, I’m the solution, I need to fix, I need to fix. It’s getting out of that was quite useful, too, just knowing that I’m only part is really freeing, it’s another good, positive result.*

The repetition in Joe’s narrative may make the tone seem frantic to a reader. My recollection of Joe, however, was of a person with a calm demeanour. Joe talks again about tools as phrases, such as “*I’m part of the solution, not **the** solution*”. He states three times that this approach is not a denial of the real problem. Seeing himself as part of the solution rather than part of the problem does not negate the existence of the problem, rather, it enables Joe to avoid ‘hooking into’ the problem as if it were his alone. He is thus able to exert agency, and focus on contributing to the solution. As he mentioned before, tools were precisely what he wanted from a therapist but had never before obtained. These tools act like discursive resources for him, ideas that he repeats almost like mantras to contend with his thoughts, emotions, and

behaviour in the pressure of the social context. Joe is self-aware and accepting of the fact that as a project manager, he will inevitably be provoked from time to time as he interacts with other work colleagues and customers. He accepts he cannot control a situation, but he still has the agency to interpret the meaning of events differently. Joe spoke about how therapy assisted him to establish a work-life balance:

Joe: *So, by that stage I'd already had some sessions here so I was trying to apply what I'd learnt and had some success, I might say. So, that was quite good. Did an experiment – leave work at work, emails and planning at work. I'll replace that with other things, I play music so did music and relaxing with my wife and thinking about worrying doesn't attribute to a different outcome. So, that was actually a good phrase as well. I try not to think about work away from work, that doesn't always happen but most of the time. That's actually a really good phrase, 'doesn't contribute to a different outcome', because I realised I was worrying about a lot of things and because I'm a processor and I process so much, that processing wasn't changing the outcome. So, that was a really great tool.*

Interviewer: *That was an insight.*

Joe: *That was an insight, yeah, and that was a clear tool from the sessions here. Then I had some outcomes.*

Again, there is a strong sense in Joe's narrative of the practical nature of CBT. The experiment he conducted may or may not have been explicitly agreed upon between Joe and his therapist. In any case, it seems in order to help him undertake the 'experiment', Joe used the "*doesn't contribute to a different outcome*" 'tool' to counter what he describes as an aspect of his own cognitive style: "*I'm a processor*". By saying to himself that the outcome will be no different, Joe effectively forestalls the over-processing of task-related information by using task-oriented vocabulary. Interestingly, although I can see in the text that for some reason I tried to conceptualise these tools as "*insight*", Joe corrects me and is quite clear and restates that these phrases are "*tools*" that he can use in a practical sense. As Joe put it:

Joe: *With the tools that I'd got, I was able to change my ... when I look back I think what changed was I changed my thinking more than anything and my reaction to things.*

Joe sought assistance for ongoing stress in the workplace environment, and because the stress at his work was unlikely to change, he needed practical help to deal with his internal responses and behaviour. He portrays the initial phase of therapy as being a process wherein he developed increased awareness of his internal responses using

conceptualisations he learned in therapy. These assisted Joe to deconstruct the ‘problem blob’ by learning to recognise physical sensations, thoughts, emotions, and behaviour that were triggered by certain situations. Once he became more familiar with his typical response patterns, he then recognised them as cues to apply the tools or ‘sound bites’ he learned in therapy. It seems that one significant benefit of the tools was that they afforded him the ability to develop a conceptual separation between himself and the problem, defining himself instead as part of the solution. This appeared to create an awareness of his agency to act constructively rather than feeling overwhelmed by the circumstances. The impression Joe gave me in the interview was that he had found the therapy to be highly practical and effective, and exactly the kind of treatment he had wanted according to his statement: “*Okay, I want some tools. I wanna go away with something that I can practically use*”.

Joe’s narrative emphasises a practical approach to problem solving and a kind of ‘fix-it mentality’. New Zealand’s ‘fix-it mentality’, also referred to as the ‘number eight wire culture’, is used to describe a kind of mentality typical of New Zealanders who are creative and use their ingenuity and unconventional tools to complete a task; a cultural discourse that developed during the nineteenth and twentieth centuries when New Zealand was isolated and improvisation was needed to solve problems, and is still relevant today (The Mighty Entrepreneur, 2010). The fix-it mentality conveys the idea that anything can be fixed with a little ‘know-how’, and has connotations of self-sufficiency and being able to solve one’s problems independently. Whilst independence is valued, this does not preclude collaborating to achieve a desired outcome. It is interesting to note that such collaboration has historically included sharing practical tasks and tools, and it is possible that this approach to problem solving may influence how clients interpret what takes place within therapy, and how positive outcomes are produced, albeit with different ‘tools’. McLeod (1997) argues that contemporary therapeutic practices are a reflection of the cultural ideas of the present day times, and that the individual is seen as a mechanism to be ‘fixed’. CBT reflects and caters for a faster paced Western society wherein time is perceived as limited, and there is an emphasis on effectiveness and efficiency, and quick, practical solutions (Dobson & Dobson, 2009).

As both John and Joe had implied, Anne speaks about how she had hoped to obtain “*actual practical strategies*” for managing her generalised anxiety, particularly in regard to changing her thoughts:

Anne: *... what appealed to me about it was that it was techniques that I could learn and actual practical strategies for managing my anxiety myself and maybe changing the way I think about things.*

The extract above suggests that Anne did not expect that the techniques she learned in therapy would be curative. Rather, she speaks of the techniques as assisting her to manage and to be strategic. Notable too is the idea that Anne wants to manage her anxiety herself, expressing her desire at the time to be assisted in a bid for personal agency and autonomy in managing her experiences. She went on to speak of two ‘practical strategies’ she acquired in CBT:

Anne: *... worrying versus problem solving – they were quite related those two but that’s quite a good exercise too, to look at. If something’s not a worry then it’s a problem, and really, everything is broken down into that. Things that make you anxious are either worries or problems and that’s quite good, too. Even for some of the deeper issues that I was worrying about, you can see a problem-solving technique to them and looking at the pros and cons of how you might tackle things and that was quite good, too.*

Anne speaks about the usefulness of discerning the difference between problems and worry. Differentiating between productive and non-productive worry and problem-solving training are commonly incorporated into CBT (Clark & Beck, 2010). Anne tells how she has applied this to some of the “*deeper issues*” she had been worrying about to positive effect. When she constructed her problem, Anne mentioned how she had been receiving long-term psychotherapy for three to four years to cope with these issues and was still engaged in this process. It appears from her narrative that she has had some success applying a skill-based technique to these issues in a comparatively short time. Anne also discussed one way in which she has been able to quell her “*repetitive thoughts*”:

Anne: *Actually thinking about, I guess, I get a bit wound up and have a lot of repetitive thoughts and things and being able to actually say “well, look at what’s going on”. This wasn’t really a technique but, again, it relates to the worry and was identifying “that’s a thought, that’s a feeling”. For me, you know, lots of people get anxious, their whole body gets anxious, they get a sore tummy, and just to be able to say to yourself, and I still practice that one quite often, “that’s just my tummy, that’s just my mind”. Then it’s kind*

of nice cos you're then reclaiming yourself back from that. You reclaim, "well, there's still me. I'm me. That's not necessarily my body. My body's doing things I don't want it to do? Then I'm still me and I'm still here".

Although Anne did not refer explicitly to 'mindfulness', her narrative suggests that she has adopted an approach to coping with her anxiety that typifies a mindfulness approach. She refers to some essential part of herself that is not her mind or her body. The stomach pain, repetitive thoughts, and the anxious feelings, still happen, but are not 'Anne' herself. Anne defines herself by what she is not; "*not my mind*" or her body, "*necessarily*". She speaks about "*reclaiming*" herself from the anxious thoughts, emotions, and bodily discomfort. The noteworthy statement, "*that's not necessarily my body*" reveals the extent to which she is prepared to question the primacy of her physical experience. The "*practice*" Anne refers to sounds similar to a mindfulness approach wherein the individual develops a 'decentred stance' and views thoughts and feelings as no more than passing events in the mind (Dienes et al., 2011). The following statements summarise her new perspective:

Anne: *So, instead, to be able to just say, well, yes, anxious, but that's not all of me. Or, yes, that's my body having an anxious response to something, but it doesn't complete me right now. I'm beyond that. I can rise above that, that's fine.*

Anne's narrative again depicts what is a typically 'mindful' stance in that she describes and open and non-judgmental attitude about what is being experienced (Huxter, 2007). The story characterises Anne as no longer identified with her internal processes and there is a transcendent feel to the narrative. She describes how she is now able to say she is "*beyond that*" and "*can rise above that*". In the extract below, Anne again speaks about how the practical strategies she received restored her sense of personal agency:

Anne: *I think a lot of the stuff about anxiety is actually actively helping yourself change. That feels really good.*

Clare, who had described needing help with multiple stressors, referred explicitly to mindfulness in her narrative:

Clare: *It's about mindfulness, and I read that all through quite thoroughly and I highlighted bits and things. So I keep sort of referring back to that now and*

again. I've kept all the readings that she gave me along the way. So, if I have a bit of a down time...sort of catching myself.

As the mother of a young child, Clare found that her enjoyment of her son had been improved by her use of the practice of mindfulness:

Clare: *Yeah, and I sought of try.....I've got a little [age] year old and I try to catch myself with him, if my mind wanders. Just enjoying what he's doing. Running around the beach or dancing or whatever he's doing.*

Interviewer: *Yeah, that's fantastic.*

Clare: *Yeah. Well she said, you know, "children are really good at living in the moment. That's sort of what we've got to try and do (laughs), as much as you can".*

Clare's narrative also depicts typical mindfulness practice in which the attention is turned to thoughts, feelings, and actions, as they appear in the present moment (Katzow & Safran, 2007). Her narrative is indicative of the idea that in practicing mindfulness, paradoxically, the less an individual is 'practicing' *per se*, because he or she becomes more simply and mindfully engaged in life itself (Fruzetti & Erikson, 2009).

As previously mentioned, Jill had described how prior to therapy she had not connected her thoughts to her anxiety and what she termed as 'panic attacks'. Like other participants, she also spoke about how she had become more "*conscious*" of her thinking since therapy:

Jill: *It's not always conscious to me that I have been thinking something negative. It's usually a feeling, maybe a bit of a tight chest or my breathing changes or something like that first, and then I notice, and now I actually realise and then think about what I was thinking, whereas before I wouldn't. I would just let it run and then get worse and worse.*

Like Joe, Jill speaks about how the first 'signals' that something is wrong are physical sensations. Jill describes how these sensations alert her to the fact that she has been thinking certain anxiety-provoking thoughts. She says that the previous lack of awareness of her thoughts meant that her anxiety would "*get worse and worse*", and implies that there has been a change in this pattern since engaging in CBT. The awareness of her thoughts is depicted as halting this progression. Like Clare, Jill also used the metaphor of a 'wandering mind' to describe not being conscious of thought

as it occurs. She contrasts this with a depiction of herself post-therapy as being more attuned to her thoughts in the present moment:

Jill: *If I start to notice that I'm wandering off, like my brain is starting to think about all sorts of thoughts and catastrophising, then I tell myself, "No, stop it, that's not likely to happen," and then try reframing it and trying to think not to critically.*

Similar to Joe's use of 'sound bites' or phrases as tools to interrupt negative thoughts, Jill tries to overcome her negative thoughts, first by identifying when her mind is "*wandering off*" and then replacing anxious and catastrophic thoughts with alternative, more realistic thoughts. Although the therapist's specific input is unclear, a critical part of cognitive assessments of panic is the identification of the "primary catastrophic misinterpretation of internal sensations" (Clark & Beck, 2010, p. 310), and this may have been identified in therapy. Rather than a mindful approach, Jill depicts combining her conscious awareness of her thoughts and recognition of when she is "*catastrophising*", with "*reframing it and trying not to think critically*". This aligns with CBT theory in that change is said to occur when clients become aware of their automatic thoughts as they happen, and make a conscious decision to change their thoughts in the present moment (Abbatiello, 2010). Clients are encouraged to become aware of and modify thought by identifying "situational misappraisals" and generating "alternative, more evidence-based appraisals" (Craske, 2010, p. 1; Neenan, 2012). Jill described how she combined this technique with another to cope in these situations:

Jill: *I practice my breathing, keeping my breathing steady and trying to think, reframing my thoughts and stuff like that now... that I didn't do before when I was having a panic attack. Also concentrating and remembering to be in the moment and not thinking too far ahead.*

Some CBT practitioners provide 'breathing retraining' to anxious clients to assist them to replace rapid shallow breathing with slower and deeper breaths, to promote a sense of relaxation that may reduce the anxious state (Clark & Beck, 2010). Jill speaks about the technique positively, and tells how she combines this technique with reframing her thoughts and "*remembering to be in the moment*". She draws a distinction between her experience of panic prior to therapy and how she is

positioned since therapy due to the skills she acquired. She also described how since CBT, she now anticipates situations where she may feel anxious:

Jill: *Now, I'm actually thinking, that's the situation where I may feel uncomfortable, so, before that putting some techniques in place to make myself feel more comfortable. Before that, I would just go into the situation and then panic because I didn't know how to cope with it. I think I was probably avoiding things before but I didn't realise why. Before that, I was just trying to say, "Stop it, stop it, don't be silly," to myself but now I actually notice that I'm getting anxious and I actually put in place stuff before I get into that situation to help me cope better.*

Jill depicts how she uses the acquisition of therapy techniques to move herself from a position of vulnerability and powerlessness over her anxiety, to one wherein she feels able to “*cope better*”. She describes herself post-therapy as anticipating when she may feel “*uncomfortable*”, but as having techniques ‘at the ready’ to pre-empt or assist any discomfort. Similar to how Anne constructed part of her problem, Jill also spoke about what she perceived were the negative effects of her anxiety on her relationships with others, and how using the deliberate modification of thought as a technique was useful in this regard:

Jill: *I think maybe before it would be if I started to get panicky I'd be, "You always do this. You always muck this up and people will be disappointed with you"; that sort of thinking going around and around. And then I notice - maybe not straight away - but maybe I start feeling a bit tense and then I notice, and then I think about what I'm thinking and then I go, "Oh, I shouldn't be thinking like that. That's not helpful". Then I employ my technique to help. It's not straight away - negative thought – "I'll try and cancel that out". It's actually a bit of time starting to feel a bit anxious about it and then going, "Oh, I must be thinking something wrong", and then thinking about what I was thinking and then fixing it.*

The idea of practicality emerges again as Jill talks about “*fixing*” her thinking by employing her technique. She also refers to being alerted to the fact that something is wrong by first noticing that she is starting to feel “*a bit tense*”. As before, she speaks of there being a delay between noticing this tension, questioning her thinking, and identifying the troublesome thought. Jill speaks about the additional strain of criticising herself and feeling as if she disappoints people. Anne had similarly spoken about how her anxiety had affected her relationships, and how she had hoped that CBT might assist her by teaching her to cope with her anxiety so that she might

become a better partner, sister, and daughter. The narratives illustrate how the effects of a client's anxiety on their personal relationships may be of significant concern to them.

Joe also spoke about receiving a thorough summary letter of techniques to assist him after therapy and how, indirectly, Joe used one CBT technique - identifying 'black and white thinking' - (Dobson & Dobson, 2009) to assist him with a problem around personal relationships that involved a kind of moral dilemma:

Joe: *I had these, I think this was my very last set of notes that I took and she followed up with a typed out version of things.*

Interviewer: *Like a summary letter or something?*

Joe: *Yeah, summary letter. I've got all these things: identifying of situations, the thoughts I related, helpful versus unhelpful analysis, worry versus problem solving, stepping back to see if it's a problem, noticing that one problem can have both types of analysis, use my filter, I was taking ownership when I didn't need to, I'm not the only factor, realisation I can discuss this without personal attachment and feel good about it. That was another thing cos I took things personally. Catching the unhelpful thinking, what are all the influences into the situation, it's great not to check work emails, keep a work/life balance, don't check email at home, I can monitor stress but rating it – that was another thing I did through here – rating stress.*

Interviewer: *That was helpful?*

Joe: *That was very helpful, yeah. Acceptance of good and bad, instead of forgiveness. Another thing was forgiving.*

Interviewer: *What was that about?*

Joe: *Basically I don't really forgive people to cut a long story short! Once crossed, that's it. It's finding that area where there's an acceptance, accepting there's good...people do good things and they can do bad things.*

Joe went on to explain how therapy techniques assisted him to come to the "realisation that I don't have to be black and white" about people; he could accept they were both good and bad, and this relieved some distress he was feeling from old hurts he had experienced within his personal relationships. He creatively adapted the cognitive technique of identifying black and white thinking and its consequences to explore an area of deep personal significance to him to positive effect. Joe went on to describe how identifying black and white thinking was also useful in producing the positive outcomes he had experienced in respect to his work pressures:

Joe: *It is, and I guess through the therapy it was just And part of why I was having all this stress was because I was thinking, "it's my fault, it's my responsibility", and that's the black part. It's seeing it as black. "Yeah, that's mine, I should've fixed that. I should've known about that. Why didn't I do something about that? I should've done better there, da da da."*

Joe describes how after he understood that his habitual, unquestioning acceptance of full responsibility was ‘black’, he then identified self-recriminating thoughts that sprung from that conclusion.

