

**THE CHANGE PROCESS: CLIENTS' PERSPECTIVES AND UNDERSTANDING  
OF CHANGE DURING PSYCHOLOGICAL THERAPY**

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## **ABSTRACT**

**Background:** Talking therapies, predominantly Cognitive Behaviour Therapy (CBT), represent a key approach to supporting mental health distress in the UK. CBT is beneficial for many individuals, yet it is common to 'relapse' and there are a significant number of individuals for whom it is unhelpful. Although research can evidence its effectiveness, decades of studies have yet to find clarity on the change mechanisms, the central tenet of therapy. Researchers propose that understanding how therapy works is a complex multifactorial process that has perhaps been skewed by a dominant quantitative approach. As the site of change and largest contributing variable of change, clients' viewpoint is considered critical to the success of therapy. However, clients' perspective of how therapy works is limited and conflicting within the literature.

**Aims:** To gain clients' perspectives by exploring their understanding of how change occurs in therapy, as well as exploring how clients define change in therapy.

**Method:** Drawing on a critical realist approach, this study utilised qualitative methods. Ten self-selecting participants who experienced positive change through CBT in NHS secondary care services partook in semi-structured interviews. Interview transcripts were analysed using Thematic Analysis.

**Results:** Three main themes were identified from participants accounts: 'Change as changeable', 'External help' and 'It's not magic'.

**Conclusions:** Findings highlighted the nonlinear, dynamic, complex and individualised process of change in therapy. A working definition of participants' understanding of change has been offered, which can be utilised in research, policy and practice. Participants emphasised common factors of change. A Perceptual Control Theory framework was considered as one possible explanation of participants' experiences as it was able to account for descriptions of change more than other theories. Implications of the study and further research ideas have been presented.

## TABLE OF CONTENTS

<b>ACKNOWLEDGEMENTS</b> .....	<b>ii</b>
<b>ABSTRACT</b> .....	<b>iii</b>
<b>LIST OF ABBREVIATIONS</b> .....	<b>ix</b>
<b>1. INTRODUCTION</b> .....	<b>1</b>
1.1 Chapter Overview .....	1
1.2 Current Context.....	1
1.2.1 Mental Health in the United Kingdom (UK) .....	1
1.2.2 Societal Impact .....	2
1.2.3 Approach to Mental Distress.....	2
1.3 NHS Talking Therapies .....	3
1.3.1 CBT in Policy .....	3
1.3.2 CBT in Services .....	4
1.3.3 CBT in Training.....	4
1.4 CBT Overview.....	5
1.4.1 CBT Research .....	5
1.4.2 CBT Specific and Common Features .....	6
1.5 Change in Psychological Therapy.....	7
1.6 Models of Change.....	8
1.6.1. Transtheoretical Model of Change.....	8
1.6.1.1 <i>Stage 1, Precontemplation</i> .....	9
1.6.1.2 <i>Stage 2, Contemplation</i> .....	9
1.6.1.3 <i>Stage 3, Preparation</i> .....	9
1.6.1.4 <i>Stage 4, Action</i> .....	9
1.6.1.5 <i>Stage 5, Maintenance</i> .....	9
1.6.2 Hope Framework .....	10
1.6.2.1 <i>Goals</i> .....	11
1.6.2.2 <i>Pathways</i> .....	11
1.7 Defining Change .....	12
1.8 Attempts to Measure Change .....	14
1.9 Change Process Research .....	14
1.9.1 Common Factors .....	15
1.9.2 Specific Factors .....	16
1.9.2.1 CBT specific factors.....	16

1.9.3 Combined Factors .....	18
1.9.4 Limited View of Change Process Research.....	19
1.10 Clients' Perspective .....	19
1.11 Change Processes from the Client Perspective: A Review of the Literature .	20
1.11.1 Summary of Literature Review.....	21
1.11.1.1 Clarke, Rees and Hardy (2004).....	21
1.11.1.2 Olofsson, Oddli, Hoffart, Eielsen and Vrabel (2020).....	23
1.11.1.3 Carey, Carey, Salker, Mullan, Murray and Spratt (2007).....	24
1.11.2 Summary: Gaps in the Literature .....	26
1.12 Current Research.....	27
1.12.1 Study Rationale .....	27
1.12.2 Clinical Relevance .....	27
1.12.3 Research Questions .....	28
<b>2. METHOD.....</b>	<b>29</b>
<b>2.1 Overview .....</b>	<b>29</b>
<b>2.2 Epistemology .....</b>	<b>29</b>
<b>2.3 Ethical Considerations .....</b>	<b>31</b>
2.3.1 Informed Consent .....	31
2.3.2 Confidentiality .....	31
2.3.3 Remuneration .....	32
2.3.4 Potential Distress.....	33
2.3.5 Debriefing .....	33
<b>2.4 Service User Consultation .....</b>	<b>34</b>
<b>2.5 Design .....</b>	<b>35</b>
<b>2.6 Participants .....</b>	<b>35</b>
2.6.1 Recruitment .....	35
2.6.2 Recruitment Criteria.....	36
2.6.2.1 Inclusion Criteria .....	36
2.6.2.2 Exclusion Criteria.....	37
<b>2.7 Procedure .....</b>	<b>37</b>
2.7.1 Initial Contact.....	37
2.7.2 Remuneration .....	37
2.7.3 Consent Form .....	38
2.7.4 Interviews.....	38
2.7.5 Data Governance.....	38

2.7.6 Transcription .....	39
<b>2.8 Analytic Approach .....</b>	<b>39</b>
2.8.1 Thematic Analysis Justification .....	39
2.8.2 Stages of Analysis .....	41
<b>2.9 Reflexivity: Researcher's Position .....</b>	<b>42</b>
<b>3. RESULTS .....</b>	<b>44</b>
3.1 Chapter Overview .....	44
3.2 Sample Demographics.....	44
3.3 Thematic Map .....	46
3.4 Theme 1: Change as Changeable .....	46
3.4.1 Rollercoaster of Change .....	47
3.4.2 Change Leads to Change.....	50
3.4.3 Changing Expectations .....	52
3.5 Theme 2: External Help .....	54
3.5.1 The Therapist.....	<b>Error! Bookmark not defined.</b>
3.5.2 Help Beyond Therapy .....	57
3.6 Theme 3: It's Not Magic .....	60
3.6.1 A Hopeful Glimpse .....	60
3.6.2 Escaping Negative Emotions .....	62
3.6.3 Control .....	66
3.6.4 Pushing Through .....	69
<b>4. Discussion .....</b>	<b>72</b>
4.1 Chapter Overview .....	72
4.2 Findings in Relation to Research Questions and Literature .....	72
4.2.1 How Do Clients Describe their Experience of 'Psychological Change' in Therapy? .....	72
4.2.1.1 Conceptualisation of the change process.....	73
4.2.1.1.1 Nonlinearity .....	73
4.2.1.1.2 Awareness .....	76
4.2.1.1.3 Evolution .....	77
4.2.1.1.4 Active participation .....	78
4.2.1.2 Summary of clients' experiences.....	79
4.2.2 How Do Clients Define Change in Therapy? .....	80
4.2.2.1 Change as a journey .....	81
4.2.2.2 The role of others .....	81

4.2.2.3 Summary of participants' definition of change in therapy .....	82
4.3 Clinical Implications .....	82
4.3.1 Individual level .....	82
4.3.1.1 .....	82
4.3.1.2 Engendering change: .....	83
4.3.1.3 Facilitating active participation.....	84
4.3.2 Service Level and Wider Systems .....	84
4.4 Research Implications.....	86
4.4.1 Review of the Literature .....	86
4.4.2. Further Research .....	87
4.5 Critical Review .....	87
4.5.1 Sensitivity to Context .....	88
4.5.2 Commitment and Rigour .....	88
4.5.3 Coherence and Transparency .....	89
4.5.4 Impact and Importance .....	89
4.5.5 Limitations.....	89
4.6 Research Reflections .....	90
4.7 Conclusion .....	92
<b>REFERENCES.....</b>	<b>93</b>
<b>Appendix A: Stages of Change Model.....</b>	<b>115</b>
<b>Appendix B: Key Terms and Concepts of Change.....</b>	<b>117</b>
<b>APPENDIX C: Therapy Common Factors .....</b>	<b>118</b>
<b>APPENDIX D : Percentages Attributed to Variables from Different Perspectives</b> <b>.....</b>	<b>119</b>
<b>APPENDIX E: Search Criteria.....</b>	<b>120</b>
<b>APPENDIX F: Literature Review.....</b>	<b>122</b>
<b>APPENDIX G: Ethics – IRAS, HRA, REC, UEL Approval and Letter of Access for</b> <b>NHS Researchers .....</b>	<b>123</b>
<b>APPENDIX H: Participant Information Sheet .....</b>	<b>137</b>
<b>APPENDIX I: Consent Form .....</b>	<b>141</b>
<b>APPENDIX J: Debrief Information.....</b>	<b>142</b>
<b>APPENDIX K: Consultation Presentation.....</b>	<b>143</b>
<b>APPENDIX L: Poster .....</b>	<b>146</b>
<b>APPENDIX M: Leaflet .....</b>	<b>147</b>
<b>APPENDIX N: Demographic Information Form.....</b>	<b>148</b>

<b>APPENDIX O: Interview Schedule.....</b>	<b>149</b>
<b>APPENDIX P: Transcription Key.....</b>	<b>150</b>
<b>APPENDIX Q: Initial Codes Generated and Transcript Example .....</b>	<b>151</b>
<b>APPENDIX R: Theme Development: .....</b>	<b>153</b>

## **LIST OF TABLES AND FIGURES**

<b>Table 1: Summary of Change Processes.....</b>	<b>116</b>
<b>Table 2 Overview of common factors in psychotherapy.....</b>	<b>118</b>
<b>Figure 1. Prochaska &amp; Nocross (2001) Stages of Change Model.....</b>	<b>115</b>
<b>Figure 2: Perception of the Change Variables.....</b>	<b>119</b>
<b>Figure 3: Final Thematic Map.....</b>	<b>46</b>

## **LIST OF ABBREVIATIONS**

Below is a list of common abbreviations used in the research.

IAPT - improving access to psychological therapies

NHS - National Health Service

WHO - World Health Organisation

HCPC - Health and Care Professionals Council

NICE - National Institute of Clinical Excellence

CBT - Cognitive Behaviour Therapy

TTM - Transtheoretical model of change

CFT- Compassion Focussed Therapy

ED - Eating Disorder

PCT – Perceptual Control Theory

# 1. INTRODUCTION

## 1.1 Chapter Overview

This chapter begins with an overview of CBT provision in the NHS. Following this, key models of change and the concept of change are critically discussed. An argument will be presented that despite studies demonstrating the efficacy of CBT, little is known about the mechanisms of change. The researcher proposes a case for clients' accounts of change process research. A literature review demonstrates existing client input identifying gaps in the research, a rationale for the current study and research questions to be addressed.