In addition to the use of CBT techniques to gain awareness of thought processes, participants used techniques to gain awareness of the physical sensations they experienced when they were distressed. At the time therapy commenced Matthew attributed his anxiety and panic attacks to worrying about what people thought of him. He had experienced debilitating and frightening panic attacks in social situations on a number of occasions. Matthew tells of his experience of having a panic attack deliberately evoked within a therapy session, and how the exercise assisted him to explore and bring conscious awareness to the internal processes that typified these attacks:

Matthew: *One of the things we did in the session was go through the stages on an anxiety attack and basically what it was, and then did some exercises to make myself sort of try and hyperventilate and basically point out that it’s a physical reaction. It’s something you can actually sort of get on top of. That was very helpful, just knowing that that’s the steps....how it all works, what it leads to and be able to catch it early. That was very, very helpful - haven’t had an anxiety attack since. Had a very bad one sort of half way through our sessions and that was quite helpful because we broke it down. Though I couldn’t stop it from happening, I was very aware of what was going on. So that was quite good being able to come to the session and go through that stage by stage of what was happening. But that was the last one I had and that was probably about at least two years ago.*

In the treatment of CBT for panic disorder, symptom induction exercises are considered important because “they allow direct activation of threat schemas and opportunity to challenge catastrophic misinterpretation of bodily sensations” (Clark & Beck, 2010, p. 315). As many of the participants did, Matthew conveys how becoming more sensitively attuned to his internal processes was of particular value to him. As Joe had similarly stated, Matthew describes the process as helpful in that it “*broke it down*” for him. He became aware of his physical sensations, breathing, and was “*very aware of what was going on*”, and the narrative suggests that exploring the experience of panic “*stage by stage*”, somehow demystified the process for him. Again, there is an emphasis on awareness of internal processes as the pivotal factor for change. Matthew also spoke about how he contributed in an active way to the therapy process:

- Matthew:** *I mean I used to....cos I used to got to [shopping centre] a lot, and we [Matthew and the therapist] used to use that. I'd make myself go every day before I came to therapy because it was quite close, and basically test myself to see how I was doing that day.*
- Interviewer:** *That was something that the therapist encouraged?*
- Matthew:** *That was just something that I decided to do on my own. I thought....just after we'd talked about it quite a bit.*
- Interviewer:** *Wow*
- Matthew:** *So I mean, when I used to go there I used to start panicking before I even got in, just the thought of going there, and then I think one day it really just clicked for me. I just walked in and I wasn't actually thinking about it, and it wasn't until I was sort of already in doing stuff and looking in shops and stuff I thought, "Oh!"*
- Interviewer:** *(laughs)*
- Matthew:** *I'm actually really fine with this.*

It may be that the therapist discussed with Matthew the benefits of confronting his own fears. CBT for social anxiety encourages clients to expose themselves to their own fears so that they might be able to process “incompatible information that disconfirms exaggerated threat and vulnerability elements of the fear schema” (Clark & Beck, 2010, p. 238). Whether this was discussed in therapy or not, what is notable in Matthew’s account is the level of initiative and agency he displays.

Anne went on to speak about the effectiveness she foresaw these tools having over the long term:

- Anne:** *[Speaking about her therapist] But actually her attitude to it was, “well, these are tools for life”, so I can turn around that kind of anxiety. I've got this forever, I can do this. These don't go away these tools.*

Anne describes how the “tools” assist her to cope when she is overwhelmed by her feelings, assisting a kind of stoic ‘realism’, and hope:

Extract 1:

- Anne:** *I know I've got a lot of tools to deal with any sort of feeling or thought other than being overwhelmed. I know now what tools to pull out.*

Extract 2:

- Anne:** *That's the optimism and things feel better.*

These participants sought practical strategies and techniques to assist them to cope with their distress. The plots of these narratives were similar to those identified by Polkinghorne (1996) in that they were ‘agentic’, showed purpose, commitment and

certainty about what needed to be accomplished and how it might be obtained. The findings reflect previous CBT clients' post-treatment accounts who have also reported therapy helped them to see something could be done about their problems by applying the techniques they had learned in therapy to cope with them, and contrasts with accounts from dissatisfied CBT clients who have reported experiencing no change or no lasting positive effects from therapy (Nilsson et al., 2007). Participants used CBT techniques to challenge negative thoughts, reduce emotional distress, alter their behaviour, and 'connect' with the present moment, and cope with the effects of stress. They adapted techniques and used them in creative ways, and at times exercised their own agency in their treatment to suit their individual needs. The acquisition of techniques provided participants with a sense of preparedness and optimism about their ability to cope in the future. The participants' appreciation of acquiring CBT techniques may be due in part to the expectations placed upon people in the society we live in, which values personal choice, independence, and the ability of people to determine and exert control over the future (Dobson & Dobson, 2009). The sense from these narratives is that like many clients (Hoener et al., 2012), these participants valued the sense of autonomy and achievement they gained from successfully employing CBT techniques and constructing themselves as active agents in their own recovery. The findings support the idea that it is the client's active engagement with therapeutic interventions that leads to therapeutic change.

Emotional Expression

This study found that although the concept of 'emotional repression' and the need to express one's feelings is not a conceptualisation that aligns with standard CBT theory, this does not preclude clients and therapists from co-constructing a therapy experience that recognises and addresses these issues. Being equally familiar with the cultural discourses that clients draw from to construct their problems, CBT therapists may be likely to validate clients' concerns and willing to accommodate their intended goals which, from a medical-model perspective, do not sit within a conventional CBT framework.

Jane had described how after losing her younger sister she had 'bottled up' her emotions, causing her to 'act crazy' and some disruption in her personal

relationships. As her narrative continues, she speaks about her lack of experiential awareness regarding her emotions:

Interviewer: *And so you're sort of saying that you realised earlier on in the therapy that...that you sort of didn't know...did you say you didn't know what emotions were?*

Jane: *Well, yeah. Didn't know what they were or didn't really understand them. Like didn't understand because I never allowed myself to go through a process of like, if I feel sad, feel the whole sadness....I kind of shut it off when it's coming and be like no, everything's okay sort of thing. Yeah.*

Jane tells how her poor understanding of her emotions was due to never having allowed herself to “go through a process” of experiencing them. The narrative tells how typically, when she began to feel emotional she habitually (and unconsciously) intervened in the process and “shut it off”, telling herself everything was okay. The idea in the story is that emotion needs to be experienced fully and in its entirety. As Jane has already explained in her story, shutting down emotions when they arise may have negative consequences. Like other participants, she regards increased emotional awareness as an important part of the change process. She speaks about needing to feel “the whole sadness”. Jane goes on to describe a process of developing emotional awareness that is very similar to the one John depicts:

Jane: *She gave me emotion.....a list of emotions from...and she gave me calendar and she would tell me to write down in that....like during...it was every two days, like how I felt at lunchtime and situations that caused me to feel that way and the emotions that I had like during the days and stuff like that, Which definitely helped me because it made me think well what am I think....what am I feeling right now? What's the emotion that I'm feeling, and so I kind of...that got the ball rolling in understanding what emotions I was feeling, and the situations I was in that caused that emotion and that sort of stuff. So yeah that was quite helpful, well yeah, it was very helpful because I understood what I was feeling and that sort of stuff.*

Interviewer: *Almost like learning a new language in a way.*

Jane: *Yeah, yeah, and that's when I realised that I didn't really know what emotions were...or understood what they were....when I was doing that exercise because I never really stopped to think 'what am I feeling at the moment?' Yeah. And so it was a good exercise in, like, teaching me emotions. Yeah.*

Similar to John's “hang on here, I've got this feeling of emotion”, Jane tells how she had asked herself, “what am I feeling at the moment?” In both stories there is an initial emphasis upon noticing or registering when emotion is there. Like Joe and John, Jane defines understanding her emotions as being more aware of them and

learning how to make connections between the emotions she feels and “*the situations*” that caused them. Also like John, who spoke of “*studying*” his emotions, she describes the therapy and her therapist as ‘teaching her emotions’, and that she was given a list of emotions by her therapist as prompts. While at one point Jane depicts the therapy relationship as a ‘friendly’ one, here, like John, the dyad is portrayed as ‘teacher-student’. Both narrators point to gaining a more nuanced understanding of their emotional experiences by developing their vocabulary and becoming more articulate on the topic of emotion. In the extract below, Jane speaks about how therapy assisted her to express herself:

Jane: *So if one thing was...something about....if we were talking about [sister's name] sort of thing...what was the most upsetting thing about her death, and then I would tell her and she would be like 'okay, go home and write out the situation about her death and how like the step by step kind of thing of what happened....and then....but then she was like instead of doing it the way I usually do it which is quite cold and I kind of step out from my emotions when I start talking about [sister]. She was like "no, you have to write down the emotions as well that you were feeling at the time and what was going....if you can remember what was going through your head' and that sort of stuff".*

Interviewer: *You mean when....when [sister] died?*

Jane: *Yep, yep, and so then instead of...so I can feel the emotion instead of just bottling it up like I usually do, so yeah, yeah.*

Interviewer: *Right, and so how did you find that as a technique?*

Jane: *Very....it was hard to do it but when I started doing it, it got easier....like it yeah, it took me a while to do it because...but I think it was a very good technique to do because it kind of showed me what I was feeling and kind ofto allow myself to feel the emotion instead of just bottling it up like I usually do and yeah, it was a very hard...hard exercise to do but I think it was...it was a very good exercise and an exercise that I needed to do.*

Jane tells how although she knew what the most upsetting thing was surrounding her sister's death, she would only talk about it ‘coldly’ and without emotion. The idea in the story is that the emotion is there, ‘bottled up’, but she isn't ‘in touch’ with it and can't express it. This is depicted as problematic and why Jane “*needed*” to do the exercise. Jane and the therapist work together to construct another ‘version’ of Jane that is as an emotionally expressive person. Imagination plays a big role in the exercise, as she describes being asked to remember ‘what was going on in her head’ at the time. The exercise involves Jane ‘going back in time’ to recapture the emotion she felt in the past so that she may feel it in the present. The process she describes

involves bypassing familial conditioning by writing down her recollected emotions, which showed her what she was feeling, in turn permitting her to feel the emotions.

Clare reported a similar technique being used in her experience of CBT. A significant part of the stress in Clare's life had been the death of her mother shortly prior to therapy. Clare recalled that her therapist encouraged her to write down the emotions that she had not expressed to her mother before she died:

- Clare:** *There were things that I didn't particularly want to do...like to write a letter to my Mum at the end because I never got to say goodbye to her, and we'd had issues. She was very tough on me, and so in retrospect the letter I wrote...I guess I kind of sugar-coated because I knew I was going to have to read it out in front of... (laughs). But I could have, you know, said a bit more, but there's no reason why I can't do that, you know. Yeah...but yes, so I think maybe just because you're aware it's an audience, you're sort of a little bit more aware of what you were saying. Yeah, and I'd sort of really worked on it and reworked the letter and yeah...*
- Interviewer:** *Because of the audience factor?*
- Clare:** *I think so, yeah, and not that she was making me feel bad or anything but yeah, you know just because you think 'I should say that a bit differently' or....yeah, yeah.*
- Interviewer:** *Yeah, and was that cathartic for you? Writing that letter?*
- Clare:** *It was good. I mean I didn't want to and I didn't think it would help one bit but it did. It sort of...whenever I walked out of the session I sort of felt just like that, you know, the tension had gone...and it was really there after that one because it was one thing I really didn't want to do and I couldn't see that it was gonna help. I thought it's just gonna upset me, and it did, but yeah, it was good, yeah.*
- Interviewer:** *So it upset you initially?*
- Clare:** *It upset me when I was writing it. It upset me every time I thought I've gotta go back and finish writing it. You know, 'I have to do this.' Yeah, and 'I've gotta read it out' and...yeah.*
- Interviewer:** *Gosh, it's powerful stuff isn't it?*
- Clare:** *Hmm, very much.*
- Interviewer:** *But you think it was a good thing?*
- Clare:** *Yes, yeah. I do.*
- Interviewer:** *Hm hmm...in what way? How do you think that helped you?*
- Clare:** *I think it...well... it let me say things I certainly wouldn't say to her face, probably, and I sort of forgave myself for all the things that had happened and had been said, sort of thing.*

My use of the words 'cathartic' and 'powerful' are reflective of the cultural assumption that there is benefit to be had in bringing up and releasing any emotion that might be repressed and unexpressed. In speaking this way I led the conversation and was instrumental in constructing a story or narrative genre that was beginning to emerge, a story about a therapeutic 'rite of passage' that moved Clare from repression to cathartic release and forgiveness. However, upon re-reading the text, it

is apparent that there is significant resistance to this idea in Clare's account. She recalls not wanting to do it, thinking the technique would not help, repeatedly avoiding completing the task, 'sugar-coating' the letter, and feeling "upset" by it.

As Jane's story continues, she describes reading what she wrote out loud to her therapist, her therapist's response, and the insight that she gained from the exercise:

Jane: *Because the homework for the last session was to do that exercise about [sister] and then before that it was...oh, what did we do? It was...because I would still talk to even my psychologist in such a like...intellectual way...even to her, and so I think that's why she made me do this exercise. The last session was pretty much saying what I wrote down...and saying it in an emotional way...and that was hard because my psychologist was crying as well so...(laughs)...but like...it was kind of weird because I wasn't really crying because I already written this out by myself and already had gone through the emotions of doing it, but I still was getting upset and so I...it was quite...to me, like I...I was a bit confused in the last session because I didn't really know how I should feel because she was crying and I wasn't so I was like a bit 'Oh, that's a bit weird.'*

Both: *(laughter)*

Jane: *So 'should I...should I be feeling this emotion too?' and stuff like that...but yep, see I still have that confusion with emotions like if someone's feeling a certain way in a certain situation...I know that everyone has different emotions at different times sort of thing, but I feel 'oh, should I be feeling that as well, should I be getting upset over certain things as well?'*

Interviewer: *What was it like for you to see her empathy for you - for what you were going through?*

Jane: *I didn't really understand it. Like...because I'm not very good with dealing with people that have like family members die. I'm not very good at it. I'm not very good at handling it because I've not handled my sister's death so I'm just like....okay...I found it kind of weird because I didn't understand why she was crying...and then I talked to my boyfriend about it afterwards and he was like "it's because you talked about it in such an emotional way...that some people feel empathy, because usually when you talk about it, you talk about it in such a cold way...that this time you've actually opened up about something and someone feels for it, and so that's...like it's normal" (laughs). And so I realise that now, but I just...I didn't understand it. I thought that...I was...to me, I would have stopped and went over and comforted her because that's what I usually do. But I was like "no, I have to keep going through this."*

The process that Jane depicts in her story enables her to experience her emotion in two phases. In the first phase Jane expresses her emotions, not to another individual, but in writing. Here she speaks of having "written this out by myself and already had gone through the emotions of doing it." In the act of writing about her emotions she becomes experientially aware of them in a context where there is no one else present. Second, Jane talks about how expressing her emotion to the therapist exposed her to the experience of communicating her emotions to another person, "saying it in an

emotional way”, and witnessing an emotional response which made her feel uncomfortable. Her story suggests that she understands her experience as one that provided a path by which she became familiarised with the experience of feeling and expressing her emotions to another before trying the same thing in the ‘real world’. Here, the therapy relationship is depicted as being central to the change process, and illustrates how people are ‘brought about’ in their interactions with others (Hogan, 2004).

Jane describes how her therapist’s overtly emotional response was initially a source of confusion for her because she was not accustomed to eliciting empathy in others. She tells how she experienced wanting to comfort her therapist because she didn’t understand that people expressing their emotions was “*normal*”. Jane observed that shutting down her own emotion by comforting others was something she did habitually. The therapist’s response is represented as having provided Jane with an illustration of her own ‘incorrect’ response, as opposed to ‘allowing the emotion to be’ and experiencing healthy and authentic communication. This is constructed as a crucial insight. She depicts her experience of therapy as relying heavily on the opportunity to express her feelings in the context of a relationship. The understanding Jane speaks of when she says, “*it’s because someone feels for you*” is implicitly related to the ‘Jane of the past’, who had not had the opportunity to witness such a response because the expression of emotion had been ‘shut down’. Thus, Jane constructs through the therapy relationship the socially interactive experience she had never had but “*needed*”, addressing the problem as she perceived it. By narrating the experience this way, Jane may be using the therapist’s empathic response to validate her emotion, making it more ‘real’ to her. Earlier in her narrative when she conceptualises her problem, she noted that it was good to talk to “*someone that was unbiased and that wasn’t involved in the situation*”. In order to accept her therapist’s honest and “*blunt*” opinion, Jane constructs her therapist as “*unbiased*”. By contrast, in this latter stage of Jane’s narrative, the therapist is depicted as emotionally involved, countering the disapproving, repressive ‘voice’ of her family and providing her with a different emotional experience. This illustrates Jane’s agency in extracting from the therapy relationship what she perceived she needed. Jane spoke about how she perceived her new way of being would benefit her relationships and her life:

Jane: *It's gonna make my life so much better. Like I'm gonna be able to handle emotions and handle...like I'm not gonna be in a situation where someone starts talking to me about sister's name] and I'm not just gonna shut down I'm going to openly talk about it and feel the emotions but not get freaked out by it or not....not be scared by it, not run away from it but rather just go through the processes of the whole emotional thing and realise that it's okay to do that...that I don't have to shut down and the way that I've been brought up – it's not my parents fault – but... well it kind of is, but that that's not the right way to kind of do things, not to shut down and not to talk about things but actually to talk about things.*

There is a strong sense of 'before' and 'after' in Jane's narrative. As Peter does, Jane anticipates that the self-awareness and understanding she gained in therapy will have a positive impact upon her life in the future. Jane's understanding of therapy is that it taught her how to handle her emotions in the "*right way*". She juxtaposes this with her tendency before therapy to repress her emotion as "*not the right way to kind of do things*". The therapy experience is depicted as providing her with a guide for future behaviour in social situations, and as a confirming experience that she is capable of going through "*the whole emotional thing*".

In Jane's narrative, popular psychological discourse defines the inappropriateness of her emotional repression, and she can be seen working through this 'deviation' in therapy. This is not a standard technique of CBT and it may be that the therapists shifted out of their established practices to do this, as they as much as their clients inhabit the same broader social context where ideas about emotional catharsis have long been represented as therapeutic. What is clear, however, is that clients may appropriate this idea easily into their own understanding of the experience of CBT. As with many of the other narratives, Jane's story is illustrative of cultural understandings about therapy that were identified by Rose (1996); she perceived that work on her emotions was needed and used therapy as a means to accomplish it. Jane alludes to this idea when she speaks about needing therapy because she had not "*handled*" her grief over her sister's death, and because she doesn't "*deal with emotions*" as she ought to. As well as providing Jane with 'cathartic release' of her repressed emotion, the story describes how through therapy Jane was 'brought about' - in relationship with the therapist - as an emotionally expressive person who can communicate her feelings effectively to others. Jane's therapy narrative and her new 'self' align with cultural ideas about 'repression and release' and 'healthy' individuals who are emotionally expressive people (Evans, 2013; Parker, 2007).

Resolving Identity Issues

When a client has experienced difficult life events, they are confronted with the challenge of incorporating these experiences into their unfolding sense of self, and may use therapy to construct a story about their experiences (Adler, 2012). The ordering of time and events through the act of storytelling provides a coherence and unity that supports the experience of the persistence of a unique self (Angus & Greenberg, 2011). Narratives about identity give form to the maintenance and development of identity (Sarbin, 1993), and “provide people with a sense of order and continuity, in the midst of potentially disconnected or even conflicting life episodes” (Roberts & Creary, 2012, p. 74). The development of a new story can ‘trump’ the old one and provide a path to healing through the individual’s imaginative ability to project into the future (Mullet, Akerson, & Turman, 2013). However, agency through the authorship of new stories does not solely depend on a person’s narrative skill, but is constrained by the client’s personal circumstances and the cultural resources at their disposal from which they might construct a sense of identity; a potential identity has to be a ‘plausible fit’ for a particular client.

It has been noted that the swing toward medicalisation in psychiatry and psychology has implications for clients’ identities as their difficulties become associated with words such as disease, disorder, and dysfunction (Duncan, 2010). Many of the participants in this study identified with cultural discourse that represents emotional distress as a sign of personal weakness or abnormality, evident in their understanding of themselves prior to therapy as “crazy” or “mad”. This understanding was derived from how they might be perceived by others and how they stood in relationship to them. The narratives illustrated how the privileged contemporary idea of ‘personal control’ had caused the participants to take on a significant amount of responsibility for their distress (Dobson & Dobson, 2009), and some narrators allude to a sense of guilt. Participants viewed themselves as having burdened their loved ones with their emotional distress, and spoke of wanting to become ‘better people’ for them. Because of the influence of cultural ideas about the weakness or insanity inherent in emotional distress, it seems from the narratives as if some participants did not feel entitled to be the person they thought they were, or therefore to burden loved ones. This illustrates the defining power of language and discourse from which an individual constructs a sense of self.

The narratives contained ideas about the kinds of personal attributes the participants either thought that they should have or wanted to obtain through therapy. Personal attributes that were desired by participants reflected cultural understandings of the ideal contemporary self which are implicitly or explicitly supported by psychologists; the idea that one should have a secure sense of identity and high self-esteem (Adewunmi, 2013; Rose, 1996). The participants sometimes found themselves wanting in light of these socially constructed ideals and aspired to have more of these attributes as part of their identity ‘makeup’. Many of the narrators described themselves as lacking other psychological characteristics deemed to be desirable: the ability to feel, articulate, or express emotion, or to manage or control emotion. In this regard, the participants viewed themselves as people who were in some way compromised, and they perceived that they needed therapy to become ‘all that they should be’. Participants hoped to and did obtain a number of other personal attributes through therapy. They wanted to become more assertive, more motivated and confident, more sociable people, better fathers, and more competent professionals. They sought from therapy an opportunity to gain self-understanding and develop new ways of ‘being’, and incorporated their experience of CBT into their self-narratives in order to support a reconstructed identity.

The particular therapeutic practice that a client engages with is likely to influence how they conceptualise their problems and come to understand themselves. Participants used CBT concepts to negate the effects of their pasts and the influence of cultural discourse on their sense of self. This validated their experiences as understandable and ‘typical’, allowing them to see themselves in a more compassionate light. The sense from the narratives was that the cognitive conceptualisations were effective in reducing self-criticism and their sense of some kind of failure, abnormality or ‘craziness’. For some of the participants, the act of articulating or ‘admitting’ to their therapists how they viewed themselves - in a relationship in which they felt safe - enabled them to gain clarity and reflect upon the negative self-concepts they had come to accept. Through the relationships they had with their therapists, some participants perceived they had ‘let go’ of or ‘dealt with’ their former self-narratives. Participants used the various forms of self-knowledge they acquired in therapy to retell their stories of identity and ‘move on’ as people who understood themselves differently.

Matthew, Stephen and Peter, had conceptualised identity issues as a source of significant distress. The analysis now follows these three participants' narratives as they continue to speak about the unique ways in which they used therapy to address their issues concerning identity. Matthew had spoken about the anxiety he experienced after a former identity he had idealised became no longer viable. That identity centred on academic achievement, but after a head injury Matthew's academic abilities were left significantly impaired. When this happened, he sensed that a negative identity had emerged that replaced the former. Matthew spoke about the process of reconstructing a new and positive alternative identity. As his narrative continues, he speaks about how a lack of self-understanding had caused difficulty for him in the past. In the extract below, he explains how not having received a medical diagnosis of Traumatic Brain Injury until several years after the event made things more difficult for him:

Matthew: *Basically, again getting an understanding of myself, and you know, why I am the way I am. A lot of it was...cos I went for years without realising that this head injury was the root cause of all this problem, and just knowing that, you know, maybe it's not...I shouldn't put all of this on myself, you know, a lot of the stuff that happened it wasn't really my fault and you know, if I'd known at the time what was going on with my head and everything maybe I wouldn't have made the decisions I made. So, you know, just let it go and knowing the stuff I do now, I can make...I can put a lot less pressure on myself.*

Matthew implies that after aspiring to achieve and failing, he felt personally culpable for his failure. It can be inferred from the narrative that he had felt guilty about 'underachieving', because it was only after he received a diagnosis that he could say, "*it wasn't really my fault.*" The narrative suggests that until that time, on some level, Matthew did not feel he had an 'excuse' for underachieving. His story again highlights the significance and importance of "*getting an understanding*" of himself and the difference self-understanding made to him. By contrast, Matthew had previously described the greater difficulty he had had in attempting to understand the more complex issues regarding his social experiences. He had known he was being 'irrational' and that people weren't judging him, but he 'couldn't get his head around it'. The story explains that his confused state prior to therapy was due to his lack of understanding, and how he established with his therapist that this was what he needed. In the extract below, Matthew uses the metaphor, "*take a step back from*

everything”, to convey the idea that therapy enabled him to gain a broader perspective on the problem and on the resources he possessed to address it:

Matthew: *Yeah, it was...one thing that the therapy allowed me to do was take a step back from everything. I guess it was kind of like a safe environment to put everything out on the table – is probably the best analogy, and I guess I laid out all the aspects of my personality, my life that you know, that I had. Took out all the bad ones – “right, right this is my little deck of cards I’m playing with”, is a good way of looking at it, and then I just added in the things I wanted to and decided to remove the bad aspects of my personality and my life. Yeah, it’s quite a good way of looking at it, actually.*

The impression the narrative gives is that therapy afforded Matthew some breathing space and was a kind of refuge when he became disillusioned and ‘on the back foot’. He refers to therapy as a “*safe environment to put everything out on the table*”. Aroha also spoke about “*being able to put that out there with the therapist and feel that it was safe to do it.*” The sense from the narratives is that the participants would typically feel vulnerable and at risk if they raised their concerns outside of therapy. Matthew’s narrative conjures up an image of the therapy process as being like a kind of ‘stocktake’ wherein he and the therapist performed an inventory of all the positive aspects of his ‘personality’ and life. The metaphor “*my little deck of cards I’m playing with*” suggests Matthew had an appreciation of the fact that he had a limited amount of material at his disposal from which he could draw from and alludes to identity construction as a kind of social competition. In the passage below, Matthew goes on to narrate how after having relinquished his former identity, therapy assisted him to form a new identity he felt good about:

Matthew: *I guess one of the things was even up until recently I’d...I was still defining myself as ‘the academic’. I mean, or maybe not so much defining myself, but I’d lost my identity. I realised that and one of the things I’ve been able to do is having got better I’ve been able to think about what my identity might be and who I am. And having a baby son, basically I’ve kind of gone into “now I’m a dad. That’s me. That’s who I am. That’s first and foremost who I want to be. I want to be the best dad I can be”. So, I mean I’ve been off work for over a year now...stay at home dad and that’s a huge....out of the horrible stuff that’s happened I’ve got this huge positive thing that I’ve been able to do because of it. And I really love to define myself as that person now. That’s, that’s my first, you know, if someone asks what is...”who am I?” “I’m [son’s] dad”. You know, cos he’s....that’s just what I want to be, and you know, ideally I’d love not to go back to work and just look after him fulltime but...as I’m sure many, many parents would like to be able to do (laughs). Yeah, and it’s something I’m very proud of as well ...cos my...my Dad was never around when I was young. He...my parents divorced when I was about ten and yeah, he just sort of ignored us for quite a long time and*

he just drifted off and yeah, he wasn't around when we needed him so the huge thing for me is defining myself as a really good dad, and that's something I strive to be, and through the therapy sessions as well, it's allowed me to be that person that I want to be.

Matthew emphasises his need for a well-defined sense of identity so that should people ask him “Who are you?” he would be able to respond. He states how “*having got better*” he was then able to rethink his identity, and that through therapy he was “*allowed*” to be the person he wanted to be. The identity that Matthew adopts does not require him to disavow the idea of achieving and ‘striving’; he tells how he is proud to be a really good dad, and that he wants to be the best dad he can be. It is an achievement because, as his narrative implies by the depiction of his own father, one can be a really bad dad. This illustrates how identities may be constructed in relation to the ‘other’ in the form of binary oppositions (Woodward, 1997). As Mishler (1999) notes, “one’s claim for a positive identity may be justified by contrasting it with another’s negative identity” (p. 136). Matthew describes how his new identity as a “*really good dad*” is particularly meaningful to him due to his own father’s absence, and he distinguishes his new identity as a virtuous one to take up.

Matthew tells how he has “*gone into*” being a dad, implying a significant perceptual change has taken place. He constructs his new identity as “*first and foremost who I want to be*”, indicating his choice and autonomy in the process. By narrating this identity he reinterprets his past and the distress he experienced as ‘worth it’ because he got a ‘huge positive thing out of it’. His narrative continues as he speaks about what the effectiveness of the therapy ‘boiled down to’:

Matthew: *I think I was surprised at how...how simple...well once it was broken down, how simple it really was. I mean it...yeah...there was a lot to it but I mean, in the end it was pretty straight forward and yeah it was...it was...I think that's why it happened so quickly. I think we tied it to all this information in about how – the worrying for example – how that all works and then sort of processed it all in my head and really it boils down to this, this, and it was like, “Oh, that's really simple. It's really easy to deal with”. So that was...that was, that was really, really helpful. That was probably one of the biggest things.*

Interviewer: *Yeah. So when it boiled down to it, what did it boil down to?*

Matthew: *I think really for me it was just the simple thing is it doesn't really matter (laughs). Yeah, I think that's what I boiled it down to. It doesn't matter what people think of me. It doesn't matter. I guess that was the main thing. It doesn't matter what people...if...they can judge me all they want. I...I'm comfortable with who I am.*

It is implicit in the narrative that Matthew again feels he has a viable position in the social world and more self-assuredness as a consequence. The story suggests that to some extent, no longer caring what people think was contingent upon regaining a sense of positive identity. By stating four times that “*it doesn’t matter what people think of me*”, Matthew sounds a bit like he is trying to convince himself (and the listener) of the fact, and there is a slight tone of ‘me against them’ in the narrative (“*they can judge me all they want*”). The feeling from the narrative is that on some level Matthew may be defending his position. Although societal views appear to be gradually changing, culturally, fulltime fatherhood is still somewhat stigmatised and there is an idea of some kind of failure attached to it. By taking up this role, Matthew evoked a ‘contradictory performance of masculinity’ (Robinson & Hockey, 2011). This may have exerted some strain on him because he did not conform to normative male role expectations (Richmond et al., 2012). Perhaps this is why he refers to the manner in which he embodies this identity as virtuous in comparison to his father. Matthew ascribes moral value to how he enacts his identity, embodying the opposite of parental disinterest or neglect. The narrative is reminiscent of a particular variation of men’s narratives that was identified by Wetherell and Edley (1999), wherein the speaker adopts a ‘rebellious position’ that is invested in the unconventional and celebrates autonomy. The authors argue these narratives tend to depict the strength, determination and courage of men to engage in what may be viewed as potentially demeaning (feminine) activities. In the extract below, Matthew compares his ‘old’ self with his ‘new’ self:

Matthew: *Yeah, I really felt like me again. I didn’t...yeah, I...the person that I...you know, that wasn’t me. The person before that, and before the therapy, I didn’t know who that was. I didn’t like that person. Yeah, I just felt like a completely new me really. It’s a great feeling, and I still feel like that person now, which is great.*

Matthew’s difficult period is constructed as a kind of ‘blip’ that he chooses not to include in his self-narrative. Post-therapy, Matthew is a ‘new me’, but a ‘me’ that Matthew recognises as having existed before all the ‘horrible stuff’ happened, a person who had a positive identity, who could achieve, and who had a sense of purpose. Matthew omits the period when he felt worthless and like an underachiever. Identity narratives often omit significant aspects of an individual’s lived experience (Angus & Greenberg, 2011). Matthew exercises agency through his narrative by

completely dis-identifying with who he had thought he was after his brain injury. That wasn't him, he says. His statement, "*I didn't know who that was*" conveys the idea that this 'negative identity' was unrecognisable in some way, or not worthy of recognition - an idea that is reflected culturally. Similarly, depressed and anxious 'underachievers' with a negative sense of identity are not acknowledged in the media as paragons of Western ideals, unless their identity story develops as Matthew's does, overcoming adversity and a sense of failure, and finding a worthwhile identity and personal fulfilment against the odds. This might be the kind of genre on which Matthew is modelling his own narrative. In narrating his reconstructed identity, Matthew no longer feels 'less than' others, affording him a sense of impunity to their possible judgement. While agency and choice are evident in Matthew's story, the depiction of limited options and potential judgement continue to thread through the narrative under the surface, illustrating how "the way one sees oneself and the way one is seen are profoundly intermeshed" (Robinson & Hockey, 2011, p. 5). In this regard, Matthew's narrative may function to construct agency and choice when forced into a position of limited options.

In a similar vein to Matthew, Stephen had conceptualised his problem in terms of how his illness had impaired his sense of identity. Particularly, he had spoken about being prevented from engaging in activities, socialising and partaking in the self-discovery process that is a normal part of adolescence. Stephen spoke about his therapist's approach to his problem:

Stephen: *I think from memory what she started to do was take me right back to the basics. So, she wanted me to start trying to rediscover myself.*

People with chronic illness often experience a disintegration of their former self-images without developing new identities that they value (Charmaz, 1983). Implicit in Stephen's narrative is the idea that there is a 'self' to discover. Unlike Matthew, who spoke about removing "*the bad aspects of my personality and my life*" to leave only what he wanted to remain, Stephen's metaphor "*right back to the basics*" conveys the idea of rebuilding an identity in a process of self-discovery. As quoted previously, Stephen had described the first steps in his process:

Stephen: *Self-identity and trying to figure out, like I say, what I liked. Not necessarily what I liked, what I'd like to try to see if I liked. What things I would like to give a go and try and develop some type of self-awareness.*

Crossley (2000a) notes that when chronic illness disrupts a person's taken-for-granted expectations, "the importance of narrative comes into effect, as the individual attempts to 'reconfigure' a sense of order, meaningfulness and coherent identity" (p. 528). The intention to reconfigure a coherent identity is evident in Stephen's narrative as he recounts how his therapist began to encourage him to explore who he wanted to be:

Stephen: *What she did was exercises to start getting me to figure out what I liked and where I would see myself. Things that I would potentially wanna do and it was a little bit scary at the start because they all seemed to revolve around something academic. They seemed to revolve around what I wanted to do as a career, what I wanted to eventually get as a job and that's only because that's what my life involved. That's what my life had been narrowed down to. I wasn't happy and as I started to realise that my life had been bottle necked or cone-shaped now, I wanted to start to figure out what I liked. Like I say, exercises to discuss values, morals and what really got me going.*

Stephen depicts his life as having become "bottle-necked" due to the restraints of his illness. He recalls that to counter this, the therapist gave him exercises to encourage him to think about what he might like to do and where his future might lead, which involved discussions with his therapist that explored his values and morals. It has been noted that attention to morals in therapy removes the focus from the individual self, and refocuses attention on the relationship between the individual and the cultural environment (McLeod & Lynch, 2000). The narrative implies that these discussions helped shape and motivate Stephen's ideas about what he might like to do and 'where he could see himself'. The successful development of Stephen's identity is associated with activity; "*the things I would like to give a go*". This realisation seems to have been a catalyst for change insofar as he began, with his therapist's encouragement, to imagine that his life could be different based on committed action that sprang from his values. While once he had been strongly identified with his illness, the narrative suggests that the process of therapy entailed assisting Stephen to conceive of a self quite independent of his illness. Having explored ideas about 'what really got him going', Stephen tells how he and his therapist moved on to discuss the barrier of his symptoms:

Stephen: *Then I started to see that this could have some potentially very, very cool benefits and it could be very, very helpful and we moved on to ways of dealing with the symptoms. Once we'd done the finding out who I am, what I wanna do, what potential activities I could engage in, I think the barrier was ... I kept saying to her, "But I still have these symptoms." And she made it very clear that we were not in therapy to get rid of my symptoms, the purpose of therapy was not to figure to why my symptoms were here and to get rid of them. They were to take them with me and to allow me to be able to live a somewhat normal life – I'm gonna say normal – with these symptoms in tow.*

It appears from the story that Stephen's therapist tried to contextualise his illness within the broader narrative of his life. Stephen may have been assisted to see that he was more than just his illnesses and that these need not necessarily dictate his life, that it was possible to think about alternative ways of responding to illness. When healing by necessity has to incorporate living with chronic illness, it cannot be reduced down to matters such as curing disease or taking away the pain (Mattingly, 2007). Another shift is evident in the narrative wherein Stephen moves from being unable to imagine being integrated into a normal life, to imagining a "somewhat normal life...with these symptoms in tow." The metaphor "in tow" conveys the idea of the diminishing significance of the symptoms, despite their persistence. Also diminished is the sense that Stephen's identity is defined by his illness. Stephen described how, in order to facilitate this process, his therapist assisted him to manage the symptoms:

Stephen: *She developed ways of me managing the symptoms while going ahead with these activities. My big apprehension, again, through that time was I just don't understand how I can do these activities with these symptoms that I've got. I couldn't understand it, I didn't know how I was supposed to function with them. One that stuck in my mind is the Z pattern that she drew and she said that as a thought comes in about your symptoms, to let it flow down this Z line and straight back out. She said, "You're allowed to see it but you're not allowed to engage with it," and that was something very, very useful. I found that I – and this, again, probably comes from a life of chronic illness – I felt that I was constantly checking in with my body. So, I was constantly saying, "Right, how does this feel? What's this symptom level at right now? What's this symptom level at right now?" I was doing mental checks which all took split seconds to be able to do but I was certainly doing it and quite regularly. She helped me to disengage from those as well.*

Interviewer: *Was there a turning point or was it more gradual?*

Stephen: *Very gradual, I would think, very, very gradual. But as the years went on I felt that I was becoming more confident. But most certainly gradual.*

Stephen tells how the combination of finding out ‘who he was’ and being assisted by his therapist to find ways to cope with his symptoms freed him and reinvigorated him to try out new activities and to “*move on with these symptoms*”, but that this was a “*very, very gradual process*”. Stephen spoke about being able to put into practice what he learned in therapy:

Stephen: *Don't think I'd known anything else for so long and, like I say, I think that my life had become so simplistic over those years that I simply didn't think it was possible to reintegrate me back into a normal life. And, I know with the gut symptoms, for the first year or two, I couldn't see how I was supposed to live outside of the home life as well. It does take you that time to become familiar with it and to know ... nothing about it is normal – about the gut symptoms or these other symptoms I got was normal – but it just took me time to be able to realise what was okay and what was manageable and to be able to draw a boundary and say, “Right, when my stomach is this sore I can still go out and have a good night out with friends and be absolutely fine. But when it's over this threshold sore, it's probably not reasonable to expect to be able to go out and be out till three, four in the morning.”*

As he had done at the beginning of his narrative, Stephen again refers to “*a normal life*”, and his narrative indicates it took some time before he realised that the ‘reintegration’ he referred to earlier was possible. Crossley (1997) notes that “most people reconcile with their illnesses” and that “reconciling oneself to illness differs from accepting it” (p. 47, 48). Reconciliation to the idea of chronic illness, perhaps particularly when a person is relatively young, is unlikely to be a quick process. The tone of reconciliation in Stephens narrative seems to be associated with his post-therapy ability to live a relatively ‘normal life’, now that on occasions his symptoms are manageable. Stephen describes how he now experiences some sense of agency within the limitations imposed by his illness. Charmaz (1983) describes the positive effects of regaining agency in the following way: “As long as an individual feels that he or she exercises choice in valued activities and some freedom of action to pursue these choices, everyday life does not seem so restrictive, suffering is reduced, and self-images are maintained.” (p. 172).

Similar to Matthew’s narrative, the impression given in Stephen’s story is that the management of symptoms facilitated the primary goal of developing a reconstructed sense of identity. Regaining the agency to explore or ‘create’ his identity appears to be a significant and positive outcome for Stephen. Crossley (1997) notes that

“controlling illness means controlling time and, moreover, emerging identity. By controlling identity, people maximise self-worth. That means keeping illness in the background, rather than the foreground, of their lives” (p. 45). In Stephen’s narrative, the perception that illness now holds a less prominent position with respect to both his experience of life and his sense of identity is evident. He summarises the benefits of therapy:

Stephen: *Now that I’m having to find all these things out now, she’s helping me to manage that and also to be able to piece my life back together and find out what it is that I enjoy.” Those are the main things that I feel like I’ve gotten out of the therapy sessions.*

The stories illness-sufferers tell offer them a way to make meaning out of what is otherwise unthinkable or un-interpretable, allowing them to assimilate their illness experience into their lives (Mattingly, 2007). Stephen narrates his movement from a position of hopelessness and scepticism, to one of reconciliation, relative agency and optimism. He depicts his therapist as playing a pivotal role in his experience of change. He characterises her as a “*mentor*” that he had “*tremendous respect*” for, who provided persistent encouragement when Stephen could not conceive of a normal life. He metaphorically describes the change process as one of integration - ‘piecing his life back together’. His narrative conveys how for people with chronic illness, returning to a ‘normal life’ is the symbol of a valued self (Charmaz, 1983).

One aspect of Peter’s problem prior to therapy had been his consternation over which kind of person he was - ‘mad’ (depressed) or ‘wise’ - and being unable to “*come to some conclusion one way or another.*” Peter perceived that there were two mutually exclusive identities available to him and could see aspects of himself in each. He then questioned the idea that his experiences were indicative of ‘depression’ at all:

Peter: *But I see it’s also not a depression in other senses. It’s...it’s ...it may be part of one’s processes in life. It doesn’t have to be called depression. It could be a spiritual experience.*

Peter’s narrative shows his agency in defining and understanding his experiences in terms that he chooses. He resists the idea that his experiences be understood as ‘depression’, redefining them as potentially a “*spiritual experience*” or broadly and indefinitely as “*part of one’s processes in life*”. As was the case for John, Stephen, and Matthew, Peter expresses satisfaction in knowing with certainty who he is:

Peter: *So in a sense I think the...the depression has probably been something that has given more than I could ever hope for....anyone could even hope for, because that spiritual direction or awareness, which is there for me to take as it were, is there. I couldn't have got to that without probably even feeling the levels of depression I have done. I mean, if I was bright and cheerful and happy I'd be out there creating big businesses, enjoying my wealth, enjoying whatever, and not wanting to die, and right now I can say well, death holds absolutely no... zero fears for me. I'm quite happy to go at any time. I know where I'm going and I know who I am and what I am, and I've dealt with some of those very fundamental core beliefs.*

As Stephen and Matthew had stated explicitly, there is also a suggestion that Peter associates the work that was achieved in therapy (dealing with his core beliefs) with being able to know and become who he wanted to be. Far from obstructing his adoption of a positive identity, Peter now considers that his former 'depressive' state has significantly contributed to an unspecified spirituality, and the story alludes to the idea that he feels he has benefited from the suffering he experienced. He implies that the stereotypical symbols of achievement (career success and the acquisition of wealth) and happiness are unable to provide "*spiritual direction or awareness*", underlining a belief that, paradoxically, it is going through emotional difficulties that provides the most benefit. Commenting on the topic of depression and the idea that people are 'broken', Hayes, Strosahl and Wilson (1999), note "it seems quite odd to ascribe illness status to a syndrome that is experienced by approximately 30% of the population over the life span. Clients have an opportunity, through their own suffering, to learn something timeless and important about the process of being human. In that sense, people who have suffered are specially advantaged" (p. 79). Peter contrasts his perspectives pre-therapy and post-therapy:

Peter: *You know, I'm not...I don't think there's anything that's not part of me anymore that makes me somehow less. In fact it makes me more, in many ways.*

Here, Peter clearly implies his experiences are *positive*, adding to his identity or 'sense of self' in a constructive way rather than 'damaging' it. He develops the theme of multiplicity as his narrative progresses:

Peter: *But I think I'm quite happy to say I can be depressed. I could be under the mental health team. I could be in any state really, and I could be as wise as I decide...as I want to be, and be available to others at that level. You know, I*

have that wisdom and I have that professional background.....skill. And if I'm mad, bad, sad, crazy.....well it could be so too.

Peter's narrative illustrates how often the stories clients bring to therapy are characterised by rigidity that prevent the emergence of preferred understandings (Rebeiro et al., 2010). Peter came to understand through the cognitive conceptualisation that his core beliefs had precluded the availability of the more positive of the two identities he had defined. It appears from the narrative that through therapy Peter has been able to overcome the rigidity of his thinking and to reconcile the tension between the two identities that he formerly could not. Perhaps the concept of core beliefs may have allowed Peter to articulate the inflexibility of his former thinking, and that he need not deny one identity in order to embrace the other. It seems from the satirical fashion in which Peter presents the array of possibilities, "*if I'm mad, bad, sad, crazy.....well it could be so too*", that he has developed a more 'light-hearted' approach to his identity construction, showing how "narratives form something like a playground - a ground that allows us to test out identity categories" (Bamberg, De Fina, & Schiffrin, 2007, p. 6). Because there is no 'natural dictate' that stories must have a coherent and stable identity (Sparkes & Smith, 2008), Peter need not perceive the diverse threads of his identity to be a problem. Implicitly, it was a less restrictive identity which enabled Peter to become "*as wise as I decide*" and to "*be available to others at that level.*" Peter's narrative illustrates how identity may emerge from more than one narrative voice (Raggatt, 2006) and how the self consists of multiple, distinct identities as opposed to one integrated identity (Mehl-Madrona, 2010).

The narratives of these participants indicated that the question, 'who am I?' was very much a part of the participants' internal dialogue, and became problematic for them when their once certain sense of self was disrupted by certain life events and experiences. The stories show how when clients are faced with a challenged sense of self they use therapy to re-author self-narratives that no longer fit their circumstances (Angus & Greenberg, 2011). Clients want to understand how they have been negatively affected or shaped by their circumstances and to explore within therapy the kind of person they want to become (Howard, 2005). Brinkmann (2008) argues that "identities are formed by our commitments to issues of moral worth" (p. 411). These men sought to and did construct identities that aligned with their personal

values and morals. The formation of identity involved the participants' consideration of where they stood in relationship to others and how their identities might be enacted. Matthew defines himself as a “*really good dad*”, Stephen explores his values and morals with respect to identity formation, Peter is “*available to others*” as a wise person, and John stated he once again felt “*like a part of the family*”. The identities narrated by the participants provide them with a sense of purpose and an understanding of their place in the social world.

The Therapy Relationship

The role and nature of the therapy relationship in CBT has long been discussed and debated (Castonguay et al., 2010). It has been noted, “there are essentially two reasons that CBT therapists seek to have a good relationship with their clients. First, a strong relationship is indirectly beneficial by providing a facilitative context for the specific techniques, and, second, their relationship can be used more or less directly as a vehicle for promoting therapeutic learning” (Castonguay et al., 2010, p. 155). In this regard, the therapy relationship in CBT is not typically regarded as the ‘mutative factor’ that brings about change (in and of itself), but it is an aspect of CBT that expedites the therapy. However, in this study, the narratives suggested that some participants perceived that the therapy relationship directly brought about change.

When conceptualising his problem, Matthew had spoken about not wanting to burden his wife, or as he put it, “*not wanting to put my problems on to her*”. In the passage below, he speaks about the nature of his relationship with his therapist, and the qualities he perceives in his therapist that enabled him to “*open up*”:

Matthew: *I clicked with her quite quick really. I mean it's just people....yeah, you're on the same wave length as. Yeah, I think we clicked quite early and yeah, she seemed to be able to read me quite well and she'd prompt me at the right time and yeah, it was very good, from probably after a few sessions into it when I was really quite comfortable and happy to open up. Yeah, it just was really good from there. Yeah, she knew when to listen and when to let me rant. Yeah, she knew when to listen and when to let me rant and just get things off my chest and yeah, it was quite good, yeah.*

In Matthew's story, it seems that early on he recognised that communication with this therapist would be easy and that he would not have to strain to be understood. He implies he had a wish to be understood by his therapist; he states it was very good

that she could ‘read him quite well’. “*Same wave length*” has a sense of bypassing formality and a kind of ‘meeting of minds’. Like Matthew, clients in previous therapy outcome studies have reported that resonating with the therapist, or as Matthew terms it, ‘clicking quite early’, is a positive therapy experience (Giorgi & Gellegos, 2005; Grafanki & McLeod, 2002). Matthew points to being listened to, ‘read well’, and prompted by the therapist, as facilitative of the “*comfortable*” environment within which he felt “*happy to open up*”, “*rant*”, and let go his frustrations by getting things ‘off his chest’. He notes that from that point “*it was really good from there*”. Similar ideas are articulated in Ruth’s narrative:

Ruth: *I feel actually talking to someone and hearing some kind of response and knowing that you’re not crazy and just getting it off your chest so it’s not just bubbling around. It does feel like a bit of a relief.*

Like Matthew, Ruth values being given the opportunity to talk to someone and ‘get things off her chest’. The sense from both of the participants is that Matthew and Ruth perceive that the act of verbalising their concerns to the therapist unburdened them. As Ruth puts it, “*it’s not just bubbling around*” and “*it does feel like a bit of a relief*”. Ruth had implied when constructing her problem that she envisaged therapy as providing her with the social support that she lacked in her life. She points to the interactive aspect of the therapy process (“*hearing some kind of response*”) as reassuring her she is not “*crazy*”. This indicates the influence of pejorative cultural discourse about emotional vulnerability that is evident in several of the narratives, and yet she describes how within the specific context of the therapy relationship, she did not feel defined by this discourse.

Matthew’s reference to prompting connotes the idea of his therapist acting as a ‘subtle facilitator’. The value of being listened to but gently guided also emerged as significant in Joe’s story:

Joe: *I found the therapist really good. Good listener... was able to steer the conversation, I guess, and draw out the right things that needed to be drawn out. There’s obviously theories and a whole lot of things that all you guys know and she had things in mind about what she would be doing and where she was gonna head with this in terms of the solution and all those kinds of things.*

It is interesting to note that in Matthew's and Joe's narratives the therapist moves from being a passive listener into a slightly more active prompting role. Joe depicts his therapist as being able to "*draw out the right things*". As in Matthew's story, there is a sense that Joe perceives his therapist had the answers and was able to "*steer the conversation*" in the right direction. Joe appreciates the value of his therapist being a "*good listener*" and there is also a feeling of positioning the therapist as the expert who knew where she was heading in terms of solutions to his problems. While CBT clients have previously reported that they did not enjoy the feeling they had been steered and restricted by their therapists (Nilsson et al., 2007), in Joe's and Matthew's accounts there is a sense that the guidance was subtle and sensitive and did not compromise their sense of autonomy. The benefit of being listened to also emerged in Clare's account:

Clare: *She was a very good listener. She didn't interrupt. She let me go but if there were any pauses she'd fill it in with theory and practice and what we're trying to do and she had lots of tissues there when that... (laughs) was needed, yeah, and she'd sort of obviously she'd write some notes but every week that I'd come, every second week she'd have a reading relating to what we'd talked about before so that, you know, it was sort of following through and she'd obviously listened to what I had to say, and not just sort of been writing 'nutcase' or whatever (laughs) yeah.*

As well as not being interrupted, Clare associates 'good listening' with the therapist having remembered what she had said in the previous session. Again, similar to many other participants, Clare depicts feeling defined by pejorative discourse about her experiences and how she valued not being perceived as a "*nutcase*" within the context of the therapy relationship. Not feeling judged was a theme that arose in several of the participants' accounts. In the extract below, Jane speaks about why she didn't "*shut off straight away*":

Jane: *Like, she's gonna give her honest opinion about things but she's not gonna say...she's not gonna put a judgmental value on it, which to me is probably why it was quite successful, because once you start feeling that you're being judged or something you're gonna shut off straight away or you're not gonna open up as much and I think she...right from the start she did build quite a good rapport with me.*

Jane's describes how her therapist built a "*good rapport*" with her "*right from the start*" and a particular quality of her therapist that enabled her to "*open up*". Jane

attributes feeling comfortable about opening up directly to her understanding that she was not going to be judged by the therapist, or that her therapist would put a “*judgemental value on it*”. She states that without this she would have “*shut off straight away*”. Presumably, this would be particularly important for Jane who presents herself as someone typically fearful of ‘opening up emotionally’ and conditioned by her upbringing to withhold emotional expression. Jane described the nature of the relationship further:

Jane: *I don't know how to describe it....it wouldn't be...like it would be like some sort of friendship but not a friendship because you know that you're paying her.....to listen to you sort of thing, but I think it was a very friendly relationship and I felt that I could open up to her and I felt that like no matter what I say, she's...she's gonna be there to listen to me sort of thing.*

Jane’s account reveals that she is unsure of how to describe her relationship with her therapist. She appreciates the personal aspect of the relationship, while at the same time acknowledging that her therapist is a paid professional. Whilst she is unable to discern precisely where the relationship lies, she appears reconciled to the contradiction and perhaps by choice and because of the nature of the relationship, describes the tenor of the relationship as “*friendly*”. Jane associates this quality of the relationship with her ability to “*open up*”. Like many other participants, she notes the significance of having someone there to listen to her. Being able to open up ‘no matter what she says’ is reminiscent of Matthew’s appreciation of being able to ‘rant’ and ‘get things off his chest’, and again, being listened to by the therapist is emphasised. There is a sense in both stories of a trust having developed between the client and the therapist, with the therapist being positioned as a ‘dependable listener’. Similar to Jane, Clare also expressed the importance she placed upon her perception she was not being judged by the therapist:

Clare: *I think she was honest and she was kind and a very gentle approach, you know, she wasn't sitting there and really making judgements or yeah...very impartial.*

Depicting the therapists as non-judgemental might also belie the participants’ wish for their therapists not to think of them as less likable or less worthy of respect. Clare notes she perceived her therapist as “*kind*” and that she had a “*gentle approach*”. The understanding of the therapists as “*impartial*” was a theme that threaded through both Jane’s and Clare’s descriptions:

Jane: *I could talk to someone that was unbiased and that wasn't involved in the situation.*

Similarly, Clare also spoke about objectivity as a valued quality in her therapist:

Clare: *Yeah, and just very objective, you know? Not touch feely or, you know, completely stand-offish.*

In Clare's view, her therapist had struck the right balance between exhibiting some warmth while maintaining a professional distance. Clare also provided a strikingly similar account to Jane's about the benefits of speaking to someone who "*wasn't involved in the situation*":

Clare: *It was getting a third person's perspective that wasn't involved in the situation. I think that was really good, you know, because a friend or a doctor or someone you've sort of got a relationship with... you sort of feel is always gonna take your side anyway. So it was nice to have someone that I had no...you know, background or anything like that. Just looking at this and saying "well actually, you didn't do that badly and actually, you didn't have control over that."*

For these narrators the benefit of having someone who they perceived "*wasn't involved in the situation*" lay in the perception that this made the therapists "*honest*", "*unbiased*" and "*impartial*". Although honest opinions by their nature involve a personal, subjective viewpoint or judgement of some kind, this understanding serves to construct their therapists' opinions as more credible and assuage any anxiety over uncertainty. By depicting their therapists in this light, the narrators can obtain what they perceive to be reliable information; honest but objective opinions that they can assimilate and utilise. As in several of the narratives, the idea that the therapist is fulfilling an important social function that cannot be obtained from the participant's own social circle is apparent. In the extract below, Clare speaks about how her therapist's opinions were something she thought about between therapy sessions:

Clare: *Yeah, and I sort of respected what she had to say, and often during the two weeks between visits I'd sort of think "What would she think about this or what would she say about that?"*

Clare's depiction here is reminiscent of previous clients' reports wherein they recall how outside of the therapy context they think about what the therapist has said or might say, and engage in internal dialogues with the 'internalised therapist' (McLeod, 2013). In this regard, Clare's account illustrates the considerable faith she came to place in her therapist's opinion and the influence this had on her everyday life.