## 1.2 Current Context

### 1.2.1 Mental Health in the United Kingdom (UK)

The dominant discourse of mental health difficulties can be understood through the World Health Organisation (WHO) definition:

“Mental disorders comprise a broad range of problems, with different symptoms. However, they are generally characterized by some combination of abnormal thoughts, emotions, behaviour and relationships with others.” (WHO, 2013, p. 38).

WHO speak to the difficulties which present in multiple areas of individuals' lives, however the difficulties as a normal response to abnormal contexts is rarely acknowledged (Boyle, 2011).

There is significant pressure on mental health services to provide support. UK statistics show that on an annual basis approximately one in four adults experience mental health difficulties. This is even higher for marginalised groups, for example 9/10 adults in forensic settings suffer with their mental health (Mental Health Taskforce, 2016). Referrals to mental health services are increasing with an estimated 3.6 million people already in contact with primary and secondary mental

health services or learning disability services during 2018-2019 (Baker, 2020; NHS Digital, 2019).

This does not account for those who seek support privately, those who seek alternative support for their mental health or those who do not seek support from professionals. Furthermore, an influx of individuals struggling with mental distress is predicted as a consequence of COVID-19 (Pierce, et al., 2020).

### 1.2.2 Societal Impact

Although mental wellbeing is valuable itself, it is important to consider other drivers of providing care. Mental health problems are the most significant cause of 'disability' in the UK (Mental Health Taskforce, 2016). This places a substantial economic burden on the country, entailing costs to individuals, families and society (e.g. welfare budgets and NHS costs; the government plans to spend £13 billion on mental health services in 2019/2020). Thus, there is a powerful economic case for offering effective input to improve and promote mental health (Mcdaid, Park, & Wahlbeck, 2019).

The NHS is increasing their focus on mental health support, with aims to deliver parity between mental and physical health services by 2020/21 (Mental Health Taskforce, 2016). In an attempt to meet current and future mental health needs in the NHS, Health Education England urgently expanded Clinical Psychologist training places this year (HEE, 2020).

### 1.2.3 Approach to Mental Distress

There are multiple approaches to support mental wellbeing. The UK, aligned with westernised values and the government's stance, predominantly places responsibility of change on individuals rather than on the system individuals live within.

Mental health is largely characterised by the government as distress located within a person, which shifts blame to individuals rather than policies (Boyle, 2011; Watts, 2016). There has also been emphasis on mental health services supporting government agenda to contribute to society. For example, priorities of getting

individuals back into employment are apparent in the attempt to integrate employment and mental health support by placing mental health workers in job centres (Watts, 2016).

Therefore, support offered for mental health mostly consists of medication and talking therapies focused on individuals. This also means that each person who struggles with their mental health may seek support from mental health services and require resources, rather than communities or groups seeking support together.

As more and more individuals are seeking support from mental health services, the impact on the NHS is becoming overwhelming and resources are being further squeezed (Anandaciva, Jabbal, Maguire, Ward, & Gilburt, 2018). As a result, it is increasingly important to shine a lens on the effectiveness of what is being offered and attain the best value for money in treatment costs. Furthermore, ethical implications of providing ineffective treatments need consideration.

### **1.3 NHS Talking Therapies**

Research and guidelines suggest that talking therapies provide key support for many mental health difficulties alongside other adjuncts such as pharmacology and befriending, for example, in guidelines for Depression (NICE, 2009). The researcher focuses this thesis on talking therapies.

#### **1.3.1 CBT in Policy**

The National Institute for Health and Care Excellence (NICE) is a government-funded organisation which makes recommendations for evidence-based therapeutic support in the NHS. They are based on the conflation of clinical and cost-effectiveness of therapeutic input rather than being driven by professional or service-user experiences (Charlton, 2007). This approach to mental health is criticised (Guy, Loewenthal, Thomas, & Stephenson, 2012) for, among other factors, its excessive medical position, privileging quantitative research, and using a classification system with questionable validity and reliability to recommend therapeutic approaches (Boyle, 2007). Even so, the researcher recognises that NICE guidelines represent a powerful authority that shapes services and imposes ways of working on clinicians,

which therefore must be taken into account when considering mental health support in England.

### 1.3.2 CBT in Services

Based on currently available evidence showing the efficacy of CBT, NICE predominantly recommend CBT as the leading approach across many 'conditions', for example, those presenting with symptoms aligned with diagnoses of depression (NICE, 2009), generalised anxiety (NICE, 2011), social anxiety (NICE, 2013) or post-traumatic stress disorder (PTSD) (NICE, 2018). Thus, the majority of NHS mental health services primarily offer CBT in various forms.

Whilst NICE acknowledges there is insufficient evidence to class CBT as superior to other talking therapies (Gilbert, 2017), the current evidence for alternative therapeutic modalities is viewed as less robust than CBT evidence in research. Non-CBT approaches are proposed but seldom promoted in guidelines and in practice (Holmes, 2002) (e.g. Interpersonal Therapy for depression (NICE, 2009)). The researcher's experience is that other approaches are generally considered following ineffectiveness of CBT in NHS services.

It is also notable that CBT is considered time limited and cost-effective (e.g. Wiles, et al., 2016), which is an influential driver at both policy and service level.

### 1.3.3 CBT in Training

CBT also has a significant influence in Clinical Psychology training. The Health and Care Professionals Council (HCPC) stipulate clinical psychologists must be able to implement CBT alongside any other, unspecified, model (HCPC, 2015). So, CBT takes a leading focus in the professional development of clinical psychologists. This may be in part due to the emphasis on the scientist practitioner approach of clinical psychologists, the 'gold standard' status CBT currently holds in psychotherapeutic support (David, Cristea, & Hofmann, 2018) and the agility CBT has to lend itself to research (Gaudiano, 2008).

This research will therefore focus on CBT as it has emerged as a dominant approach within Clinical Psychology at policy, service and training levels. Furthermore, CBT

explicitly focusses on change (Longmore & Worrell, 2007), as such participants in the research may have better insight into the process of therapy.

## **1.4 CBT Overview**

The aim of CBT, as established by Beck and Ellis (see Rachman 1997 for further reading), is symptom reduction, improvement in functioning and remission of the 'disorder' aligned with the psychiatric medical model (Hoffman, Asnami, Vonk, & Fang, 2012). CBT uses approaches such as psychoeducation, socratic questioning, behavioural experiments, exposure to that which is feared and facing the avoided (Gilbert, 2017). Milton (2008) highlights utilisation of techniques as a conscious process to break cycles of 'dysfunctional' thinking and behaviours. The premise of the therapy is that clients in CBT are active participants and there is collaboration between therapist and service user (Beck, 1995).

### 1.4.1 CBT Research

CBT has a large body of evidence and has been subject to extensive randomised control trials (RCTs) and meta-analyses (e.g. Baranoff & Oei, 2015; Hoffman, Asnaani, Vonk, Sawyer, & Fang, 2012; Olatunji, Cisler, & Deacon, 2010). While limitations in research methods and in privileging RCTs need to be considered, there are consistent findings to demonstrate the efficacy of CBT for some 'disorders' with moderate-high effect sizes compared to no support.

However, when CBT is compared to other therapeutic modalities the evidence is mixed. For example, meta-analyses revealed CBT for depression to be equally effective compared to alternative input, for example peer support (Pfeiffer, Heisler, Piette, Rogers, & Valenstein, 2011), and published research reveals a declining efficacy from 1977-2014 (Johnsen & Friborg, 2015). Meta-analyses on CBT for 'anxiety disorders' such as panic and social anxiety were consistently strong, revealing medium to large effect sizes (Hoffman, Asnami, Vonk, & Fang, 2012).

Reviewing the evidence available, CBT has emerged as the dominant paradigm and is currently considered the gold standard in psychotherapy in the UK. This merely denotes that it is the best standard in the field at this time, however, not the best

standard possible (David, Cristea, & Hofmann, 2018), and the efficacy of CBT for some disorders is questionable (Hoffman, Asnami, Vonk, & Fang, 2012).

Holmes (2002) emphasised that the research finds CBT to generate change under 'laboratory' conditions (efficacy), however, its effectiveness and clinical relevance remain questionable. Furthermore, although CBT might be beneficial for many people, there is also a common rate of relapse (Ali, et al., 2017) and a significant number of clients for whom it is unhelpful (Wiles, et al., 2013), suggesting further improvements and understanding of CBT approaches are needed.

#### 1.4.2 CBT Specific and Common Features

Disorder-specific approaches have dominated research and clinical practice (Newby, McKinnon, Kuyken, Gilbody, & Dalgleish, 2015). Beck (1976) argued the content-specificity hypothesis, that the content of cognitions and maintaining factors are distinctive to specific 'disorders' (Baranoff & Oei, 2015). Therefore, CBT has traditionally posited disorder-focused models to be efficacious as they aim to address the unique content of cognitions and behaviours identified in the 'disorder' by placing emphasis on different techniques (Otte, 2011) (e.g. Social Anxiety (e.g. Clark & Wells, 1995), Psychosis (e.g. Garety, Kuipers, Fowler, Freeman, & Bebbington, 2001), Obsessive Compulsive Disorder (e.g. Clark, 2004), Post Traumatic Stress Disorder (e.g. Ehlers & Clark, 2000), Depression (e.g. Beck, Rush, & Emery, 1979) and Panic (e.g. Clark, 1986)).

Although disorder-specific treatment protocols show differences in some specific therapy techniques, they share the same core model and overall approach to therapy (Hoffman, Asnami, Vonk, & Fang, 2012). Barlow, Allen and Choate (2004) revealed that more variance of change is accounted for by common features of emotional 'disorders' than disorder-specific characteristics. Furthermore, there seems to be equal efficacy across the different 'disorder' approaches of CBT without an explanation as to why (Gallagher, et al., 2020).

Therefore, Beck and Haigh (2014) developed a generic cognitive model which highlights the common underlying processes across 'disorders', and recent waves of CBT have encompassed more of a process-based approach. There is growing

support for the focus on common cognitive and behavioural processes (e.g. Craske, 2012; McManus, Shafran, & Cooper, 2010).

Furthermore, clients often present with comorbidities (Newby, McKinnon, Kuyken, Gilbody, & Dalgleish, 2015), and significant issues with the categorisation of mental disorders are highlighted in numerous debates (e.g. Krueger & Eaton, 2015). Consequently, this research will not distinguish between categories of 'disorders'.

### **1.5 Change in Psychological Therapy**

Change is considered the core of psychological therapy (Olivera, Braun, Gomez Penedo, & Roussos, 2013). People seek therapy, or others seek therapy for them, because they would like something to be different in at least one aspect of their life (e.g. they would like to feel happier).

Change in therapy has therefore been a focal area for researchers, commonly conceptualised as synonymous with outcome measures (Gondek, Edbrooke-Childs, Fink, Deighton, & Wolpert, 2016), and psychological therapies are considered effective when favourable change has been achieved. Research has investigated factors that contribute to therapeutic gains, with the aim to demonstrate the effectiveness of therapies with emphasis on symptom reduction (Klein & Elliott, 2006).

Kazdin (1999) highlighted that much of the research thus far had focused on Kiesler's (1966) question of what works for whom and when in therapy, which has led to extensive empirical research proving therapeutic change occurs. Kazdin (2007) elucidates that, however, the 'how'- mechanisms, processes and causes of change in therapy had been overlooked. Although researchers have since investigated "how" therapy works, little understanding has been revealed (Moldovan & Pinteá, 2015). Nonetheless, understanding the mechanisms of change is a significant component of evidence-based interventions in the medical model of western medicine. The examination of the context of the history and progress of psychotherapy highlights that medical interventions are created based on understanding the mechanisms of disease; however, at times interventions are found

to be effective before in-depth knowledge of the biological mechanisms of disease was available (e.g. Aspirin was used as an anti-inflammatory medication prior to understanding its biological mechanisms (Wampold & Imel, 2015)).

Much of the research covers therapeutic talking therapies that are somewhat effective in alleviating psychological distress. However, these have been promoted before understanding how psychological change is achieved (Gianakis & Carey, 2008). Insight into the mechanisms of change is essential and would help to optimize change in therapy, as resources could be focused on effective components; it would assist in organising and informing which psychological interventions are offered, would clarify the connection between therapy and outcome effects to get the desired results (these are quite diverse at present), and could inform societal changes that would reduce distress at a community level (Kazdin, 2007).

## **1.6 Models of Change**

Kazdin (2009) suggests using theory as a guide to a better understanding of change. The researcher outlines two dominant change theories, Transtheoretical Model of Change (TTM) (Prochaska & DiClemente, 1983) and Hope Theory (Snyder, 2002). TTM has been selected based on its popularity, relevance, and application to CBT. Hope Theory was also chosen as a cognitive model, research reveals that this accounts for potential relevant mechanisms of change in CBT (Gallagher, et al., 2020).

### 1.6.1. Transtheoretical Model of Change

The stages of change model (Prochaska & DiClemente, 1983; Prochaska & Nocross, 2001; Prochaska & Velicer, 1997) is one of the most prolific frameworks for understanding change. Discovered through empirical research and predominantly developed around smoking cessation (DiClemente, et al., 1991), it has largely been used in the field of Health Psychology to promote intended behaviour changes. Prochaska and Velicer (1997) describe the model as transtheoretical, meaning it integrates processes and principles of change across theories of intervention (e.g. cognitive, behavioural and Freudian theory).

TTM posits that individuals progress systematically through a series of five stages whereby there are different change processes: precontemplation, contemplation, preparation, action and maintenance (Krebs, Nocross, Nicholson, & Prochaska, 2019).

*1.6.1.1 Stage 1, Precontemplation:* This is the stage prior to the individual being aware of the problem, or aware of the extent of it, and thus not being ready for change. Prochaska and Nocross (2001) highlight that others (e.g., family or the health system) may be more aware of the problem and encourage the individual to seek support to change. It is important to note that questionnaires were used to assess individuals' intent to change as opposed to asking individuals whether they wished to change. This would not capture those who wish to change who are unable to envisage that change is possible, and therefore may report to have no intent.

*1.6.1.2 Stage 2, Contemplation:* This is where individuals acknowledge a problem exists and are considering the need to overcome it. According to Prochaska and Nocross (2001), those considered to be at the contemplation stage intend to change their behaviour within the next six months.

*1.6.1.3 Stage 3, Preparation:* This stage combines intention and steps towards action. Individuals take small actions to reduce their problem behaviour and intend to act within a month.

*1.6.1.4 Stage 4, Action:* Behaviour is overtly modified by individuals. Change at this stage is observable and therefore attracts the most external recognition. Individuals are believed to be in this stage within the first 6 months of changing a behaviour.

*1.6.1.5 Stage 5, Maintenance:* Following six months of successful action whereby the individual successfully alters their problem behaviour, they work to maintain their gains and to prevent relapse. If the individual continues to remain 'problem free' and/or consistently engage in new behaviours, and no longer has the temptation to engage in the previous behaviour, they are considered to have completed the process of change.

TTM constructs change as something observable that occurs over time, as opposed to a singular event (Prochaska & Velicer, 1997). Prochaska and Nocross (2001) propose that individuals can regress to previous stages and then progress onto the next stage again, progressing through cycles of stages sequentially. This repeats in a spiral evolution until the termination phase is reached (see Appendix A, Figure 1).

Prochaska and DiClemente (1983) identified eight to ten common processes of change that occur during these stages (see Appendix A, Table 1 for a summary). Prochaska and colleagues' (1997; 2001; 2010) research suggests that cognitive change processes and behavioural change processes are transformative across the change cycle. Therefore, it is expected that individuals partaking in CBT interventions aligned with these processes would progress through the stages of change described.

Littrell and Girvin (2002) argue that although TTM adds a rich heuristic to the perspective of change, this model is an oversimplification of the change process, and evidence to support sequential shifts through discrete stages are lacking. Despite these limitations, meta-analyses show support for the usefulness of stage-matched therapy (Nocros, Krebs, & Prochaska, 2010). Yet, it is notable that research is lacking in mainstream psychotherapy and there is limited evidence for applying this theory into Clinical Psychology practice. Furthermore, West (2005) highlighted the dangers of applying TTM in services - for example, interventions not being offered to those who would benefit. Therefore, further understanding towards a better model of change is necessary.

### 1.6.2 Hope Framework

Hope is argued to be one of the predominant mechanisms of therapeutic change (Gallagher, et al., 2020; Greenberg, Constantino, & Bruce, 2006) and is considered a key aspect of CBT (Neenan & Dryden, 2002). The introduction of the Hope Theory Framework (Snyder, 1989; 1994b) offered an overarching framework for understanding common factors in behaviour therapies (Snyder, et al., 2000), especially in its conceptualisation of goal pursuits. As such, the framework potentially offers a valued contribution to understanding key change processes.

Building on motivational literature (e.g. Frank, 1975), Snyder, Rand and Sigmon (2002) conceptualised two components of the goal-driven change process - goal-directed thought pathways and agency. This aligns with CBT, which takes a 'problem-focussed' approach and utilises strategies to reach the specific goals (Gallagher, et al., 2020).

Snyder (2002) illustrated that hope is a cognitive motivational process that is comprised of goals, pathways and agency which feedforward and feedback to achieve success. Hope is conceptualised as the perceived competence that a person has as to whether they can achieve a goal and their motivation to initiate and sustain movement towards achieving the goal; as such, goals guide intentional behaviour.

**1.6.2.1 Goals:** Long or short term targets one aims to achieve, that are somewhat attainable and being worked towards (Snyder, 2002). There are three functions of goals - to create a context for specific pathways and agency thoughts, to measure outcomes, and to provide feedback about ability (Cheavens, Heiy, Feldman, Benitez, & Rand, 2019).

**1.6.2.2 Pathways:** The route to achieving the pursued goals. Those with high-hope are thought to generate more pathways towards their goal, pre-empt barriers and problem-solve to find alternative routes (Snyder, Rand, & Sigmon, 2002).

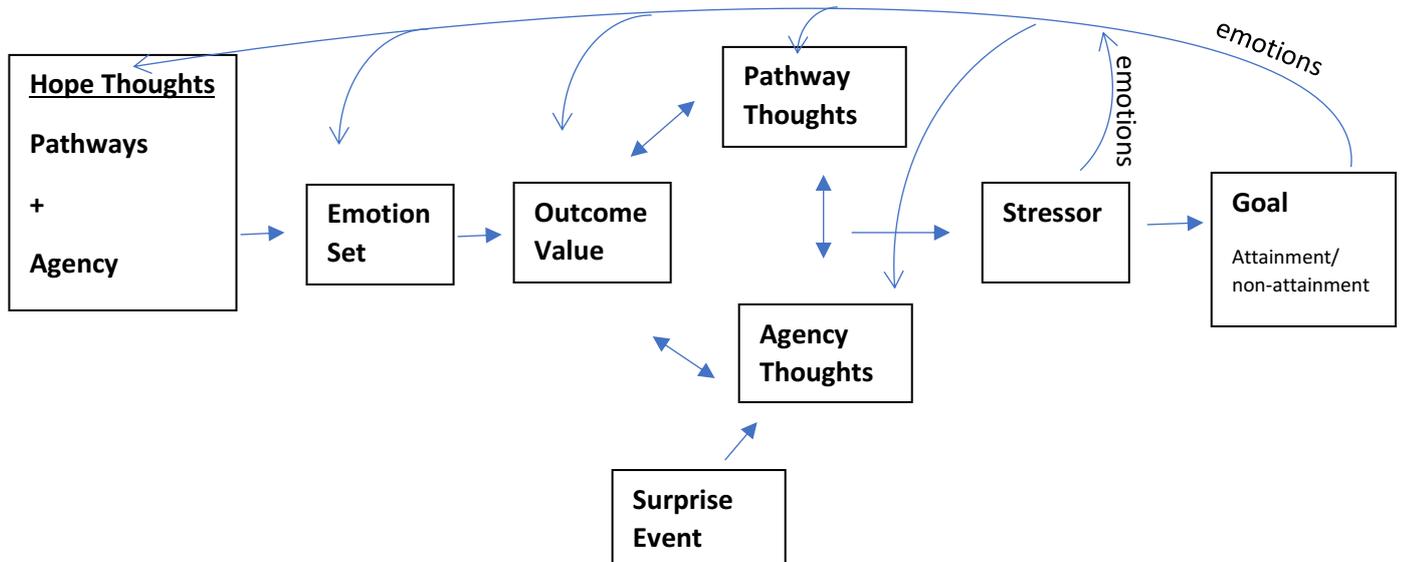


Figure 2. Feed-forward and feedback functions (Snyder, 2002).

Snyder (2002) posits that hopeful thinking is learned within interpersonal relationships and change occurs where individuals are able to identify the chain of thoughts and actions. The emotional feedback and environmental stimuli shape and inform individuals' cognitions, which allows them to make conscious decisions and thoughtfully act to actualise goals (Shorey, Snyder, Rand, Hockemeyer, & Feldman, 2002). The positive feedback in the process is seen to motivate and encourage individuals to move through the sequence.

The theory faces scrutiny over its conceptualisations, appearing reductionist, and placing too much focus on individual agency, thereby disregarding the impact of the social context and incorporation of similar concepts such as optimism and self-efficacy (Peterson, 2006). Furthermore, Lazarus (2000) argued that individuals can hope even without an ability to change outcomes (considered helpless), bringing into question the proposed purely cognitive conceptualisation of hope towards an affective explanation. Although in preliminary research, Snyder (2002) utilised interviews to seek individuals' views about their thought process; the development of the model and the construction of Hope Theory has been dominated by researchers' and therapists' views (Chamodraka, Fitzpatrick, & Janzen, 2016), so little is known as to whether it offers an explanation of clients' experiences.

## **1.7 Defining Change**

Change process literature largely depicts psychological 'change' without first defining it (e.g. Klein & Elliott, 2006; Cuijpers, Reijnders, & Huibers, 2019). The researcher acknowledges the varied capacity in which the term 'psychological change' is employed in the literature. Thus, it is difficult to gauge whether the literature is investigating a shared construction of the term (Roussos, 2013).