Stephen had suffered from two chronic illnesses throughout his adolescence and his lifestyle had consequently become very restricted. His therapy took place over a relatively lengthy period of two years. At the time that he began therapy, Stephen was cynical about the potential benefits of therapy for someone in his situation. His narrative indicated that part of the effectiveness of therapy was due to his therapist's ability to engage him in the therapy process despite his wariness. The following extracts depict how the therapy relationship was instrumental in assisting Stephen to overcome his initial reluctance to engage in therapy. Below, he speaks about how he felt about therapy in the beginning:

Stephen: *I think it was a lack of being able to see the big picture and to be able to understand how this was eventually going to help me. I simply thought that this wasn't possible. That whatever we were suggesting, trying to integrate me back into this normal - whatever 'normal' is - but this normal life just simply wasn't possible.*

Stephen recalls how he didn't feel that the idea he and his therapist were discussing - being integrated back into a normal life - was possible, and for this reason he was "unable to see the big picture" and could not envisage how therapy could help him. Within this context the therapy relationship became a crucial factor in Stephen's experience. In the passage below, he speaks about the early phase of the therapy relationship:

Interviewer: *How would you describe the relationship during that initial one year period?*
Stephen: *It certainly was not hostile. Again, and I give [name of therapist] full credit for this, she's really, really good at what she does in making people feel very comfortable, so despite this maybe my slight confusion and apprehension about partaking and what she was suggesting, she's very, very good at keeping you engaged and keeping you interested and making you feel very cared for.*

Arguably, finding ways to cope with chronic illness is one of the more difficult tasks therapists and clients can approach together. For a therapist, it may be difficult to find an alternative focus to the compelling experience of pain and illness, and even more difficult for a client to be ‘philosophical’ and to regard thoughts and behaviour as being somehow implicated in the problem. Stephen’s narrative implies that his “*confusion and apprehension about partaking*” in therapy were assuaged by feeling “*very cared for*” and the therapist’s ability to keep him engaged and interested. It is interesting that Stephen remarks on the absence of any hostility in the relationship, as if that were a possibility he had countenanced due to his initial reticence. Respect, an idea that emerged in Clare’s account, featured strongly in Stephen’s account:

Stephen: *I’d built up a tremendous respect for her and I still do have a tremendous respect for her and anything that she does say to me, even if I don’t want to hear it, I don’t think it ever changes my respect for her. I think it probably only increases it, simply because I know that I can count on her to give a true, honest opinion, and tell me what I need to know.*

Stephen talks about his “*tremendous respect*” for his therapist as being “*built up*”, and implies that the development was a gradual process. The gradual development of respect for his therapist is associated with his subsequent inclination to receive his therapist’s opinion. As in Jane’s and Clare’s narratives, Stephen values the therapist’s “*true, honest opinion*”. Even if he doesn’t want to receive it, he understands it is something he needs to hear. Stephen is specific about the nature of his relationship with his therapist:

Interviewer: *How would you describe the tone of the relationship?*

Stephen: *Mentor’s probably quite a good word. It’s not ‘teacher-pupil’ and it’s not ‘doctor-patient’. Mentor I like...and a relaxed feeling about it. Mentor is a good word because if I’m honest, there’s probably three people in the world whose opinion I value and she would certainly be in that three. And that’s saying something because people that know me know that I’m pretty stubborn and strong willed! Mentor’s good, a relaxed feeling to it and one of respect. Like I say, what she says, despite if I wanna hear it or not, I receive it well and I’m always open to it.*

This characterisation (mentor) is congruent with Stephen’s willingness to accept and assimilate what he ‘needed to know’ and with his respect for his therapist and her opinions. Positioning the therapist and himself in this way may function to facilitate the flow of information, making him more inclined to “*receive it well*” and to be

“*always open to it*”. From Stephen’s account the sense that he was cared for and kept interested and engaged, reduced his scepticism and developed a respect for his therapist that led him to a point where he felt open to receiving her opinions. Stephen’s narrative included an example of this receptivity:

- Interviewer:** *How do you think that therapy helped you appreciate that about yourself?*
Stephen: *Do you mean what did she do to bring it out or just any comments on that?*
Interviewer: *Yeah, any comments. You were talking about a tendency that you’ve noticed now to want to control things, I was just wondering how that was brought to your attention.*
Stephen: *She said it to me straight up. Potentially, I kept on pushing for what is wrong with me and, “what am I not doing right in this situation?” I was constantly wanting to analyse how I could do better or what I was not doing right, and I’d give her a situation and say, “What am I doing wrong?”*
Interviewer: *Say, a social situation?*
Stephen: *Anything. Whether it be that, or whether it be... I guess, this would fall in the social barrier but a situation with Mum and Dad that ended up like this – what did I do wrong to make it do this? Those sorts of things, and one thing that she very much brought to my attention was, like I say, the controlling aspect.*
Interviewer: *And she said that to you straight up?*
Stephen: *Directly, yeah.*

As well as indicating Stephen’s receptivity to his therapist, in this extract he describes how he ‘pushed’ his therapist for answers. Qualitative studies into clients’ perspectives to date have found that while some clients have been found to prefer coming to their own decisions about what is ‘wrong with them’, others have reported wishing to receive advice from their therapists and appreciating being given firm direction when they thought they needed it (Levitt, Butler, & Hill, 2006; McLeod, 2011). Stephen describes how his therapist informed him “*directly*” of his “*controlling aspect*” that “*she very much brought to my attention*”. Rose’s (1996) understanding of the typical dynamic between client and therapist is that the client is neither subordinate nor persuaded by the therapist, but enters into a kind of ‘discipleship’, held in place by a desire for certainty and ‘truth’ and the promise of self-improvement and self-understanding. In this study, some participants expressed valuing their therapists ‘prompting’ them and ‘drawing out the right things’, while others like Stephen, Clare, and Jane, expressed preferring a more directive approach. Jane describes how she came to understand her pattern of trying to “*fix things*” in relationships when they ‘can’t always be fixed’:

- Jane:** *I think it was....it was good, like it was a good insight like of course you don't like hearing bad stuff about yourself or things that you need to change. But when you sit down and like think about what people are saying to you then...they can...they see a different side of you or....sort of thing and so you just have to...I took it on board, but yeah.*
- Interviewer:** *So you're....you're glad that she was up front like that?*
- Jane:** *Yep, yep. Yeah, definitely, because if you...if you go....like a soft approach you're not gonna listen you're just gonna be like, yeah. Well, that's for me. Like I need someone to directly tell me and not beat around the bush about certain things cos sometimes I don't get it. Like someone says in a roundabout way I'm just like....I don't actually get what you're saying. So I need it told to me directly, and even though I don't like hearing it, it does sink in and yeah, so yeah, I think that's probably the best approach.*
- Interviewer:** *Was it....was that sort of what you expected? Did you expect to hear her sort of give.....I don't know if it was a 'her', but whoever's opinion, sort of....quite... quite, you know, openly like that?*
- Jane:** *I really had no expectations about like....therapy and stuff like that, like I think I kind of avoided it a little bit because yeah, I don't like people telling me what to do and that sort of stuff, but yeah, so when...I guess yeah, when she was quite blunt at certain times I didn't expect it and it was kind of a little bit of a...okay....(sounding unsure)...but it made me kind of listen a bit more and take it on board because it was kind of shock value.*

Jane's account portrays the direct (rather than "soft") approach as exactly the one she perceived she needed, and how she appreciated the "shock value" in having being told things directly. The 'shock value' that she refers to did not seem due to her unfamiliarity with the ideas her therapist conveyed to her, but rather appeared to be about the suddenness and explicitness with which the ideas were expressed. Jane values this as a kind of 'tough love' approach that made her really take notice. 'Taking something on board' conveys the idea that Jane accepts that in some sense she was 'in the wrong' back then, but has since self-corrected because "it did sink in". The therapist's conceptualisation may have seemed blunt to Jane because in asserting one version of the problem, other possibilities were foreclosed. Jane's story might function in part to dismiss any discomfort about her therapist's opinion, however, she implies that any discomfort she felt was worth the insight she gained from the conceptualisation.

Participants also described the therapeutic benefits and curative effects of simply being able to articulate their thoughts and feelings in the context of the therapy relationship:

- Matthew:** *A lot of it was just...I think probably half of the benefits I got were just being able to say things out loud. Just talking to someone and having someone listen and actually hearing myself say things out loud. Just...as I even said*

them....you know, when I was talking about why I was worried and what I was worrying about, I thought, "Gosh, that sounds ridiculous". Just hearing myself say it out loud was probably...yeah, was very therapeutic in itself. Just having someone there to talk to really.

Interviewer: *And was it that it needed to be somebody outside of your personal life?*

Matthew: *Absolutely. Yeah, yeah. I think that was the biggest thing I can...my wife's great. We have great communication. But what had happened...we're both guilty of it. I'm still guilty of it now, is not wanting to put my problems on to her, and she does the same thing with me. So that's why we need that outside person to, you know, to talk to, cos I knew she was obviously really stressed and quite down about everything as well, she was the last person I wanted to put my worries on, and I've always been really protective of my friends and close ones as well and I don't want to make their lives any harder, even though that's what I was doing by not telling her about stuff [his wife], and those sorts of things, but yeah, so yeah, having that outside person was exactly what I needed.*

Here, Matthew is referring to articulating his thoughts and feelings about being an underachiever and his anxiety over his belief that other people viewed him similarly. In the extract above, Matthew estimates that "*half the benefits*" of therapy were due to being able to hear himself "*say things out loud*", and "*having someone listen*". The process of talking in therapy and putting feelings into words has been identified by clients in previous post-treatment accounts as valuable and generative of positive effects (Bury, Raval, & Lyon, 2007; Lilliengren & Werbart, 2005). Matthew describes how this experience was "*therapeutic in itself.*"

Matthew implies there was no need for the therapist to challenge or persuade him in any way about the 'ridiculousness' of his thoughts about being perceived as an 'underachiever', because he knew it as soon as he heard himself say it out loud to her. 'Ridiculous' conveys the idea that Matthew may have felt some sense of shame about his thoughts. However, Matthew may have had a quite realistic apprehension about his future. His options had been reduced in that he no longer had the option of studying for a career and was working in mundane, low-paying occupations. In addition, he would have been familiar with cultural ideas or 'meta-narratives' about the characteristics of an 'achiever' and, by implication, which people are excluded from this category. In this regard, Matthew may have been positioned as anxious when he felt objectified by society's 'gaze' (Smail, 1987). If Matthew had come to believe he did not fit society's criteria for achievement, the value of being able to open up and get things off his chest with a therapist who would listen might be felt more keenly. Lax (1992) notes that people define 'who they are' through their

relationships and how they are perceived by others. It seems from Matthew's account that his sense of self moved from feeling defined by what he imagined was society's perception of him to a different social construction. In being able to articulate his thoughts and feelings to his therapist, he was able to see - in a different social context - the falsity of his previous inferences, and this was a therapeutic experience. Notably, Matthew makes no mention in this passage of anything the therapist said or did, other than listen. Rather than being facilitative of a CBT technique, the therapy relationship itself is represented as a crucial factor for change. As noted, this was made possible because of the nature of the rapport Matthew described establishing with his therapist "*right from the start*".

Aroha provided a similar account to Matthew about the benefits of articulating her thoughts about herself to her therapist, which she relates to her 'core beliefs'. In the extract below, Aroha identifies the addressing of her core beliefs as the most significant aspect of therapy, and goes on to describe how the therapy relationship was the crucial factor concerning positive change in this area:

Interviewer: *...so how did the...how did the CBT kind of help with that, and the gaining more confidence and you know, the [substance abuse] and stuff? Like, how did it work?*

Aroha: *I think it was a lot around core beliefs.*

But rather than discussing the significance of the core beliefs, or referring to the typical CBT process of being encouraged by the therapist to consider the evidence 'for and against' core beliefs (Laird & Metalsky, 2008), Aroha explained how the therapy relationship itself was a crucial factor for change in this area:

Interviewer: *So the core beliefs were identified, and was it...was it just identifying them...was that kind of.....*

Aroha: *It was therapeutic. It was actually therapeutic for me to admit to it and to say this is the reason, like this is my belief about myself. You know, being able to put that out there with the therapist and feel that it was safe to do it - feel that it was really safe to do it and feel that I wasn't gonna be invalidated for that, or told that I was... 'that's sort of silly.' Just about the core beliefs and the therapeutic... I felt that it was therapeutic. The therapy itself, just kind of talking about it, letting it go, and I suppose for me, sort of talking about it was like taking away...if you like, the power that it had over me.*

For Aroha, her ability to open up with her therapist is associated with her knowing she wasn't going to be "*invalidated*" or made to feel "*silly*". Similar to Matthew,

Aroha describes how ‘admitting’ that her core beliefs were “*the reason*” for the problems she had been experiencing was therapeutic. The story also suggests Aroha had preconceptions about the kinds of things she might be expected to say and the function of therapy prior to receiving it. The therapist as witness is emphasised as important and therapeutic as Aroha speaks about the benefit of ‘putting it out there’ and admitting to the therapist her core beliefs. Aroha tells how bringing these beliefs out into the open with the therapist was a crucial aspect of the change process or, as she put it, “*just talking about it*” took the power that it had over her away. This idea is reflected in Matthew’s and Ruth’s narratives also when they associate ‘just saying it out loud’ to the therapist and ‘getting things off their chests’ as a kind of catharsis. The accounts indicate a perceived need for their self-expression or ‘admissions’ to be witnessed in relationship with another. This therapy process has been conceptualised as a kind of ‘confession’; the assumption that the more a person speaks the freer they will become (Parker, 2007). In the narratives there is a slight sense of ritual about the process, with an emphasis on relationship and being listened to purposefully in a private place of disclosure. In popular culture, therapy is endorsed as the appropriate place for ‘getting to the bottom of issues’ and facilitating an emotional catharsis by ‘outing’ them (Parker, 2005).

As with other participants, there is a slight sense of shame in Aroha’s narrative about her beliefs, as she describes fearing that someone might think her “*silly*” for having them. Clients may particularly value the opportunity to talk freely about their distress and being listened to by their therapists if they are embarrassed to talk to those close to them. Confessing in social circles a lack of self-worth and feelings of inferiority may be difficult for people, particularly for those who live in a culture that places such an emphasis on high self-esteem (Mruk, 2006; Rose, 1996). If a person’s distress has been prolonged, as Matthew portrayed in his account, they may feel defeated and assume that others may not want to hear about it. By contrast, the participants portray their therapists as ‘safe’ and appropriate confidants to whom they could express their vulnerabilities and self-doubt without fear of judgement or ‘ridicule’, being thought ‘silly’, ‘crazy’, ‘mad’ or a ‘nutcase’. Aroha spoke of the difference this made in her life:

Aroha: *Like I...I feel more confident...like so much has probably changed in me in six months' time, in that I feel like more confident when I talk, and I'm sort of like open to being criticised by others.*

Aroha's narrative depicts how she values the improvements in her personal relationships, depicting the change in how she feels; feeling "more confident" when she talks and more open to the criticism of others. Her appreciation of gaining more confidence in relationships aligns with her conceptualisation of the problem as having had "an immense amount of social anxiety". Her narrative begins with an appreciation of the effects of her childhood experiences and there is a strong emphasis on the therapy relationship as producing the curative effects of the therapy process.