Change is typically assumed to be gradual and linear in literature; however, post-traumatic growth research highlights that change can also be unintentional, unexpected, unpredictable and sudden (Hayes, Laurenceau, Feldman, Strauss, & Cardaciotto, 2007). Evans (2013) identified four features of therapeutic change acknowledged within research literature:

*“There must be something identified as change worthy for both the individual and society; another is that the person moves discernibly from one state of being to another (literal change); the third is that the final state, the end-point of therapy, meets some social criterion of success or personal satisfaction with the outcome, and fourth is the pattern (sequence) of alteration over time.”*  
(pp. 28-29).

This understanding omits speaking to the nature of the pattern, and rather highlights the political context of therapy, emphasising societal views for a process that is also individualised.

Further, Gianakis and Carey (2008) use a more general definition - “*change as a generic, natural human process*” (p. 36) - which results in resolution or remittance of psychological distress. This is consistent with the practice of using symptom reduction measures to identify change.

Aligned with the idea of change as a process, change in therapy is often talked about using growth metaphors and conceptualisations. Language such as being on a ‘journey’ and ‘healing the wounded’ constructs change as the creation of newness or restoration of wellbeing (Evans, 2013).

Psychological change is primarily a professional term that is meaning-laden. Social constructionists argue that there is no ultimate truth, and knowledge is co-created in context through language and social interactions (Burr, 2015). Therefore, attending to the process of clients’ co-construction of change through language can challenge taken-for-granted truths and allow alternative perspectives (Grace, 1987). As discussed, change is connected with worth to society and is often attached to capitalist views of productivity - for example, the aim of providing therapy so that individuals return to employment in IAPT services (Layard, Clark, Knapp, & Mayraz, 2007). Current change definitions, as illustrated, have been formed from clinician and researcher views; it is unknown whether clients share these constructions.

## **1.8 Attempts to Measure Change**

The way change is measured in therapy helps to shape knowledge of change. Change is predominantly assessed through outcome measures focused on symptoms. However, the measurement through questionnaires that change has occurred does not tell us how the change occurred (Gianakis & Carey, 2008).

Moreover, research presumes that a change in symptoms on outcome measures is synonymous to meaningful change. This, however, may be a one-size-fits all approach that may not be salient for individuals in therapy (Green, 2016). Not all clients are seeking symptom reduction in therapy, thus change is likely to be more idiosyncratic. Research conveys that clients', therapists', and researchers' concepts of change in therapy differ (Greenwood, et al., 2010). Therefore, attempts have been made to factor in client's priorities and to capture the outcomes they view as most important. Greenwood, et al. (2010) developed an outcome measure for CBT-P, and Green (2016) posits an idiographic assessment approach. However, this is yet to be common practice in therapy, and the encompassing of clients' voice in change measurement remains lacking (Elwyn & Charles, 2001).

Given the difficulties in measuring change, it is important to recognise that failure to respond to treatment, as commonly identified through standardised measures, may be problematic. It may also challenge the use of current measurements in provision and evaluation of NHS services (Bower, Gilbody, & Barkham, 2006). Gaining insight into change processes will contribute to understandings of how to measure change more effectively, which will allow for a more successful measurement of the efficacy of treatment, and service and policy decision making.

## **1.9 Change Process Research**

Change process research is the study of the process of how and why change occurs (Elliott, 2010). This type of research looks at both what happens within therapy sessions and outcome research. It evolved as the dichotomy of the how change occurs and why change occurs was acknowledged to create a flawed picture of change (Elliott, Slatick, & Urman, 2001). Greenberg (1986) explains that the aim of

change process research is to focus on “identifying, describing, explaining, and predicting the effects of the processes that bring about therapeutic change” (p4). This type of research is proposed to expand on clinical and scientific advances, applications, and understanding of specific therapies (Crits-Christoph, Connolly Gibbons, & Mukherjee, 2013).

Decades of studies, primarily quantitative and realist in approach, have attempted to answer the question of why and how therapy leads to change (Elliot, 2012). Although clarity is yet to be gained on this, there have been extensive explorations of constructs that may explain therapy effects - for example, the therapeutic relationship, catharsis, therapist warmth, learning, change in expectations, mastery and common factors across different therapies (Kazdin A. , 2009). Yet, researchers have struggled to identify mediators and moderators of change, as well as the mechanisms (see Appendix B for distinctions and definitions).

### 1.9.1 Common Factors

Change process research initially focused on common factors across therapy modalities to explain the ‘how’ and ‘why’ question of change (Orlinsky, Ronnestad, & Willutzki, 2004). Common factors (see Appendix C, Table 2 for example) are considered to be therapy techniques that are not model specific and include the client, the therapist, their relationship and their expectations (Spence & Blow, 2004). The common factor approach posits that the change seen in therapy is due to the factors shared across therapies rather than because of the specific techniques therapies adopt (Laska, Gurman, & Wampold, 2014). This assumption was born from the observation that therapies resulted in comparable outcomes (Rosenzweig, 1936). Cuijpers, Reihnders and Huibers (2019) acknowledged that there are only estimates of how much change in therapy can be attributed to common factors, and there is no empirical evidence to support this. Furthermore, this does not offer an explanation towards the causal effects of common factors in therapy (Cuijpers, et al., 2012; Lambert, 1992).

Correlational relationships have been shown between common therapeutic factors (e.g. therapeutic alliance and change in therapy), which support potential causal roles within the limitations of correlational research design (Crits-Christoph, Connolly

Gibbons, & Mukherjee, 2013). For example, in their meta-analysis Horvath, Del Re, Flückiger and Symonds illustrated an overall aggregate relation  $r=.275$  ( $k=190$ ,  $p<0.0001$ , CI: .25-.30) between alliance and treatment outcome. However, this is a modest association and there was variability across the research samples.

Furthermore, in their review of the research, Crits-Christoph, Connolly Gibbons and Mukherjee (2013) found mixed views on the importance of therapeutic alliance, with some studies showing technical treatment interventions were stronger predictors, while other studies revealed that when other variables were controlled, therapeutic alliance did not predict outcome (e.g. Strunk, Brotman, DeRubeis, & Hollon, 2010). They note methodological issues, highlighting that there has not been attention given to issues of reverse causality, dependability of assessments, multilevel modelling, temporality or specificity of effects. In practice, this means that it is not understood whether change leads to a stronger alliance, or a stronger alliance creates a process of change.

The conclusions that can be drawn regarding causal influence are thus limited (Crits-Christoph, Connolly Gibbons, & Mukherjee, 2013). Although researchers are advancing methodological processes to address these issues (e.g. Zilcha-Mano's (2017) attempt to address temporality), further advances exploring a wider breadth of therapeutic factors are needed to be able to address the complexities of change mechanisms (Mulder, Murray, & Rucklidge, 2017).

### 1.9.2 Specific Factors

Wampold (2015) illustrated that although common factors are necessary and important, they are not sufficient. Given that there is uncertainty regarding the active processes underlying change across therapies, it is also important to gain understanding within specific approaches (Sauer-Zavala, et al., 2017).

1.9.2.1 CBT specific factors: The majority of specific factor change process research has concentrated on CBT (Cuijpers, Reijnders, & Huibers, 2019), perhaps due to its prolific utilisation and the ease with which specific techniques can be examined.

Research has highlighted factors that contribute to the positive outcome of therapy - for example, therapeutic alliance (Crits-Christoph, Connolly Gibbons, & Mukherjee, 2013; Horvath, Del Re, Flückiger, & Symonds, 2011), self-efficacy and anxiety sensitivity (Gallagher, et al., 2013), behavioural experiments (Bennett-Levy, 2003) and compensatory skills (Crits-Christoph, Gallop, Diehl, Yin, & Connolly Gibbons, 2017).

Despite the extensive research to demonstrate CBT's efficacy, relatively little is known about the mechanisms of change (Santoft, et al., 2019; Gallagher, et al., 2013; Kazdin, 2007; Bennett-Levy, 2003). Kazdin (2007) outlines several criteria for determining mechanisms of change:

- Strong Association,
- Specificity,
- Consistency,
- Experimental manipulation,
- Timeline able to be established,
- Gradient where greater activation leads to greater change,
- Plausibility and coherence of how the mechanism works.

Although causal roles have been found using correlational research (Crits-Christoph, Connolly Gibbons, & Mukherjee, 2013), Kazdin's criteria have not been met, as the studies are not methodologically robust. Similarly, in their review of process-based research, Crits-Christoph, Connolly Gibbons and Mukherjee (2013) revealed mixed findings in support of the relationship and causality of exposure techniques for phobias, limitations in the research methods of mechanisms of habituation in anxiety therapies and limitations in the research methods of change in cognitions in therapy.

However, there is some supporting evidence of the role of altering dysfunctional thoughts, schemas and compensatory skills in the change process, although specificity is questionable (Crits-Christoph, Connolly Gibbons, & Mukherjee, 2013). Further studies have offered support for various potential mechanisms, such as self-efficacy and anxiety for CBT with 'personality disorder', yet, research method limitations inhibited definitive conclusions about the specificity of the mechanisms to

be drawn (Gallagher, et al., 2013). Similarly, Lemmens, Muler, Arntz and Huibers (2016) identified several processes to be associated with change in a systemic empirical update of mechanisms of psychotherapeutic change in depression, including dysfunctional attitudes, negative automatic thoughts and rumination; however, again, methodology was limiting.

Further limitations to understanding CBT change mechanisms are indicated in research which reveals that individuals with 'depression' can experience change prior to cognitive change or the challenging 'dysfunctional' thinking. Thus, calling into question the principle of timeline and suggesting that altering cognitions is not key in achieving change (Burns & Spangler, 2001).

Even though CBT is developed with a clear theoretical explanation of the change process in the therapy, there is insufficient empirical support and limited scientific understanding of the mechanisms (Cuijpers, Reijnders, & Huibers, 2019). Therefore, although existing research illustrates some theories of correlation, the nature of the processes and whether they are causal or specific to the therapy technique remains unclear (Hoffman, Asmundson, & Beck, 2013).

### 1.9.3 Combined Factors

A further consideration is that common and specific factors may not be as dichotomous as they are treated in research. For example, there is a strong focus on the process of therapy and on tailoring therapy to the individual in CBT. Additionally, therapists are typically trained in broad counselling skills, which emphasise common factors such as engagement, goal setting and positive regard (Mulder, Murray, & Rucklidge, 2017).

It is clear following extensive research that the question of how therapy works is a complex multifactorial process, and it remains unclear whether therapies work through common or specific factors, or both (Cuijpers, Reijnders, & Huibers, 2019). Although the research to date has helped to assist the development of therapies, there has been little progress in understanding how change occurs, and researchers continue to test the mechanisms proposed decades ago (Carey, Griffiths, Dixon, & Hines, 2020; Lemmens, Muler, Arntz, & Huibers, 2016). Kazdin's (2007) finding that

mechanisms of change in therapy are poorly understood remains a gap in the literature, and targeted research with appropriate designs is necessary.