While some participants valued the impartiality of the therapist as one who was 'not involved in the situation', Matthew refers to the benefit of the therapist being an "outside person" who could listen to him when he did not wish to burden his wife with his problems. Reluctance to burden loved ones was an idea also expressed by Jill and Anne when constructing their problems and similarly by Ruth and Clare when they spoke about the therapy relationship:

Ruth: *Then my friends, when I'm depressed I think to myself, I don't wanna just be that whiny friend who is always complaining about something. I think, my friends don't wanna be that friend to me and it makes you feel like you've got no one because you don't wanna be that burden to them. It's hard to find someone to lay that on!*

By stating "my friends don't wanna be that friend to me" Ruth suggests that, to an extent, the therapist is fulfilling the role of a friend. Ruth had conceptualised her problem as a lack of social support, and her narrative progresses toward the intended goal of obtaining the personal support she needed from her therapist. Furthermore, as Jane had, Ruth gives a similar account of the therapy relationship as like that of a friendship:

Ruth: *She remembered everything as if we were old friends and she was, "How's this going?" It was good. It felt like she truly did care. That was very good.*

As expressed by Stephen, Ruth sees in her therapist a caring quality. The narratives emphasise a kind of intimacy and position the therapists as 'helpers' that genuinely

care about them. Clare also values having a confidant outside her family and social circle:

Clare: *Hmm...that it wasn't, you know, a husband or...You sort of think, well, you know, they're going to say nice things anyway.*

Again, Clare implies that she valued her therapist as an 'outside person' who was objective and honest, rather than receiving the 'biased' opinion of someone who may have motives for 'saying nice things'. In prior studies clients have previously reported valuing having an 'outside person' to share their concerns with (Lillengren & Werbart, 2005). Participants also spoke about the effects of receiving encouragement and affirmation from their therapists:

Ruth: *When you first tell all the bad things, the next time you come back you're almost really proud to say about the good things. You want to show them that you've been improving, which was almost more of a motivation. I actually felt really good when she was, 'Oh, you did this, you did that so well. You're doing so well for all the things you're blah, blah, blah.' That makes you feel good. Cos when you've got depression you think everything's terrible and everything's bad and blah, blah, blah, but then she was saying, 'You're doing this really well, blah, blah, blah.' And I'm, 'Oh!' It springs you up a bit.*

Interviewer: *Do you mean it was a motivation to please her in some way?*

Ruth: *Kind of. Seeing how proud almost she was – that you are getting better for yourself, motivated you to do more so that you could share more positive things. But it wasn't for her.... But it motivates you so that you can be almost proud of yourself as well –hard to explain.*

Ruth describes how she felt “*proud*” to show her therapist how well she had been doing in between sessions and that this motivated her. One interesting aspect of Ruth’s depiction of her eagerness to make her therapist proud is that by believing she witnessed her therapist’s pride in her progress, she began to notice feeling some pride in herself too. This again reflects the co-construction of the self within the context of the therapy relationship, which for Ruth stemmed from her enjoyment in showing she had “*been improving*” and witnessing what she perceived was her therapist’s pride in her. Another significant idea in the text is that Ruth feels proud that she is ‘getting better *for herself*’. This finding supports prior research that has shown that a client’s sense of well-being is associated with agential thoughts and narratives, and that ‘doing the work’ themselves and feeling involved in the process affords them a feeling of accomplishment and empowerment for their own self-healing (Bohart & Wade, 2013; Hoener et al., 2012). Ruth’s enjoyment of feeling

newly self-motivated alludes to a feeling of empowerment and a greater sense of autonomy, which have both been cited by clients in previous studies as valuable and have been linked to positive outcomes (McElvaney & Timulak, 2010; Timulak, 2010; Timulak & Elliott, 2003). Notably, in Ruth's account, her sense of agency is directly linked to the dynamic of the therapy relationship. The pride Ruth perceived as emanating from her therapist may have been partly due to Ruth's perception that the nature of the therapeutic relationship was similar to those that are commonly shared between family members:

Ruth: *I felt that [therapist's name] was so loving and warm. She was almost a Grandma with fresh, baked cookies! She felt empathic. It seemed like she actually cared.*

Ruth went on to describe how she perceived that her therapist genuinely cared about her:

Ruth: *I feel like people do care about you. Even someone you've just met can see that, "yes, you're going through hard times but you're still this person"...definitely was motivating her being so responsive and motivating.*

Interviewer: *What would you say would've been the most helpful aspect of it?*

Ruth: *I felt this because she was so caring I was able to tell her anything. I didn't feel embarrassed to tell her anything. Some of my health issues and things are embarrassing but I didn't feel embarrassed to tell her anything. I didn't feel like she was gonna judge me negatively or laugh about it later. That was good to feel like I could truly open up. That was very helpful.*

In response to being asked what the most helpful aspect of the relationship was, Ruth replies that it was her perception of her therapist as "caring" and someone to whom Ruth could 'tell anything' without feeling "embarrassed". Ruth recalls how she found her therapist "loving", "warm", and "empathic". Prior research has also indicated that clients value the quality of warmth and empathy in their therapists (Bachelor, 1988; Binder, Holgersen, & Nielsen, 2009). It seems that like other participants, Ruth wasn't "embarrassed to tell her anything" because she did not feel the therapist was going to judge her "negatively or laugh about it later". Again the idea of potential shame emerges that is assuaged by the benefit of a non-judgemental therapist. Ruth directly connects perceiving her therapist as non-judgemental with being able to "truly open up" and that this was "truly helpful". As with other participants, Ruth appears to trust that it is safe to confess her vulnerabilities to her therapist.

In the extract above, Ruth describes how she perceived that her therapist was able to separate Ruth's 'hard times' from 'who she was as a person', and that this motivated her. It is not quite clear whether Ruth is referring to situational factors as being 'hard times', or the 'hard times' she was facing 'internally' regarding her thoughts and emotions, or both. Either way Ruth represents her therapist as making a distinction between one 'hard times self' and another more stable and essential self, ("*you're still this person*"). It seems from the narrative that Ruth's depiction of her therapist's de-emphasis of the self that Ruth initially had described as "*struggling*", and her suggestion that Ruth was in fact something 'other' than this 'struggling self', facilitated Ruth's ability to motivate and feel good about herself. The narrative portrays the therapist as conveying to Ruth that she was not the impaired person that she thought she was; she was actually someone else who was 'quite okay'. The depiction of the therapist's implicit opinion here, 'no, you're not like that *really*' or 'you're better than that', might be exactly the kind of response one might expect from a family member who "*actually cared*". Ruth states that because the therapist was 'responsive', 'empathic' and 'motivating', she felt motivated too. As well as assisting Ruth to 'open up', implicit in the narrative is that the therapist's encouragement, affirmation, and caring and non-judgemental approach enabled her to perceive herself in a more positive light, and as an agential and capable person who was not 'abnormal' because of her experiences.

It is also possible that Ruth's statement, "*but it wasn't for her,*" may be an acknowledgment on her part that culturally, the idea of doing things to please other people or moulding yourself to fit another's expectations is generally considered unwise. Perhaps these kinds of ideas are associated with cultural values about 'being your own person', individuality, and autonomy (Rose, 1996). One idea behind the value of doing things for yourself rather than for someone else is the assumption that any positive effects that derive from attempting to change for another person probably won't be long-lasting or could 'backfire' in some other way. Nevertheless, it seems that Ruth's narrative functions to adopt a transmitted image of who she really is, enabling her to feel newly motivated, and to believe that "*people do care about you.*" The positive outcomes that Ruth refers to are attributed directly to the therapy relationship.

Clare's account of the benefits of the therapy relationship is similar to Ruth's in that she also expresses valuing her therapist's encouragement and the affirmation of her achievements:

Clare: *...I just think when you go to a GP the visits are so quick and you know, they'll just say 'Oh, well that's not your fault or, you know, this is gonna help you and off you go', and yeah, this was sort of something that you had to listen to, practice, and take on board I guess. Or just decide to ignore. But she was very good at being positive as well and she said 'look, some people come to me every week, spout off for an hour and go home, and they don't do any of the readings or they don't do any of the 'this', you know, she said 'you have done everything along the way', and you know, that was really nice...you have to look where you've started and where you've come from and, yeah, so that was good, yeah, very good.*

Like Ruth and Clare, clients in previous studies have reported that having their determination and accomplishments affirmed by the therapist is experienced as valuable (Timulak, 2010). While many participants were readily accepting of the direction their therapists offered, Clare reveals her own personal agency in the relationship when she notes that she retains the right to “*decide to ignore*” what her therapist is suggesting. As has been found in previous studies, clients do not merely ‘absorb’ what their therapists say, but actively make choices within therapy, and are reflexive and exert control (Bohart & Wade, 2013; Hoener et al., 2012; Rennie, 2000).

When people first begin to form relationships with others, they usually show some amount of caution and tentatively test the waters before ‘getting in too deep’. Getting to a point where one is willing to talk about personal history and problems that are emotionally significant and difficult is typically a gradual one. Clients, on the other hand, are somewhat thrust into a relationship that has skipped a phase or two. Beginning therapy may potentially threaten a client's need for autonomy and competence, because it might be understood as an inability to cope with life problems on one's own (Adler, 2013; Binder et al., 2013). From the participants' accounts a number of common elements concerning the perceived attributes of the therapist and the nature of the therapy relationships emerged that enabled the participants to feel comfortable to ‘open up’ with their therapists. Due to these experiences, and perhaps the participants' expectations of therapy, the participants

were not concerned (as they implied they might have been) that they might be perceived negatively by their therapists.

Also valued were a number of other perceived qualities in the therapists, including, objectivity, impartiality, honesty, and a lack of bias. These perceptions appeared to function to lend credibility to the therapists' 'honest opinions', and reassure clients of the validity of the therapeutic conceptualisations and processes. This may have facilitated the participants' assimilation of knowledge in that the qualities the participants ascribe to their therapists are associated with their willingness to accept their therapists' 'honest opinions' as something they can rely on and utilise. It has been noted that clients have a tendency to paint their therapists as experts and reliable sources and dispensers of wisdom (Rose, 1996). Clients may have the intention of getting 'answers' from their therapists, and may convince themselves of the unlikelihood or impossibility of alternative interpretations in their search for a definitive solution.

Participants differed in their preferences regarding the therapists' approach, with some clients appreciating a more directive and forthright manner, and others a more gently facilitative approach. Some valued being subtly 'steered' and the therapist's skill in being able to draw out the right information, while others valued receiving direct opinions from the therapist about what was required for positive change. Participants positioned their therapists as a type of 'opinion-giver', mentor, friend, or family member. There were many indications in the participants' accounts that as well as being facilitative of the therapy process, the therapy relationship brought about change directly. The participants depict using the therapy relationship agentially to meet their needs.

In summary, CBT clients may vary widely with respect to the nature of their problems, and the kinds of outcomes they wish to obtain from therapy. Although standard CBT theory and practice focuses on mental health issues and symptom reduction, CBT clients may present with a variety of problems they wish to address. Some of these participants' narratives aligned with standard CBT conceptualisations, while others drew from different discourses to understand and evaluate their experiences. The narratives represent the participants as agential and active contributors to the therapy process, who were able to extract from therapy what they

perceived they needed. Clients sought help for the ongoing effects of stress, the effects of childhood experiences, emotional repression, problems concerning identity, and mental health issues. In the majority of cases the narratives were progressive, ending in therapy outcomes consistent with the problems the clients conceptualised. Across the group of participants there was a strong emphasis on the beneficial effects of the therapy relationship, which was represented as being both facilitative of change and curative in itself. With the exception of one participant, participants were satisfied that their experience of CBT had enabled them to produce outcomes they considered practical and valuable, and which continued to be of benefit to them up to two years post-treatment.

Chapter 5

Conclusions and Implications

The aim of this research was to gain a greater understanding of clients' perspectives on Cognitive Behaviour Therapy. By using an open narrative inquiry method to explore twelve clients' experiences, the research aimed to go some way to redressing the gap in CBT outcome research that to date has largely neglected clients' perspectives. Clients could speak freely about the aspects of the therapy process and the outcomes they viewed as most relevant to them. It was hoped that the findings might be useful for enhancing clinical practice and inform potential avenues for future CBT research.

The key findings that emerged from the analysis that are discussed in this chapter are: there is a wide variety in the problems clients conceptualise and the outcomes they construct; CBT clients may use therapy conventionally or adaptively to meet a variety of needs; the cultural environment influences how clients construct and evaluate therapy; clients perceive that the therapy relationship contributes to change directly; clients' are agentially involved in therapy and co-authors of their own change processes.

Conclusions

The narratives showed a wide variety of problems and experiences, some of which aligned with the way CBT has been conceptualised and others not. Many of the participants did not value symptom reduction - or symptom reduction alone - as a therapy outcome. Also valued were increased self-understanding, improvements in personal and work relationships, learning to express emotion, understanding and letting go of the influence of their past and, of implicit and explicit concern to all participants, their sense of identity. Participants were concerned with how they believed the events and circumstances of their lives reflected upon and defined them. These defining experiences included psychological distress itself. The findings suggest that social and cultural influences shape clients' perceptions of their problems and their expectations of CBT, their input into the process, and consequently the benefits they take away from the experience. They also point to a

clients' agency in the therapy process and the flexibility of CBT to meet a number of different needs.

The Perceived Usefulness of CBT Techniques

Participants in this study who perceived their problems were due to the effects of stress or mental health issues conceptualised their problems in ways that aligned well with standard CBT practice, approaching CBT pragmatically with the intention of learning practical strategies to manage emotional distress and associated behaviour on a day to day basis. These hopes or expectations of therapy 'matched' a CBT approach, which typically provides a variety of techniques to assist the client to manage emotional distress (Clark & Beck, 2010; Dobson & Dobson, 2009). The therapy goals of these participants reflect the findings of prior studies (Lilliengren & Werbart, 2005) wherein clients reported a preference for action-oriented interventions that link therapy to their ordinary lives. As has been found in previous CBT clients' reports (Nilsson, et al., 2009), there was evidence to suggest that the discourse and framework of CBT may have shaped how these participants evaluated therapy; participants perceived that in becoming experientially aware of their 'internal responses' and behaviour in the present moment and applying the techniques they acquired in therapy, they could manage their distress. The structure of the cognitive-behavioural conceptualisations appeared to instil in the participants a sense of relative mastery by affording them the ability to break down a body of seemingly chaotic information into conceivable and understandable 'parts'. Participants then applied techniques in ways in which they were intended to be used, but also adapted techniques to suit their own needs and a variety of purposes.

Although prior studies have indicated that the specific techniques that are prescribed in CBT account for a smaller percentage of variance in outcome than previously thought (Dobson & Dobson, 2009), from the perspectives of some participants in this study, the specific techniques acquired in therapy were highly effective in reducing distress after therapy was completed. Many participants neither expected therapy to eliminate distress, nor were dissatisfied with the persistence of distress post-treatment. These perspectives reflect those of clients in previous studies (McLeod, 2011) who perceived their problems as ongoing and something they need to learn to cope with. However, from the participants' perspectives, CBT techniques afforded

them a sense of personal agency, autonomy and optimism due to the belief that distress could be managed successfully in the long-term. Many of the participants' perspectives aligned with those of CBT clients in prior studies (Nilsson et al., 2007) who similarly reported an increase in their sense of agency and responsibility as potentially active agents of change, and that the application of techniques became automatic and natural parts of their lives and integrated into their habitual behaviour. There was a strong sense that this is what some participants had hoped to obtain from CBT and they were continuing to use the concepts and techniques adaptively and successfully. The findings reflect one aim of CBT, which is to provide clients with skills to address their own problems after the completion of therapy (Dobson & Dozois, 2010).

Clients use CBT Flexibly to Address Identity Issues

Clients often story their experience of therapy as an important event in their personal development (Lieblich, 2004). The need to have a strong and positive sense of identity is a culturally ingrained notion, and therapy is commonly regarded as a place wherein one's identity may be cultivated (Rose, 1996). This cultural imperative was apparent across participants' narratives wherein explicit and implicit references were made to the significance of these issues and their relevance to participants' subjective sense of well-being or distress. Additionally, the experience of distress itself appeared to cause some participants to infer abnormality. Participants inferred fault or some kind of personal defectiveness when identifying with depreciatory and anachronistic cultural discourse that associates psychological distress with 'insanity', and seemed influenced - as has been argued clients often are (Dobson & Dobson, 2009) - by cultural ideas that lead them to believe they were 'lacking control'. A sense of 'difference' was similarly described by participants who, due to difficult life experiences, perceived that the development of their identity had been thwarted, or was no longer certain or tenable, as were feelings of frustration and loss. Investment in a narrowly defined identity may position a client as vulnerable to distress should they be prevented from the continued development or maintenance of the identity.

The findings of this study point to the therapy relationship as offering a potentially powerful relational experience for clients to reconceptualise themselves more positively. Participants described feeling 'safe' to articulate their self-narratives to

their therapists, and by doing so became aware and were able to reflect upon the meaning of their narratives and the ways in which they had constructed their identity. For some participants, this increased their awareness of how their sense of identity had been shaped by cultural discourse and the influence of past experiences. By bringing the negative aspects of their self-narratives 'into view', participants were positioned to question their identifications with cultural discourses and, as a result, consider how they might reshape their narratives. Implicit in the narratives was the significance to the participants of articulating self-narratives which, outside the therapy environment, they had felt unable or unwilling to express for fear of judgement. There was the sense that participants' experience of being accepted by their therapists and perceived in ways that were incongruent with the negative self-narrative both invalidated these narratives and contributed to the construction of a positive identity. Additionally, some participants described valuing their therapists' active collaboration in developing latent positive self-narratives through an exploration of their values and morals, and participants' appreciation of their personal resources. The sense in the narratives was that the therapy process entailed the uncovering and identification of 'inactive' discursive material with which participants might re-author new identities.

The findings also suggest that the potentially 'normalising' and 'validating' effect of CBT conceptualisations (Kuyken, Padesky, & Dudley, 2009) assisted some participants to understand that their experiences were neither atypical nor indicative of their own personal failing. Some participants pointed to the usefulness of CBT concepts for stimulating their self-reflection and facilitating exploration of the influence of cultural discourse on their sense of self. For others, the use of these concepts assisted them to perceive that their experiences were structured and predictable, affording them the sense of control they had felt they had lacked, and enabling them to re-author their identities as more agential and autonomous people.

The participants' ability to address matters relating to identity challenges the idea that, due to CBT's focus on diagnoses and mental health problems, clients who seek the identity transformation implied in 'personal growth' may find it difficult to use CBT to their advantage (Wills & Sanders, 2013). Similar to the findings of this study, prior qualitative research into CBT clients' experiences has found that clients may perceive that a trusting relationship wherein they feel able to explore alternative

ways of interpreting their experience may be viewed as a significant ‘collaborative act’ (Messari & Hallam, 2003). Although ‘identity issues’ are not usually a focus of standard CBT practice, in this study participants showed their agency in adapting CBT successfully to construct valued outcomes in this area.

Clients’ Adaptation of the Concept of ‘Core Beliefs’

An emphasis on the past is inconsistent with the approach of most CBT practitioners who typically focus on current problems and do not delve into ‘deeper issues’ (Beck, 2011; Leahy, 2008; Mansell & Taylor, 2012; Neenan, 2012). Some participants in this study, however, adapted the concept of ‘core beliefs’ - a framework that was culturally familiar to participants and hence readily appropriated - to construct an understanding of the effects of a difficult childhood on their sense of self, relationships, thoughts and feelings. The findings suggest that for these participants there was no need for the thought-challenging techniques that typify CBT practice; the self-understanding acquired through the concept of ‘core beliefs’ was considered by these participants to be a valuable and transformative therapy experience. Rather than challenging ‘core beliefs’, paradoxically, some clients may perceive benefit from their ‘validation’. That the modification of thought is not necessary for CBT to be successful is an idea that has been previously put forward (Hayes et al., 2004; Longmore & Worrell, 2007).

The participants used the concept of ‘core beliefs’ as a kind of narrative scaffold by which they could understand the development of their distress and their negative sense of self. It was implicit in these participants’ perspectives that the self-understanding they acquired was an integral component of the process of change and facilitated their ability to ‘let the past go’. New forms of self-understanding are a prerequisite to reformulate self-narratives, which may be one reason why clients value increased self-understanding as a therapy outcome (Binder et al., 2009; Levitt, Butler, & Hill, 2005; Levitt, Holgersen, & Nielsen, 2009; Nilsson et al., 2007). The findings highlight that rather than focusing on current problems or challenging ‘negative core beliefs’, understanding the influence of the past on the present can be of central importance for some clients.

Clients' Perspectives on the Therapy Relationship

In contrast to other approaches, traditionally, CBT is said to resolve the client's problems using CBT techniques rather than utilising the therapy relationship (Wills & Sanders, 2013). The majority of CBT approaches operate on the assumption that change is brought about by the specific therapeutic techniques a therapist employs (Castonguay et al., 2010; Dobson & Dobson, 2009; Wills & Sanders, 2013). The therapy relationship is regarded as a vehicle that promotes therapeutic learning and as indirectly beneficial in that it facilitates the use of these techniques (Castonguay et al., 2010). In this regard, the relationship has been considered 'necessary but not sufficient' for therapeutic change to occur (Beck, Rush, Shaw, & Emery, 1979). However, clients in this study who had engaged in CBT strongly emphasised the social, interpersonal element of therapy as a mutative factor that directly brought about a variety of outcomes they valued.

'Collaborative empiricism' is described as a goal of CBT and conveys the idea that therapists and clients work as a team to address the client's problems (Dobson & Dobson, 2009; (Kuyken, Padesky, & Dudley, 2009). A collaborative therapy relationship is considered useful for assisting the client's engagement in specific techniques (Castonguay et al., 2010; Leichsenring et al., 2006), and achieving therapy goals (Ekberg & LeCouteur, 2014; Gilbert & Leahy, 2007; Kuyken, Padesky, & Dudley, 2009). The depiction of CBT as a collaborative effort was notable in this study, with some clients using the pronoun 'we' to narrate their therapy experiences. However, while some participants described collaborating with their therapists to use specific CBT techniques, collaboration was also implicitly linked to the existence of an enabling personal relationship and interpersonal 'contributions' from both client and therapist, which directly brought about positive changes. In this regard, the findings of this study support the argument that more elaboration of the construct of collaboration is required both in terms of clients' processes and the various ways in which client and therapist activities combine to form a collaborative effort (Bohart & Wade, 2013).

Participants in this study perceived that articulating their concerns and stories to the therapist was an essential part of the therapy process. This contribution was made more significant by the implication in some narratives that their stories were volunteered, despite some initial embarrassment and reticence, and was made on the

understanding that their conscious decision to do so would be a curative experience. In this regard, it was the participants' understanding that they had agentically extracted the curative benefits from the relationship that they perceived they needed. In addition to the experience of being able to articulate concerns, participants stressed the importance of their therapists' readiness to listen.

It was implicit from the perspectives of participants in this study that their ability to articulate their concerns and construct new self-narratives was dependent upon their perception of certain qualities in their therapists and in the characteristics of the therapy relationship: kindness, care and warmth, empathy, attentive listening, a sense of safety and support, and affirmation and encouragement. These are qualities that have been found to be valued by clients in previous studies (Bedi, Davis, & Williams, 2005; Norcross, 2010; Binder, Holgersen, & Nielsen, 2009; Castonguay & Beutler, 2005; Giorgi & Gallegos, 2005; Levitt, Butler, & Hill, 2006; Lilliengren & Werbart, 2005; Timulak, 2007), and appear to reflect clients' perception of a real and genuine relationship. In this study, some participants perceived authentic, personal relationships with their therapists comparable to those they would have with a friend or family member. Participants stressed the importance of perceiving their therapist was non-judgemental and objective, and that the relationship felt 'safe'. These factors were perceived as both enhancing their ability to speak freely without fear of criticism or being misunderstood and implicitly linked to the development of a more positive self-narrative and sense of self. The therapy relationship can be experienced as a curative counterpoint to cultural discourses. An individual's identity is formed through their relationships with others (Elliott, 2005; Hogan, 2005; Speedy, 2008), and new relational experiences and the presence of a 'witnessing other' in a therapist may be constructed by clients as evidence of the falsity of former, negative self-narratives, and validating the 'truth' of a preferred identity.

Although in the minority, some CBT theorists have argued that the therapy relationship may be utilised to the client's benefit by assisting them to gain understanding of, and potentially alter, interpersonal behaviour patterns (Wills & Sanders, 2013). The findings support the idea that a client's experience of feeling understood by their therapist when disclosing painful experiences may become the basis of new, corrective interpersonal experiences (Angus & Kagan, 2007). In this study, the unfamiliar experience of what it felt to invoke empathy from another

person, through the therapist's empathic response, was felt to be associated with gained insight into habitual interpersonal behaviour and the experience of change. Relational experiences with therapists that are new for clients may be perceived as producing lasting, positive changes in how clients experience their relationships with others. Clients may use the therapy relationship in CBT to achieve the change they hope to achieve, such as expressing and sharing emotions openly, by utilising it to experience new ways of 'being' in relationship to others.

It is argued that despite the fact that the therapy relationship in CBT has been conceptualised as a 'secondary factor' in regards to its contribution to therapeutic change, research suggests the relationship has more power to bring about change than CBT theories historically acknowledge (Castonguay et al., 2010). The findings of this study support McLeod's (2013) argument that a therapy relationship that is perceived as non-judgemental and safe can involve more than just working together to address problems; it can be a 'curative' experience in itself.

Client's Agency in the Therapy Process

It is now widely-accepted that a client has particular expectations of therapy which shape both their experience of the process, and the outcomes that ensue (Westra et al., 2010). A client's expectations of therapy are argued to be one of the more influential factors in therapy outcomes (Frank & Frank, 1991), and arise from the influence of the social and cultural environment, and from the way in which a client understands their problem. As has been reported previously in CBT clients' accounts (Nilsson et al., 2007), it appeared in some of the participants' narratives that the framework and discourse of CBT may have shaped how problems were understood. However, clients also drew from alternative cultural discourses to understand and evaluate their therapy experiences. Although many of the problems participants conceptualised did not align with standard CBT practice, participants used CBT agentially to meet their perceived needs. Participants had a strong belief in the authenticity of the problems they conceptualised and exercised agency in utilising therapy to address these problems. This included seeking practical strategies to manage distress and agential adaptation of CBT techniques and concepts to suit a variety of purposes for which they were not originally intended.

There was a strong sense in participants' narratives of an association between agency in the therapy process and a positive and productive therapy experience. Within some participants' accounts, agency was evident in the therapy relationship in ways which were similar to the experiences described by clients in prior studies (Knox & Cooper, 2011) who reported that their experiences of relationship depth with their therapists were preceded by their conscious decisions to assume a 'state of readiness' and to be vulnerable within the relationship. In this study, some participants displayed a commitment to a 'state of readiness' in their willingness to disclose and 'declare' their vulnerabilities in the expectation that this would be a healing experience. Drawing from cultural discourse, clients may understand there will be benefit in revealing personal experiences and self-narratives to their therapists (Parker, 2007), and engage in therapy with this understanding and preparedness.

The findings of this study support the argument that ultimately, a client's agency is at the heart of the therapy experience (Adler, 2013). Clients in Western society live in a culture that places an emphasis on individualism and fosters a belief that one should and can have personal control over one's 'mental health' (Dobson & Dobson, 2009). Participants in this study believed in their need and capacity for personal change and held an implicit belief they would be able to achieve it. Their perspectives align with the findings of prior research (Hoener et al., 2012), wherein clients reported valuing being involved in the therapy process and the idea that they are 'doing the work' themselves. Rather than simply assimilating a therapist's input, clients see themselves as making active choices within therapy and being the authors of their own change processes (Bohart & Wade, 2013; Duncan, Miller, & Sparks, 2004; Hoener et al., 2011; Lillengren & Werbart, 2005).

Implications for Clinical Practice

There are five major implications for clinical practice that emerge from this research. These are: clients' increased self-awareness may restore a sense of agency and facilitate the effectiveness of CBT techniques to manage distress; therapists should assist clients' awareness of the way the cultural environment both enables and constrains how clients construct their problems; clients may be assisted in therapy to address concerns pertaining to identity; the concept of 'core beliefs' may be useful for clients who want to develop their self-understanding in relation

to the influence of the past; there are a number of ways in which the therapy relationship may contribute directly to the change process.

Developing Self-Awareness and Increasing Client Agency

The findings of this study suggest that for some clients, developing the ability to ‘step back’ and become aware of emotion, thought, physical sensations and behaviour as they occur may be perceived as a critical component of change. The study also indicates that although high levels of distress may be experienced by clients, awareness in the present moment of these phenomena and their nature may be an unfamiliar experience. As well as using CBT models to provide a conceptual understanding of ‘internal responses’, therapists might consider the use of imaginal exposure during therapy sessions to assist the client to induce the experience of distress so as to increase their awareness of and familiarity with these responses as they occur (Clark & Beck, 2010). Clark and Beck (2010) suggest that therapists use guided discovery to help clients develop an ‘imagery script’ or narrative that can then be meditated upon by clients to promote this experiential learning. Mindfulness techniques may also be a useful adjunct as clients’ tolerance of emotion can be increased using these techniques by assisting them to develop awareness and acceptance of the emotional experience without judgement or avoidance (Huxter, 2007; Fruzzetti & Erikson, 2009). Therapists can teach mindfulness techniques so that clients can ‘decenter’ themselves from their experiences and refrain from becoming engaged with thought in an evaluative manner (Clark & Beck, 2010). These techniques can also increase clients’ awareness of their physical sensations and the content of their thoughts as they occur, and heighten clients’ awareness of the relationship between thought and emotion; outcomes clients in this study found valuable. In this study, clients’ associated their increased awareness in the present moment with a sense of clarity, relative detachment from distress, and an ability to be agential and strategic through the recognition of occasions when the implementation of therapy techniques would be of most benefit.

Working with Identity

Although issues relating to personal identity are not a focus of standard CBT practice, these issues may present commonly and may be of concern to clients.

Therapists should aid clients' awareness of how the social and cultural environment both constrains and enables different ways of understanding identity. Polkinghorne (1988) contends that it is one of a therapist's roles to bring to a client's awareness the language they are using in the narratives they have developed to give meaning to their lives. Therapists may increase clients' awareness by the use of questions that help clients to uncover and carefully explore discourses that may be oppressive, but which are commonly given credence (Duvall & Beres, 2007). I would suggest therapists actively assist clients to reflect upon the connections between their sense of identity and the cultural discourses they draw from, and endeavour to expand their awareness of 'subordinate' positive narratives that could potentially be developed. A therapeutic process in which rich and detailed descriptions of a client's narrative are garnered may enable a client's consideration of multiple interpretations and their ability to create alternative narratives (Brown, 2007). To increase a client's awareness of their narrative ability and the influence of their meaning-making capacities, therapists might draw contrasts between the alternative stories that appear, and explore and discuss with clients the potential effects of these stories.

However, it is possible for therapists and clients to develop a preferred story without claiming that a 'real self' is being discovered (Brown, 2007). Rather than focusing on the idea of a fixed, unchangeable essence, the re-authoring of identity may focus on an individual's preferences, agency, and values in relationships, and at the same time amplify the fluid, changeable nature of identity (Augusta-Scott, 2007). Increasing a client's understanding of the inherent changeability and fluidity of identity, and the creativity that is involved in its construction, may position clients as less vulnerable to distress should a constructed identity become dissatisfying, threatened or 'undone' in the future. Polkinghorne (1988) suggests a number of ways in which therapists may assist clients to re-author narratives that have been overly restrictive: therapists can question clients about the freedom of choice and the quality of existence their narrative allows, draw attention to attributes and events not accounted for in clients' narratives that test and challenge the narrative as told, offer alternative narratives to the client that more fully incorporate their experiences, and remove the restrictions of a personal narrative by helping the client to develop a new plot through the reorganisation of experience.

The findings of this study highlighted clients' ability to reinterpret experience and alter self-narratives to support the authoring of a preferred identity. Therapists can assist clients in this creative endeavour by collaborating with them to explore these possibilities. People come to know their identity through the narratives they tell to others (Anderson; 1997; Lieblich, 2004; Tuval-Maschiach, 2006), and as narratives are created between people, the role of the therapist includes being both a witness to, and co-author of, the narratives the client tells (McLeod, 2004). In this study, discussion around clients' values, morals, and their perception of their own personal strengths generated renewed enthusiasm about engaging with life and relationships. Therapists can also explore with clients the possibility of finding new self-referent meanings from relationships and activities they are already engaged in. Roberts and Creary (2012) argue that the 'claiming' of identity happens when an individual's performance of identity embodies his or her self-view. In this study, 'embodiment' provided clients with an identity that felt authentic and that could support a story of the self that seemed credible. It may be helpful to some clients if therapists not only assist them to imagine a meaningful direction for their lives, but encourage engagement in activities which bring about a restored sense of self (Wilson et al., 2011).

Understanding the Self Through the Concept of 'Core Beliefs'

For some clients, understanding how the past is implicated in their experience of distress may be a preferred emphasis for therapy (Valkonen et al., 2011). Prior studies exploring clients' perspectives have found that a therapy's usefulness to a client is dependent upon its capacity to assist the client to move ahead in line with their own meaning-frames in a way that signifies to them that progress has been made (Valkonen et al., 2011). This study suggests that clients may be aware of cultural discourse about the negative effects of difficult childhood experiences on one's sense of self, and may believe that progress will be achieved if they are able to understand these influences. The concept of 'core beliefs' may be readily adapted by some clients and used as an opportunity to understand these influences and construct in therapy the self-understanding they perceive they need. While typically CBT focuses on current problems and does not delve into deeper issues and the past (Beck, 2011; Leahy, 2008; Mansell & Taylor, 2012; Neenan, 2012), therapists should be willing to adapt to a client's needs and accommodate their

preferred emphasis, notwithstanding that these conceptualisations may not align with standard CBT practice. Although the identification of ‘core beliefs’ from a therapist’s perspective may be associated with problem conceptualisation, from clients’ perspectives a fuller understanding of the development and effects of ‘the problem’ may be central to the change process itself. Therapists should be active in assisting clients to use the concept of ‘core beliefs’ to articulate their narratives, explore their meaning, and understand the connections they perceive between the past and the present. Some clients may prefer an exploration and in some sense ‘validation’ of their beliefs rather than immediately questioning them. Attempts to help clients recognise ‘faulty thinking’ can be experienced by a client as judgemental (Gilbert, 2007). By refraining from challenging beliefs, a therapist provides a client with time to reflect and avoids the possibility that the client may confuse thought-challenging with criticism.