#### 1.9.4 Limited View of Change Process Research

Quantitative approaches have dominated change process studies (Binder, Holgersen, & Neilsen, 2010; Klein & Elliott, 2006), which has aided the commissioning of services and facilitated therapy provision. However, examining the complex nature of how therapies work cannot be achieved through randomised control trials alone; the analysis requires multiple complicated approaches (Cuijpers, Reijnders, & Huibers, 2019). Prioritising and privileging quantitative research, the voice of researchers and therapists' perspectives has restricted the lens through which change-process research has been examined, and limits both observation and interpretation of evidence (Kuhn, 1962).

Studies have shown there are often differing views between clients, therapists and researchers (Hodgetts & Wright, 2007). This is illustrated in Thomas' (2006) review of the big four common factors contributing to the most change in therapy, further to Miller, Duncan and Hubble's (1997) research. For example, researchers attributed 40% of change to client and extra-therapeutic factors, whereas clients attributed 13% and therapists 22% (see Appendix D).

Furthermore, clients' active involvement and collaboration in therapy is considered critical to its success, with client factors accounting for a large proportion of the unexplained change outcomes in therapy (Bohart & Tallmans, 2010). As active participants and enactors of change, it is therefore imperative that clients' contribution to understanding change processes in therapy is sought.

### **1.10 Clients' Perspective**

Clients have been recognised as the site of change (Greenberg, 1991) and are thought to contribute to the change process more than any other factor (Wampold, 2015; Bohart & Tallmans, 2010). Additionally, collaboration between therapist and client is central to CBTs' effectiveness (Kilbride, Byrne, & Price, 2013). Considering this alongside Pilgrim's (2009) argument that clients are more concerned about their

individual fate than what aggregate data say about effectiveness, it seems fitting to be asking individuals about their experiences of the process of change. Involving clients in research has been increasingly recognised as providing vital authentic insights (McCauley, McKenna, Keeney, & McLaughlin, 2017), and is aligned with the service user involvement and competing choice agenda (Department of Health, 2009), reinforcing political and therapeutic value (Foskett, 2001).

Weinberger (2014) further highlights that although therapy can be found to be effective, little has been done to address the common rate of relapse, and also suggests that client insights into the changes they have experienced in therapy impacts on likelihood of relapse. Furthermore, literature demonstrates that clients' expectations of therapy shape the experiences of process and outcome (potentially a mechanism linked to therapy outcomes) (Westra, Aviram, Barnes, & Angus, 2010; Greenberg, Constantino, & Bruce, 2006).

Whilst limited qualitative research into clients' experiences of therapy exists, as well as some explorations of clients' view of helpful factors in therapy (Levitt, Pomerville, & Surace, 2016), there is rarely a focus on 'how' the change process in therapy occurred, or what change means to clients. It is therefore concerning and important to acknowledge that clients' perspective of change process research is yet to catch up with the breadth of research from the researchers' and therapists' perspective (Gordon, 2000; Hodgetts & Wright, 2007; Olivera, Braun, Gomez Penedo, & Roussos, 2013). Thus, understanding and depth of knowledge of therapeutic change is limited, and draws into question whose perspective is privileged and what the research drivers are.

### **1.11 Change Processes from the Client Perspective: A Review of the Literature**

Although scarce, there is some literature exploring change processes in therapy which encompasses clients' perspectives (e.g. Olivera, Braun, Gomez Penedo, & Roussos, 2013). The researcher will review and discuss this literature in the following section. However, where CBT has not been explored in any capacity the research will not be included.

Recommendations suggested by Booth, Sutton and Papaioannou (2016) were adopted.

Their framework suggests identifying the following:

- Who - Clients
- What - The 'how' in change process research
- How - Situate and rationalise the current research which aimed to explore how clients understand change in therapy.

To identify relevant literature, five databases were searched: PSYCHINFO, SCOPUS, Science Direct, CINAHL Plus and Psycharticles, together with grey literature through the use of Google Scholar and other open source platforms (e.g. Research Gate). Further details such as studies identified, search terms, limiters, inclusion and exclusion criteria can be found in Appendices E and F. A total of three papers were identified as addressing the process of change in therapy from clients' perspectives. The researcher will now provide a narrative review to summarise the papers.

#### 1.11.1 Summary of Literature Review

*1.11.1.1 Clarke, Rees and Hardy (2004):* This study explored clients' perspective of change processes in therapy using a grounded theory approach. Cognitive therapy was offered, which is a significant component of CBT, and participants spoke to behavioural aspects in extracts. Additionally, the study is particularly relevant to the research and so has been included in the review. Five participants with a diagnosis of depression, aged 24-56 in an NHS and University research study in Northern England partook in semi-structured interviews. Eighty percent of the sample were female. There was a focus on the positive aspects of therapy and what participants found helpful, without discussion on barriers to change. The authors highlighted three category clusters; 'the listening therapist' and 'the big idea', which discussed the therapeutic relationship and therapy events naming common and specific factors, and 'feeling more comfortable with self', which spoke to clients' positive feelings of change. Clarke, Rees and Hardy (2004) then mapped client experience onto the stages of change proposed in the assimilation model (Stiles, et al., 1990), which

suggests that clients progress through predictable sequelae of change in cognitive, affective and behavioural patterns related to the problem.

The paper represents an important attempt to understand clients' perspective of change in cognitive therapy. However, the authors drew tentative conclusions about how participants moved through the stages of change, rather than specifically asking clients about this. They also suggest that clients value specific and common aspects of therapy. However, there was no examination of the change processes. The research focused on the 'what changed' and 'what helped' in therapy rather than the 'how'. Although some tentative conclusions can be drawn by the authors on the 'how' this represents the therapists' voice rather than the clients'.

Participants were selected by researchers to partake in the research based on a change of symptoms reported on outcome measures. As previously discussed, symptom measures are problematic; they focus on the lessening of negative symptoms and do not necessarily indicate that there was a meaningful change for participants. Clients are able to identify change which may not be captured in measures, and are therefore excluded from the study by researchers. Thus, researchers' recognition of change and values were placed above participants'.

Participants had all completed higher education, were largely functioning in their daily lives prior to therapy and seem to have scored between 0 and 3 on the Beck Depression Inventory at the end of therapy. This is potentially a reason they had been selected, and it is questionable whether the research represents an accurate picture of clients with depression partaking in CBT. Therefore, the extent to which this research can expand knowledge of clients' understanding of the change process in therapy is limited. The authors themselves recommended a further study with more participants and exploring barriers to change.

1.11.1.2 Olofsson, Oddli, Hoffart, Eielsen and Vrabel (2020) conducted individual semi-structured interviews with 11 females with childhood trauma following their participation in a three month inpatient eating disorder treatment in Norway. Participants had taken part in an RCT comparing CBT-ED to CFT-ED. Four (1 CBT) of the participants were considered to have 'recovered' or 'partially recovered', determined using measures and criteria for ED diagnosis as assessed by clinicians. The rest were categorised as 'unchanged/poor'. The authors acknowledged that outcome studies to date had failed to inform clinical practice about how and why clients experience change and aimed to bridge this gap by exploring participants' perspectives of the therapeutic change processes in relation to good and poor outcomes.

The researchers utilised elements of grounded theory and interpretative phenomenological analysis to interpret the data. Two main categories relating to therapeutic change were identified. The first was 'Change-related descriptions' (with nine subcategories), which captured participants' description of skill acquisition, gradually taking charge of own recovery, new experiences, therapist role, exposure to trauma, emotion and body connections, psychoeducation and inspiration and learning from others in treatment. Second 'obstacles to change' (with six subcategories), which encompassed the difficulties of engaging in change. Authors explored participants' experiences of change in therapy, however, did not ask participants for their view on 'how' the change occurs. Although there is value to these descriptions, for example findings that agency may be related to better outcomes, the authors fall short of making the connections of 'how' this helps.

The authors did well to define what they meant by change processes in their research. However, it is noteworthy that they used a researcher definition of change (Orlinsky, Ronnestad, & Willutzki, 2004), which may or may not be relatable to clients. Furthermore, change was identified by the researchers as a difference in outcome measures based on physical, behavioural, and psychological symptoms. It does not appear that clients had input into their view as to which category they felt they fit into in terms of outcome of therapy. The authors themselves acknowledge that there was not 100 percent concordance between favourable ED outcomes and participants' experiences of positive change processes. Therefore, it is particularly

pertinent to acknowledge that the client's definition and identification of change is lacking. This limits the study's contribution to further understanding of change processes.

Authors have drawn conclusions based on small samples; some subcategories encompassed just two out of 11 participants' experiences. Additionally, the distribution of data showed that 'change-related descriptions' were mostly from participants with good outcomes, with few subcategories including experiences of those with poor outcomes. Although smaller samples may offer richness and depth of analysis (Siersma & Guassora, 2016), Olofsson, Oddli, Hoffart, Eielsen and Vrabel (2020) can be criticised for focusing on breadth over depth in their analysis (e.g. in having 15 subcategories, leaving little space to describe or develop ideas, and in having multiple foci such as CFT, CBT, poor outcomes and good outcomes); therefore, further investigation with a bigger sample is needed.

Although the researcher was suitably qualified to translate the data from Norwegian to English linguistically, that does not account for culture and meaning constructed in language, or whether the same construct is being explored across borders. This may further impact on the study's transferability, especially in the context of understanding change processes in therapy undertaken in NHS secondary care settings.

*1.11.1.3 Carey, Carey, Salker, Mullan, Murray and Spratt (2007):* Carey et al. (2007) interviewed 27 people, aged 18-65. 18 were female, through purposive sampling using a sampling grid to systematically select participants. The authors did not specify which psychotherapy orientations were offered, stating that participants undertook a range of therapy programmes. This researcher assumes that some participants were offered CBT, as the authors note that therapists for the study were four clinical psychologists, one counselling psychologist and two CBT therapists. Authors were interested in change in general and so included those who felt they had changed over the course of therapy as well as those who did not; 22 of the participants experienced change during therapy. The aim of Carey et al.'s (2007) study was to explore what psychological change is and how it occurs from a client perspective.

Carey et al. (2007) employed a framework analysis to identify three domains where change occurred - thoughts, feelings, and actions. Six themes emerged - motivation and readiness, perceived aspects of self, tools and strategies, learning, interaction with therapist and the relief of talking. The authors liken the process of change described by clients to the explanation of processes of insight and reorganisation described in Perceptual Control Theory (PCT) (see Powers (2005) for further reading). Participants also highlighted common elements in their accounts of change despite undergoing different modalities of therapy, and described change as both a gradual and sudden process, thus drawing into question the current stages posited in sequential change models.

Although participants were able to quantify the change they experienced, authors found participants were unable to define change. Participants instead gave accounts of what had changed or what they would have liked to change (e.g. "I feel better" and "it definitely made a difference"). The authors were surprised by this finding and were unable to hypothesise an explanation for this. This researcher questions whether this was due to the methodology engaging participants across mixed therapeutic modalities, as some therapies (e.g. CBT) have a much more explicit and openly discussed focus on change than other therapies (e.g. psychoanalysis). Perhaps another explanation would be in the meaningfulness of the concept of change to clients, participants' socialisation to 'therapy language' and the questions asked in the interview by the researcher. This study highlights that knowledge of how clients' understand psychological change is yet to be grasped.

The above paper provided key insights into clients' conceptualisation of change in therapy and is a good step towards furthering understanding of the change process. It was promising to see the authors directly asking clients' view and understanding of the process of change, rather than drawing conclusions from clients talking about what change they experienced. A further strength of this study is that researchers were led by clients' identification of change rather than outcome measures. Further to this, researchers asked participants to rate the amount they perceived themselves to have changed out of 10 to get an idea of the scale.

Although extensive information has been provided for some parts of the methodology, other key areas are lacking. It is unclear which country this research took place in, as information was not provided; however, the interviewer is based in Australia. Furthermore, the authors have not specified where the samples have been drawn from – i.e. which services, or the severity or chronicity of mental health difficulties experienced. As a larger study, findings may have increased transferability; however, themes may have been influenced by the variance of modalities included in the research. The reader also notes that participants and therapists discussed the research from the outset which is likely to have impacted on the focus on the therapy process and the extent of clients' awareness of the change process throughout therapy, thus questioning the transferability of these findings to more natural community therapy in NHS settings.

#### 1.11.2 Summary: Gaps in the Literature

Some promising conclusions can be drawn from the data; however, it is limited and within this review conflicting. For example, Carey et al. (2007) present clients' understanding of change as involving sudden and gradual change, which is distinct from Clarke, Rees and Hardy's (2004) earlier conclusions suggesting clients progress through predictable sequelae of change aligned with stages of change models.

Furthermore, the studies emphasise the importance of understanding 'how' the process of change occurs from the clients' perspective, yet, only Carey et al. (2007) sought participants' views on this. Researchers of the first two studies imposed a construct of change without seeking participants' perspective and despite Carey et al.'s efforts, participants were unable to offer a definition of change. Therefore, clients' understanding of what change is and experiences of how change occurs in therapy remains unknown.

From the three studies reviewed, only Clarke, Rees and Hardy (2004) focused on one modality of therapy. This reflects Levitt, Pomerville and Surace's (2016) review, highlighting that most of the research has been conducted within diverse orientations of therapy looking at common factors of change. As discussed, until there is sufficient knowledge of change processes, it is also important to pursue specific

factors (Crits-Christoph, Connolly Gibbons, & Mukherjee, 2013). However, none of the literature examined clients' understanding of change in CBT therapy from their own perspectives.

## **1.12 Current Research**

### 1.12.1 Study Rationale

Despite being the central tenet of therapy, and decades of research, the mechanisms of change remain poorly understood. Although clients' perspective and involvement in therapy is considered critical to its success (Bohart & Tallmans, 2010), there has been limited consultation with clients about their understanding of what change is and how change occurs in therapy. McLeod (2001) argues that until there is clients' understanding, our impression of therapy will be skewed and the full array of psychotherapy will not emerge.

Additionally, the literature review reveals that research into clients' perspective of change processes within the NHS is limited, with only one study including NHS clients. It further seems important to explore clients' perspective of psychological change in the most prolific and widely used model in the NHS. It is difficult to gauge from the existing research whether findings would be clinically relevant and transferrable to therapies offered in the NHS, especially in secondary care settings where mental health difficulties are more complex.

Thus, further research examining clients' understanding of 'how' change occurs in therapy is needed, with emphasis on clients' perspective of the change.

### 1.12.2 Clinical Relevance

By exploring clients' perspectives of how change occurs in therapy, this study hopes to contribute further understanding of how change in CBT works. This is an important question to address, especially in the NHS, which is currently stretched and potentially at the brink of an influx of referrals due to the impact of COVID-19 on mental health (Pierce, et al., 2020). Understanding how change occurs could help clinicians tailor assessment and guidance of what works in therapy, improve clinical practice, improve client experience and outcomes, and inform/modify where

resources are focused. It could ultimately inform which clients are likely to gain the most from therapy and under which conditions (Carey, Griffiths, Dixon, & Hines, 2020; Olofsson, Oddli, Hoffart, Eielsen, & Vrabel, 2020).

Furthermore, research from the bottom up could help to uncover which therapeutic processes lead to meaningful change. This could be used to develop outcome measures that meaningfully measure change in therapy and to review and inform which mechanisms need further quantitative investigations to further improve understanding and practice.

### 1.12.3 Research Questions

This research aims to gain clients' perspectives by exploring their understanding of how change occurs in therapy, through answering the following research questions:

- 1) How do clients define change in therapy?
- 2) How do clients describe their experience of 'psychological change' in therapy?

## **2. METHOD**

### **2.1 Overview**

This chapter will begin by considering the key ethical issues relevant to the study in order to attend to and acknowledge their impact, as methods employed unavoidably influence the object of inquiry (Mays & Pope, 2006). A clear account of the design, procedure and analysis will be presented. The chapter will conclude with personal reflexivity to examine the relation between research and researcher.

### **2.2 Epistemology**

A critical realist position underpins the present research. This can be understood through an exploration of ontological and epistemological assumptions. Ontology refers to assumptions about the nature of existence and the knowledge of reality (Crotty, 1998). Epistemology is how knowledge is understood and discovered (Burr, 2003).

The archetypal epistemology of naïve realism is positivism, whereby the ‘truth’ is thought to be discoverable and observable through scientific study, for example, through quantitative research. An example from psychiatry would be the continued study of the categorisation of mental disorders to hone a more accurate description of diagnoses - the belief that there exists an external natural disease “out there” in the world independently of being perceived (Pilgrim & Bentall, 1999).

In contrast, social constructionism posits there are multiple realities that are constructed through language within social, political and historical context (Burr, 2003). Social constructionism recognises there is no ultimate truth that transcends culture and context (Burr, 2015). For example, homosexuality has been depathologised (Drescher, 2015) as societal constructs have shifted. Thus, knowledge can be understood as being created in the context of social interactions centred around culture and language.

Rooted in Bhaskar's theory (1978), critical realism in a sense sits between these two paradigms. "Theoretical entities are not merely hypothetical, but considered real; conversely empirical observations are not the rock bottom of science, but are tenuous and always subject to reinterpretation" (Stickley, 2006). Critical realism assumes a realist ontology, the notion that material and social structures have an objective reality that exist, that can be observed, measured and exists independent of one's awareness and beliefs of it (Willig, 2016). It posits that there are multiple dimensions to reality; within this there is a subjective reality to clients' experiences, as such the influence of the researcher is acknowledged. (Willig, 2016). Thus, aligned with the notion that psychological change is a 'real phenomenon', it also acknowledges that it emerges within a historical, political and social context.

Therefore, in line with a critical realist position, the researcher acknowledges the existence of psychological change as a phenomenon can only be examined through the client's context, and therefore acknowledges that clients' perspectives on change will vary. The researcher also recognises that attempts are made to measure psychological change, which have important materialist implications in funding and access to services. Data is accessed from participants sharing of their reflections and experiences. The researcher's context is acknowledged as a lens through which this data is examined.

The researcher highlights the avoidance of the "language of disorder" and medicalisation of clients' understandable responses to their experiences (Kinderman, Read, Moncrieff, & Bentall, 2013) throughout this thesis. Instead this research has taken the service users' view of difficulties and looked across diagnostic categories so as not to assume socially constructed categorisations such as 'schizophrenia' as real-world entities. Furthermore, Stickley (2006) posits that critical realism does not merely identify discourses, it delves into a deeper understanding of how things come to be the way they are, an important level of recognition for process research such as this.

## **2.3 Ethical Considerations**

The study was registered with the University of East London. Ethical approval was sought and granted from the West Midlands NHS National Research Ethics Service Committee (Appendix G). Ethics is an integral part of research, consequently the design and implementation of the study is aligned with the British Psychological Society's (BPS, 2014) Code of Human Research Ethics. This code outlines the importance of maximising the benefits of partaking in research whilst minimising harm that could come to participants. In order to protect participants from adverse effects the researcher gained informed consent, maintained confidentiality, anonymity and managed the levels of distress in interviews.

### 2.3.1 Informed Consent

Informed consent was obtained for this study by providing all participants with a participant information sheet (PIS, Appendix H) prior to interview so that they had time to read and understand the details of the research. This outlined the benefits and disadvantages of participating, what to expect from taking part, withdrawing without consequence, confidentiality and data protection. Miles and Huberman (1994) (Miles & Huberman, 1994) stressed the importance of gaining informed consent as they found a correlation between consent and richness of data.

Participants were also advised that quotes from their interview may be anonymised and used in the final report and publication of the research. The contact details of the researcher and supervisor were provided. Participants were encouraged to contact the researcher to ask questions if they wished to before agreeing to take part. The researcher verbally checked participants understood the information sheet before asking them to sign a consent form (Appendix I).

### 2.3.2 Confidentiality

Participants were informed that their information would be anonymised, and how their confidentiality would be maintained throughout the data collection, analysis and storage stages/phases. The limits of confidentiality were also communicated on the PIS (Appendix H).

The researcher informed participants that they would not communicate with services about who opted to participate. However, participants were made aware that if interviews took place in services then it would be likely staff in services would be aware of participation. The researcher clarified that if this was the case no details of their participation would be shared by the researcher with staff .

Interview transcripts were anonymised and stored on password protected devices only accessible to the research team. This information was kept separate to signed consent forms and there was no way of linking personal details from the consent form to interview data. Participants were informed that their information would be held under a pseudonym to preserve their anonymity . Participants were aware that the researcher's supervisor and examiners may read full anonymised transcripts and they consented to the use of short extracts in the research report and in future publications. Once the study is completed, data will be kept electronically on a password-protected file for three years on the researcher's electronic device in accordance with the Caldicott Principle (Department of Health, 2013) and the Data Protection Act (1998,2018).

### 2.3.3 Remuneration

Participants were offered a £10 'Love2Shop' voucher to thank them for their time. In no way was this intended as coercion; the researcher believes it to be exploitative and unethical to ask participants to volunteer their time, particularly as this could potentially exclude those financially less resourced to volunteer their time. There are no clear ethical guidelines for payment for research participation (HRA, 2014) and therefore following consultation with a service user group, the researcher opted to offer a voucher as compensation, which participants could choose to either accept or not. The amount offered is considered to be reflective of the Living Wage and therefore "authentic compensation" (Belfrage, 2016), thus not considered to be coercive and not affecting participants ability to give informed consent (Head, 2009).

The researcher offered the voucher prior to the interview commencing and made it clear that it represented compensation for attendance. The researcher was explicit that participants were free to end the interview at any time, were not obligated to

answer any questions and that participation would have no impact on the care they receive from services.