The Therapy Relationship in Practice

The findings of this study suggest that clients’ understanding of a collaborative therapy relationship may be broader than the theoretical conceptualisations usually drawn. In addition to collaborating with therapists in the use of specific techniques, clients may perceive significant benefit from the interpersonal, collaborative processes of the relationship. This study highlighted both similarities and variation among clients in terms of what they expect or value in the relationship, and therapists might consider discussing with clients whether they perceive that each party has or should have a respective role, what clients perceive they need from the therapy relationship, and how the therapy process is understood. Bird (2000) suggests that therapists negotiate the therapy relationship with clients openly, and that a useful beginning point for conversation is to provide clients with a description of their own understanding of the therapeutic relationship. Encouraging a client’s active contribution provides them with a sense of agency and ownership of the therapy process, and an opportunity to collaborate with the therapist. It is important to position the client as co-architect of the therapy process, able to identify his or her own needs and to steer the process into areas they perceive will be of most benefit to them.

Due to cultural discourse, clients in Western societies may feel an inordinate amount of responsibility for their psychological health, that they are lacking ‘control’ (Dobson & Dobson, 2009; McLeod, 1997), and stigmatised by cultural ideas that paint ‘therapy-seeking’ as a sign of personal weakness and psychological distress as evidence of ‘madness’. Disclosing vulnerabilities and negative self-narratives may be difficult for clients given the discourses circulating within the cultural environment in which they live. It is important, therefore, for the therapist to acknowledge that although they themselves may perceive there is no cause for discomfort or shame, a client may view things differently. Therapists should be attuned to clients’ concerns about engaging in the therapy process with understanding and compassion (Newman, 2007). However, while clients may be reluctant to express their vulnerabilities in their personal and social relationships, they may approach the therapy relationship with a preparedness to be vulnerable and a desire to share their self-narratives, and may view this experience as an integral component of the process of change. From the perspectives of participants in this study, a vital part of the therapy process was the experience of sharing their stories in a ‘safe’ environment wherein frustrations could be vented and stories told without fear of invalidation or judgement. Therapists should be sensitive to any signs of clients’ reticence and explore with clients how they might best assist them to feel safe within the relationship. It is important that therapists adapt their own response style in accordance with the way in which each individual client defines or experiences helpfulness (Lambert & Barley, 2001).

This study supports prior research that has found that some clients find being given an opportunity to narrate their experiences, put their feelings into words, reflect, and ventilate as valuable and curative experiences that provide clarity and bring a sense of relief (Bury, Raval, & Lyon, 2007; Lillengren & Werbart, 2005). Clients have been found to value storytelling because they perceive it enables them to revise and ‘work through’ their lives (Lillengren & Werbart, 2005). Therapists might consider stating explicitly to their clients that their stories are important and express their keen interest in hearing the stories fully, and should be prepared to alter their plan for therapy if necessary to allow clients to articulate their narratives without impediment. While CBT therapists are encouraged to maintain predictability in regards to how each session is structured (Beck, 2011; Dobson & Dobson, 2013), it is also acknowledged that some flexibility is at times appropriate (Dobson & Dobson,

2013). Some clients prefer therapists who are adaptive to their needs such that the client feels accepted, unhurried and able to take their time (Nilsson, et al., 2007), and value being able to speak with their therapists in an unstructured context (Lillengren & Werbart, 2005).

Clients may be assisted to explore their narratives by a therapist's use of Socratic questioning, a CBT technique commonly used to stimulate a client's thinking and self-reflection (Gilbert & Leahy, 2007; Neenan, 2012; Padesky & Beck, 2003; Wills, 2012). Also of potential use to therapists for eliciting stories is a commonly used explorative questioning technique in CBT, that of the 'downward arrow', wherein a therapist utilises repeated questioning, typically, to explore the assumptions a client has made, in order to identify the 'core belief' that these inferences have derived from (Dobson & Dobson, 2009). Rhodes (2014) argues that the concept of 'downward arrow' questioning assumes a network of meanings, and that this technique of repeated questioning can also assist clients to articulate narratives and to understand the content and interconnection between the network of meanings of their experiences (Rhodes, 2014).

The therapy relationship should be instrumental in establishing a constructive balance between acknowledgement of the client's experience of distress and patience when encouraging the client to conceive of a way forward. As has been reported by clients in previous studies (Bury, Raval, & Lyon, 2007; Lillengren & Werbart, 2005), one highly significant experience of the therapy relationship reported by participants in this study was their perception that the therapist fulfilled the role as active listener and witness to their narratives. A therapist's attentiveness, responsive body language and explorative questioning may assist clients' perception that they are being truly heard by the therapist. One aspect of active listening involves providing clients with sufficient time to pause and reflect when articulating their narratives. Clients have previously reported that periods of silence are experienced as highly productive moments in therapy, valuable in that they stimulate insight by allowing clients to make connections (Levitt, 2002). While occasional questions may be useful at particular points, refraining from interrupting clients is advisable lest clients feel the therapist is not willing to listen, or feel hurried and prevented from making connections and exploring their narratives satisfactorily.

The therapy relationship provides clients with an opportunity to experience themselves in relationship with another person in ways that contradict the dominant self-narratives they may hold that support a negative identity. The findings of this study suggest that clients' perception of their therapist's qualities and the nature of the therapy relationship are not only facilitative of a client's engagement in the therapy process and specific techniques, but may assist the re-authoring of an alternative identity. Many clients in this study appeared susceptible to fears of being judged by others and by their therapists. Therapists should be sure to convey their understanding and acceptance when clients articulate their narratives, the experience of which may weaken clients' identification with negative cultural discourse and enable them to conceive themselves in a more positive light. Clients who are vulnerable to criticism may find evidence to contradict that belief in a CBT therapist who behaves in a sensitive and open manner (Wills, 2012), and in receiving a therapist's compassionate validation of their experiences clients may begin to see or judge themselves differently as they adopt their therapist's perspective (Gilbert, 2007).

This study found that some clients may perceive a loss of a sense of agency because of their psychological distress, and may hope and expect to use therapy to restore it. Changes in a client's perception of their own personal agency have been found to precede clinical improvement (Adler, 2012). Therapists may assist clients to construct identities as more agential individuals through the relational experiences they have with clients in therapy. Clients who see themselves as motivated and engaged help-seekers, and who are seen as such by their therapists are more likely to achieve better outcomes (Orlinsky et al., 2004). Therapists should acknowledge and affirm a client's determination and faith in their capacity for change, and convey to the client the value of these personal resources. Therapists might also ensure that clients feel they are contributing to and actively engaged in therapy, and attribute a client's progress to their own efforts. This study supports prior research that has found that clients value the feeling of achievement they derive from the understanding that they have authored their own recovery (Hoener et al., 2012). The findings of the current study also indicate that therapists' affirmation and encouragement may reflect to the client an image of themselves as an agentic person. Emphasising a client's personal strengths, progress and achievements may help a

client to construct a self-narrative wherein ‘agentic’ is a developing attribute of their identity. Studies have found that CBT treatments which focus upon a client’s strengths are more effective, improve the therapy relationship and bolster a client’s self-esteem (Fluckiger, Caspari, Holtforth, & Willutzki, 2009). In addition, Bruner (1994) argues that an ‘agentic identity’ is constructed by an individual conceptualising and gathering agentic instances from their past and foreseeing that these will occur and continue in the future. I would suggest that therapists listen for instances of personal agency in clients’ narratives, show their curiosity about and explore these instances, and assist clients to develop these ‘narrative threads’ which may affirm identities that support agency and self-determination.

While the idea of expressing repressed emotion or ‘catharsis’ does not align with standard CBT theory and practice, it is a culturally familiar idea that may influence how clients construct and evaluate the therapy experience. Therapists may promote and validate a client’s awareness and acceptance of emotional experiences, and assist them to develop alternative ways of expressing emotions (Greenberg, 2007). CBT clients are typically encouraged to conduct experiments outside of therapy to confront their fears and disprove their own (negative) hypotheses (Clark & Beck, 2010; Dobson & Dobson, 2009), however the findings of this study suggest that the therapy relationship may be similarly used as an environment wherein the expression of emotion can be explored and ‘experimented with’ by clients. The sharing of emotion within therapy may move the experience beyond the hypothetical into the ‘real’, potentially making therapy more compelling and persuasive to clients. A therapist’s ability to convey empathy at such moments may generate insight for a client into how they habitually respond to such interactions, and how they might respond in the future. Clients may value perceiving that their therapist is feeling what they are feeling in the moment, and this relational experience may be associated with positive impacts on the client’s life and the perceived helpfulness of therapy (Bachelor, 1988). However, clients respond idiosyncratically to different expressions of empathy (Bachelor, 1988), and a therapist should therefore exercise sensitivity and personal judgment in deciding how to express empathy with a particular client.

Finally, this study illustrated how exploring clients’ perspectives may challenge conventional understandings about how clients’ problems may be perceived. For example, clients who hold spiritual beliefs may perceive the experience of

depression as valuable to them, which then behoves therapists to determine how they might best assist such clients to explore the meaning of their experience and how they might learn and grow from it, rather than eliminate it. Similarly, clients may not interpret their distress as evidence of a mental illness but due to extrinsic factors, and may find being ascribed a diagnosis an invalidating experience. In this study, one participant's experience of diagnosis was perceived as the 'wrong focus' and as obstructing the therapy process from meeting her needs. Similar experiences have been reported in prior research wherein clients have described feeling invalidated by the experience of diagnosis and that they have not been understood as unique individuals (Binder et al., 2013). This might particularly be an issue within the New Zealand public health service where clients can only receive help if they are given a diagnosis. 'Losing' the client at the beginning of therapy is likely to prevent therapy from progressing and lead to a negative outcome for the client. Perhaps for such clients, therapists can be transparent about the required procedures while at the same time ensuring clients' views are acknowledged and respected. Therapists might discuss any concerns clients have regarding diagnosis, acknowledge their perspective and adjust the emphasis on diagnosis accordingly.

Implications for Clinical Research

Implications for clinical research that emerge from this study, relevant to both CBT specifically and psychotherapy research more generally are: more attention needs to be paid in future CBT research to clients' perspectives on the therapy relationship; the principle of collaboration in CBT may be insufficiently broad and requires further research; qualitative research exploring how clients engage agentically with therapy may increase our understanding of the ways in which clients actively construct their experience of therapy and contribute to the process of change.

One reason why CBT's change mechanisms may be poorly understood is the comparatively little research attention to date investigating how the therapy relationship in CBT influences therapy. While there has been a modest increase in interest in CBT over the last decade in the potentially curative nature of the therapy relationship (Wills, 2012), due to the emphasis in current CBT research on empirically supported treatments, research has focused on the technical aspects of CBT and the therapy relationship has been given relatively little attention (Dobson &

Dobson, 2009; Leahy, 2008). The research that has been done in this area has largely utilised quantitative methods and has limited the capacity of researchers to understand the complexities involved (McLeod, 2013). One challenge that faces CBT researchers is the need to understand how relationship factors interact with other 'specific' factors (such as therapy techniques) or other 'common' factors, such as a client's expectations of therapy (Hardy, Cahill, & Barkham, 2007). Additionally, it is argued that searching for causal links between outcome and the alliance risks oversimplifying what may be viewed by clients as a process of reciprocal causality, wherein the quality of the relationship and the interventions used by the therapist interact in complex ways (McLeod, 2013). Research needs to move beyond correlational designs and use methods that are capable of investigating the complexities involved in the relationships among clients and therapists and treatment outcome (Norcross & Wampold, 2011). I would contend that interview-based, qualitative studies are the most appropriate method for researching the nature of the therapy relationship because they afford participants the opportunity to provide the level of detail that is required when attempting to understand such complexities.

An interesting area for researchers to explore with respect to the therapy relationship in CBT research might be the concept of collaboration. As previously stated, a collaborative therapy relationship is regarded as useful in that it assists a client's engagement in the specific techniques of CBT (Castonguay et al., 2010; Leichsenring et al., 2006). The concept of 'client collaboration' has sometimes been restrictively defined in CBT research in terms of clients' participation in impersonal processes such as homework compliance and 'treatment adherence' (Bohart & Wade, 2013; Tryon & Winograd, 2011). However, the findings of this study suggest that clients may have a broader understanding of their collaborative experience with the therapist and the ways in which both parties contribute to a collaborative endeavour. Rather than researchers defining in advance what collaboration is, I would suggest that researchers might look to broaden the concept by investigating CBT clients' perspectives of what constitutes a collaborative act and collaborative relationship, how they perceive each party contributes to the interpersonal process, and how they perceive a collaborative relationship produces change.

There are relatively few studies exploring clients' agency in the therapy process (Bohart & Wade, 2013). However, research exploring clients' perspectives has found

that clients attribute their experience of change as being due to their own agentic efforts in therapy (Hoener et al., 2012), and often have their own plan for therapy and steer the process into areas that they envisage will most benefit them (Bohart & Tallman, 2010; Rennie, 2000). The findings of this study suggest that clients are actively involved in all areas of the therapy process and agentially adapt therapy in a variety of ways to construct change and produce valued outcomes. Areas of interest for CBT researchers investigating client agency might be clients' use of CBT concepts, their employment and adaptive use of therapy techniques, and the therapy relationship. Qualitative methods are most suited to this area of research as these methods make visible the ways in which clients are agential actors who relate to therapy and influence therapy outcomes in a variety of ways (Gordon, 2000; Rennie, 2010).

In conclusion, clients' perspectives on their experiences of CBT should be of particular value to researchers and practitioners. This study showed that discovery-oriented interview-based approaches to CBT research based on small samples may do much to increase our understanding of how the experience and outcomes of CBT may be constructed by clients. While some clients may construct an experience of CBT which is in line with the way it has been theorised and commonly regarded - a practical therapy that provides strategies for managing current problems - others may draw from cultural discourses in the broader social environment to understand their problems and evaluate the therapy process. Clients engage actively and agentially with CBT in the way they conceptualise their problems, expect a pathway for change, adapt CBT concepts and techniques, author their own change processes, and produce valued outcomes. Although not typically regarded as such in CBT theory, the therapy relationship may be a highly significant 'mechanism of change' from a client's perspective. The therapy relationship may be perceived by clients as directly contributing to change by fulfilling functions and clients' needs that can only be met within the context of an exchange between two people. This study highlights the value of clients' perspectives as a research topic and the potential worth of further qualitative research which allows clients to make agentic use of the research process, as they do of the therapy process.

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APPENDIX A



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Letter of Invitation

The Centre for Psychology is conducting some research aimed at improving our services. We would like to invite you to participate in a research project being undertaken by one of the Clinical Psychology students in the School of Psychology, Rachel Hallas. In the attached sheet is information about the study that will enable you to make an informed decision about whether or not you would like to take part in the research.

If you have any questions about the research Rachel will be happy to answer these. She can be contacted through the administrator at the Centre for Psychology, Helen McMaster. If you have any issues related to the research that you would like to discuss with a senior member of the School of Psychology, you may contact Professor Kerry Chamberlain, who is one of the supervisors involved in this study. Ph: 414-0800 (41226)

Thank you for your consideration. If you would like to participate, please contact Helen McMaster at the Centre for Psychology 441-8175 or just sign the attached Consent Form and return it in the enclosed, addressed envelope to:

Rachel Hallas

School of Psychology

Massey University

Private Bag 102904

North Shore Mail Centre

Auckland

Yours Sincerely

Dr Clifford van Ommen

Director

APPENDIX B



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Information Sheet and Letter

Principal investigator:

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INFORMATION LETTER FOR STUDY INTO CLIENTS' EXPERIENCES OF THERAPY

The aim of the research is to gain a greater appreciation of clients' experiences of therapy. While there have been a variety of surveys and questionnaires that have been used to explore and learn from clients' experiences of therapy, there has been little in the way of providing clients the space and freedom to describe their experiences in a less constrained way. An appreciation of clients' perspectives from more detailed accounts will progress our understanding of the important aspects of the therapeutic experience, and may ultimately assist psychologists to provide a better service to their clients. I would like to provide you with some information about this project and what your involvement would entail if you decide to take part.

With your permission, I would audiotape an interview with you, of up to one hour in length, about your experience of therapy. This could take place either at the Centre for Psychology, Massey University (Albany) or at another place of your own choosing (e.g. your own home or workplace). The interviews will be free-flowing, unstructured, and conversational by nature. You do not have to answer any questions you choose not to and may end the interview at any moment you wish. The transcripts will be anonymous due to the use of pseudonyms and I will not be aware of the identity of your therapist. Other than myself, my supervisors - Kerry Chamberlain, Bev Haarhoff, and Kerry Gibson - will have access to the information provided by participants, but they will only have access to this information via the use of the pseudonyms.

The anonymous narratives and transcripts will then be analysed and written up as part of the 'results' section of the study. In the analyses, I will be seeking an in-depth understanding of the meaning and effects of the stories that participants have narrated about their therapeutic experience, with a view to supplementing the existing body of research in this area.

As part of my Doctorate in Clinical Psychology, the completed study will eventually be held by the Library at Massey University. It is possible that a part of the study may be submitted for publication to academic journals, but again, all narratives and transcripts will be identified only by their given pseudonyms.

I would like to assure you that this study has been reviewed and received ethics clearance through the Ministry of Health.

Thank you for your consideration.

Kind regards,

Rachel Hallas

APPENDIX C



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CONSENT FORM

I have read the information letter about the study being conducted by Rachel Hallas, Clinical Psychology student at Massey University, Albany in Auckland. I have had the opportunity to ask any questions related to this study, to receive satisfactory answers to my questions, and any additional details I wanted.

I am aware that I will be interviewed for up to one hour and the interview will be audiotaped to ensure an accurate recording of my responses.

I am also aware that the transcripts of the interview will be made by the researcher into a narrative (story) form, and excerpts from the transcript of the interview may be included in the thesis and/or publications to come from this researcher, with the understanding that the quotations will be anonymous to readers, due to the use of pseudonyms.

Date: _____

Signature: _____

Print name: _____

Phone number: _____

By signing this consent form, you are not waiving your legal rights or releasing the investigator(s) or the involved institution from their legal and professional responsibilities.