#### 2.3.4 Potential Distress

The PIS explicitly acknowledged the possibility that partaking in the research may remind participants of distressing experiences and thoughts from therapy sessions. This gave participants the opportunity to assess in advance, as much as was possible, whether they thought partaking would cause them too much distress. The researcher took care to approach the interview in a sensitive manner and check in and respond to participants' emotional expression, both verbal and nonverbal. Distress during the interview was managed by articulating the emotion the researcher observed and offering to pause or end the interview. Participants were reminded that their participation was voluntary, and they could end the interview at any point without repercussion. A "process consent" approach was taken, whereby consent was verbally continually re-sought throughout the interview to continue talking about potentially distressing experiences (Polit & Beck, 2009). The researcher provided space at the end of the interview to debrief and offer support. This was reliant on the participant communicating their distress at the time. Therefore, participants were also given a list of agencies they could contact to seek support should they want to discuss their distress further. Consent was revisited at completion of interviews in case material had arisen that participants did not expect to communicate.

#### 2.3.5 Debriefing

At the conclusion of interviews, the researcher offered the participant space to reflect on the experience of participating and to explore any concerns that may have arisen. Participants were reminded that they could withdraw their interview data for up to two weeks post-interview if they wished, beyond this point their data would still be included in the analysis, however no extracts would be used in the final report. Following the interview, participants were offered a debriefing sheet (Appendix J) which reviewed the purpose of the research, provided a list of sources of support, and provided contact details for the researcher and supervisor.

## 2.4 Service User Consultation

There can be substantial discrepancy between what is researched and what is important to service users (Marks, 2009). This research attempted to address questions which are relevant to service users. Tierney et al. (2016) highlight the unique expertise and positive impact that service users offer to research. In particular, they note the real-world connection to the research that service users contribute. Aligned with the aims of gaining service user perspectives, the researcher consulted with service users in the planning, design, and procedure of this study.

The researcher considered conducting focus groups to consult on and develop the research. However, consideration was given to the practicalities of arranging these in a meaningful and productive way. Furthermore, the literature highlights known challenges of managing tensions and power dynamics between group members, and ensuring discussions stay on topic, especially for those with relatively little experience in facilitating focus groups (Braun & Clarke, 2013). Therefore, the researcher opted to consult with an existing service user group within the Trust of one of the recruitment sites.

The researcher consulted with a service user and carer group (SCG) which advises on research. The group consisted of 11 individuals with lived experience of 'mental illness'<sup>1</sup>/distress and service use, and two carers of individuals with 'mental illness'. The group meets monthly to consult on research, with support and facilitators from academic researchers. Members receive education and training in research processes and methods, but their expertise lies primarily in their lived experiences of 'mental illness'/distress, service use and through association with others with lived experience. Members receive remuneration for their time and expertise which is funded and supported through a partnership between an NHS Trust and London University.

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<sup>1</sup> The term 'Mental Illness' is depicted in single quotation marks to acknowledge it is a socially constructed concept. It has been utilised in line with the terminology adopted by the group.

The researcher conducted a 20-minute presentation to the group (Appendix K); the group then consulted with the researcher for an hour offering suggestions and changes to the research. It is noteworthy that each member of the group shared enthusiasm and encouragement for the research. The researcher proceeded to make the suggested changes based on the feedback from the consultation. Key areas of discussion were timings of interviews and the interview schedule. Agreement was also made to consult with the group on themes arising from analysis.

## **2.5 Design**

In consideration of the research questions and epistemological stance, this research employed a qualitative approach, as recommended by Barker, Pistrang, and Elliot (2002) for research aimed at understanding experiences and processes. Individual semi-structured interviews were utilised to assist the design of the research's exploratory stance as clients' perspectives in this area have received little attention (Frith & Gleeson, 2012). A qualitative approach also provided opportunity to gain unexpected insights (Wilkinson, Joffe, & Yardley, 2004) via conversations to promote a deeper understanding of participants' experience of psychological change in therapy. Whilst the researcher acknowledges their position in shaping the research, this approach maximised the scope to hear participants' voice and understanding of psychological change.

## **2.6 Participants**

### 2.6.1 Recruitment

Participants were recruited via opportunity sampling from two NHS secondary care mental health services in the UK. These two sites were chosen in an endeavour to maximise the recruitment of a diverse range of participants. As the services offer therapeutic support to a broad range of clients aged 18-65 within different geographical areas, the aim was to reach a point at which conceptual generalisations could be drawn (Mays & Pope, 2006). Pertinently, the services were keen to support the research and enthusiastic to gain feedback on how to ensure effectiveness of therapeutic interventions.

Participants for the research either responded to poster advertisements (Appendix L), which were placed in service waiting rooms, or leaflets (Appendix M) advertising the research, which were offered with every discharge letter. In addition, therapists were asked to signpost clients nearing the end of their therapy towards advertisements for the study. Care was taken with therapists' involvement in research to safeguard potential ethical and role conflicts (Yanos & Zidonis, 2006). Power relationships between therapist and client, the risk of subtle coercion, and therapist biases, have important implications for both the client and the research findings (Holloway & Wheeler, 1995). Therefore, emphasis was placed on equity of advertising the research. Therapists were asked to advertise the research to everyone and to allow clients themselves to decide whether they met the inclusion criteria.

Thematic analysis was chosen and the literature was reviewed which suggested that between eight and 12 participants should suffice for data saturation (Guest, Bunce, & Johnson, 2006).

### 2.6.2 Recruitment Criteria

The researcher aimed to be as inclusive as possible. Recruitment utilised participants' self-definitions, thus, relying on clients' view of change rather than outcome measures.

#### 2.6.2.1 Inclusion Criteria

The inclusion criteria were anyone:

- Who had completed or nearly completed (within two sessions of being discharged) psychological therapy in the past 12 months.
- Who had undertaken a course of Cognitive Behavioural Therapy (CBT) according to the clients' perspective.
- Aged 18 and above.
- English speaking.

### 2.6.2.2 Exclusion Criteria

- Individuals who had experienced a significant life stressor in the past four months according to service users' judgement.
- Individuals currently waiting to start a new therapeutic intervention.
- Individuals unable to understand the information sheet (with support) and unable to consent to participation.
- Individuals who by their own definition would feel too vulnerable to participate.

## **2.7 Procedure**

### 2.7.1 Initial Contact

Interested participants viewed advertisements (leaflets and/or posters) of the research and contacted the researcher by phone (a private number solely created for the study) and/or email. Following this, the researcher shared further information about the study and sought permission to provide the PIS, (Appendix H) and the consent form (Appendix I) either by phone or email based on the participant's preference. The researcher offered participants a week from the point of receiving the PIS to fully consider and reflect on the potential challenges and benefits of the research, ask questions, and make a decision about their participation. However, participants could consent sooner if they wished, with a minimum consideration of 48 hours (to give them sufficient time to decide without pressure). The researcher then arranged a convenient date, time and place for interviews for those interested in participating. Participants were given the option of meeting in a private confidential space at the service in which they received therapy or at UEL.

### 2.7.2 Remuneration

Participants were offered a £10 'Love2Shop' voucher and reimbursement for their public transport travel costs. The researcher clarified that the remuneration was a thank you solely for their attendance. The researcher was explicit that participants were free to end the interview at any time, were not obligated to answer any questions, and that ending the interview would not impact on their remuneration for attendance.

### 2.7.3 Consent Form

Participants were given verbal information and were asked to review PIS. They were then asked to review and complete the consent form (Appendix I) and were given an opportunity to ask the researcher any questions before providing written consent. Consent was obtained by initialling boxes on the consent form and signing the end of the form, prior to the interview commencing.

### 2.7.4 Interviews

Prior to commencing interviews, participants were invited to complete a short demographic information form (Appendix N). An interview schedule was used as a flexible guide to facilitate discussion associated to the research questions. The researcher used the schedule flexibility to gain bottom up data giving participants opportunity to reflect on their experiences as much as possible. Prepared probes were developed to support discussion if participants struggled to elaborate on their experiences (Appendix O). The interview schedule was developed with input from the researcher's supervisor, research questions, and the literature around psychological change. The researcher consulted with the SCG group to form the interview schedule and to guide a meaningful discourse relating to the concept of psychological change. Their feedback led to the reordering and rewording of questions, as well as an addition and a removal of a question. The final interview schedule can be seen in Appendix O. SCG's reflections led to the use of the term 'change'. It also highlighted that the researcher should ensure they attended to the inherent power imbalance between researcher and participant.

In person interviews were audio recorded and took approximately 60 – 90 minutes in total. At the conclusion of interviews, the researcher provided a written and verbal debrief (Appendix J), where participants were given the opportunity to reflect on their experience of participating in the study and consent was revisited.

### 2.7.5 Data Governance

As outlined in the PIS and verbally discussed with participants, the data collated in this research was treated in accordance with the Caldicott Principle 2013 and the Data Protection Act (1998, 2018). Files containing personal information or signatures (e.g. from the demographic form) were kept separate to data. There was no way of

linking personally identifying information to interview data. Personal information files were deleted upon completion of the research. Paper information, such as consent forms, were secured in a locked cabinet until scanned and stored electronically; paper versions were subsequently destroyed. Audio recordings were immediately electronically transferred to a password-protected file on a secure device and deleted from the audio recorder. All files were kept in a password-protected file on a secure device which could only be accessed by the researcher and their supervisor. On transcription of interviews, pseudonyms were adopted for participants, any personally identifying information was anonymised, and names of places or people were changed (Thompson & Chambers, 2012). The data will be kept electronically for three years as described, after which it will be destroyed.

#### 2.7.6 Transcription

The researcher conducted and transcribed the interviews to immerse and become familiar with the data, as well as to reflect on their role as an interviewer. An orthographical style of transcription, the verbatim recording, was utilised as recommended by Braun and Clark (2012) for thematic analysis (TA). Conventions outlined by Bannister et al. (2011) were adapted and used as guide to transcription (Appendix P). Names were replaced by pseudonyms, identifying information was replaced by words within {}, and the text was punctuated for ease of reading. Pauses are thought to be of limited analytic value (Banister et al., 2011); as such, only pauses of more than one second were recorded. Transcripts were re-read multiple times to check for accuracy and anonymity (Gibbs, 2007).

### **2.8 Analytic Approach**

#### 2.8.1 Thematic Analysis Justification

TA was selected over alternative methods of analysis such as Interpretative Phenomenological Analysis (IPA; Smith, Flowers, & Larkin, 2009) as it was the most appropriate method for the aims of the research, namely understanding clients' experience of psychological change and their understanding of change. Although IPA's approach is useful for under-researched phenomena, it focuses on personal idiographic experience and how participants make sense of their experiences.

Therefore, it is less fitting for this research which casts a wider lens exploring experiences across individuals.

TA offers theoretical flexibility (Braun & Clarke, 2006; Willig, 2013) and so fits with the epistemological approach of the study. TA is the process of identifying patterns that arise in the data, facilitating interpretation and sense-making (Braun & Clarke, 2006; Braun & Clarke, 2013). It offers the researcher the opportunity to make interpretations that consider the socio-cultural contexts and processes that shape participant's account of their experiences.

A hybrid approach of inductive and deductive TA was utilised, with an emphasis on the inductive. It was inductive as themes and interpretations were guided by the data (Braun & Clarke, 2006). However, the researcher notes that their experiences, understandings and reflections of phenomena based on their beliefs and assumptions influence their active construction of themes in the data (Braun & Clarke, 2013). Mishler (1986) criticises TA for under-recognising the researcher's role in interviews, therefore the researcher adopted a research journal to reflect on their influence on the data and analysis (Ortlipp, 2008). Furthermore, utilising an interview schedule also enforces a top-down approach to the data, therefore a partly deductive approach is unavoidable. As suggested by Joffe (2012), to enhance the quality of research, the researcher also aimed to attend to both manifest and latent level themes, representing respectively the obvious observations, and ideas and assumptions beyond the verbatim data. To avoid the potential of decontextualisation that TA is criticised for (Mishler, 1986), the researcher adopted a 'contextualist method' (Braun & Clarke, 2006), which acknowledged that the participants' experiences were influenced by their historical, political and social context. It should be emphasised that the critical realist approach to the research recognised interpretations as tentative, and the researcher notes that there are always alternative understandings to the data.

### 2.8.2 Stages of Analysis

Braun and Clarke's (2006) six-phase approach to TA was employed as a guide to the analysis. Although presented as a linear model, the research analysis was an iterative and reflexive process built around the six phases described below.

- 1) Familiarisation with the data: The researcher immersed in the data through the process of conducting interviews and transcribing the data. Following this, the researcher read and re-read the transcripts, making notes on initial thoughts and observations that arose.
- 2) Initial code generation: Codes are the basic elements of the text that can be assessed in a meaningful way (Boyatzis, 1998). NVivo (12) Software was utilised to systematically code the data set. Initial codes identified manifest and latent features of interest in the data and began the process of organising the data. Initial codes and example transcript can be seen in Appendix Q.
- 3) Searching for themes: The researcher clustered codes sharing unifying features into themes and subthemes. Visual mind maps of themes were created, capturing the most salient patterns in the data.
- 4) Reviewing themes: The researcher and supervisor reviewed themes alongside the original data to assess their coherence and accuracy of reflection. The entire data set was re-read, and additional data was coded. It was agreed that the themes adequately captured the patterns in coded data. The lens was then broadened, and the researcher and their supervisor considered the validity of themes in relation to the whole data set.
- 5) Defining and naming themes: This overlapped with the previous phase whereby the 'essence' of each theme was reflected upon within the context of defining and refining the themes (Braun & Clarke, 2006). Concise informative names were selected to represent themes and to structure the 'story' of the research.
- 6) Producing the report: A coherent story of the data was brought together in the writing of the final report. Themes were supported using anonymised extracts capturing the essence of each theme. The researcher carefully considered the order in which themes and subthemes were reported to ensure a coherent and clear narrative (Braun & Clarke, 2006).

## 2.9 Reflexivity: Researcher's Position

Reflexivity is an essential component of qualitative research, as the researcher plays a pivotal role in collating and constructing data (Stratton, 1997). This is especially relevant when adopting a critical realist stance, where the impact of the researcher on the construction of the research and interpretation of data is inevitable. Willig (2008) refers to personal reflexivity as an acknowledgment and reflection on how the researcher's values, experiences and assumptions have shaped the research, and in turn how the findings affect the researcher both personally and professionally.

As mentioned, the researcher kept a reflexive journal (Ortlipp, 2008) to reflect on the process of research and her responses to issues of change, stuckness, CBT and service experiences. Supervision also took a reflexive stance where the researcher questioned assumptions they were making, particularly noticing strong reactions that arose in relation to the data and research processes.

To invite the reader to consider the researcher's influence on the data, the researcher has outlined aspects of their own identity and experience that seem pertinent to the development, interviewing and analysis of the research:

- Middle-class background and considers themselves to belong to various minority groups, largely influenced by non-western ideals and values finding some CBT ideas valuable and others unhelpful. Leading to the researchers' curiosities and desire to explore this further.
- Experiences of therapy accessed privately through choice and through others decision making, with varying experiences of change. This shaped the researcher's critical approach to therapy, feeling aligned with clients and values in seeking client perspective.
- Personal and professional positions witnessing unhelpful experiences with NHS mental health services shaped the researcher's beliefs that the system can be unhelpful at times.
- The researcher holds strong beliefs in the importance of attending to power in relationships and creating space to hear marginalised voices. They consider

the slogan “nothing about us without us” an important value and guiding principle.

- Training as a clinical psychologist at University of East London has influenced the researcher’s critical approach to multiple models and theories leading to their questioning of the effective components of therapy and prioritising client’s experiences.

The researcher took a reflective position throughout the study and returns to this in the discussion.

## **3. RESULTS**

### **3.1 Chapter Overview**

This chapter presents participants' discussion of the change process. To locate the sample, demographic information is provided. The research questions were explored using thematic analysis, and a thematic map is presented to provide a visual overview of the themes and subthemes. Discussion of the analysis is organised around these themes and subthemes with extracts from the transcripts used to support the researchers' interpretations. Some quotes have been altered slightly for readability purposes and ellipses have been inserted where words have been removed.

### **3.2 Sample Demographics**

Ten participants opted to take part in the study. All participants completed the individual interviews, with no dropouts or withdrawals of consent to use data. No concerns arose from the interviews and consequently, no participant required following up. Table 3 outlines the demographic information collected from the sample. Pseudonyms have been used and higher-level information has been presented in categories (e.g. age ranges) to maintain confidentiality.

Table 3: Participant Demographics

Name	Age	Gender	Ethnicity	Mental Health Diagnoses given by professional	Participant description of psychological difficulties	Psychoactive Medication	Number of current therapy sessions	Number of times in past psychological help sought
Jo	35-39	Female	Asian	Yes	Depression, social anxiety, work and social adjustment difficulties.	0	13	3
Wil	45-49	Male	White-British	No	Depression	2	15	0
Suaid	35-39	Male	Pakistani	Yes	Stress and anxiety	2	17	3
Syed	25-29	Male	British Bangladeshi	Yes	OCD	2	18	3
Lara	55-59	Female	White European	Yes	Anxiety	0	19	3
Georgie	30-34	Female	White British	Yes	OCD, Anxiety and Depression	2	20	3
Fola	35-39	Female	Black African	Yes	PTSD	2	17	0
Saba	20-24	Female	European	No	Depression, Anxiety and PTSD	1	26	4
Izzy	20-24	Female	White British	Yes	Borderline personality disorder, Anorexia	1	48	10
Amy	20-24	Female	White British	Yes	Anxiety and Depression	2	6	2

Key: OCD- Obsessive Compulsive Disorder, PTSD- Post Traumatic Stress Disorder.

All participants self-reported as having CBT therapy as their most recent therapy in a secondary care service and felt that they had experienced positive change from it. All participants had either completed therapy or had their final session remaining at the time of interview. Seven participants had attended therapy in the past which they described as being unhelpful, one had a positive past experience. Half of the participants were from White ethnic backgrounds, one identified as non-white European and four participants were from ethnic minority groups. Seven participants identified as female and three identified as male. Of the 10 participants eight had received mental health diagnoses from professionals, not necessarily mental health professionals (e.g. diagnosed by General Practitioners), not all participants agreed with these and shared their own descriptions of distress. Only one participant received a new diagnosis which directly related to the current CBT intervention received. Participants ranged from taking no psychoactive medication to two medications for their mental health, this was predominately for symptomatic relief rather than for a specific diagnosis.

### 3.3 Thematic Map

Interview data was analysed with an inductive and deductive approach using TA following Clark and Braun’s (2013) guidelines. Multiple thematic maps were developed from the initial larger map to refine and collapse themes. The final thematic map is presented in figure 3, see appendix R for earlier versions.

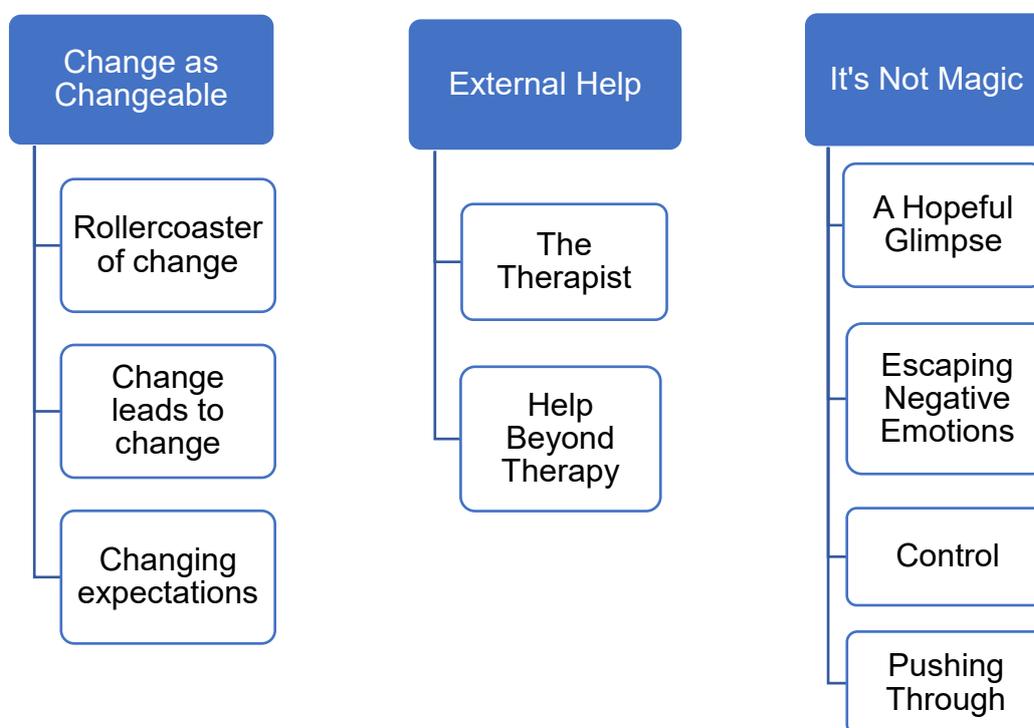


Figure 3. Final Thematic Map

#### 3.4 Theme 1: Change as Changeable

This theme captured participants’ overarching description of change as dynamic and a varying concept. Participants shared that it was difficult to define what change actually is for them, perhaps because their conceptualisation of change differed across time and different points in therapy, “*change uh should be thought about in in different ways it can’t be just confined to one single metric*” (Syed). Izzy explained

this as *“I don’t really know how to explain change to you apart from describing it”*. Participants proceeded to describe change as dynamic: Jo highlighted change as a “fluctuating process” and Saba illustrated change as *“just not staying in the same place”*. This variability, thus, seemed to contribute to participants difficulty in defining change as a concept.

Participants’ accounts suggest change experiences may differ across time in therapy, and beyond, supported by Syed who felt that getting out of a situation *“is change in itself”*. As well as talking about progression of change participants discussed how the change created momentum for further change *“gave me that confidence to be able to look into other things as well”* (Georgie). Participants also discussed that their expectations of change also progressed and shifted over time.

#### 3.4.1 Rollercoaster of Change

Most participants described the ups and downs of going through change:

*You know I felt bad all day. Got, went to bed, got up a couple of hours later and yeah I felt, felt all right you know!*

*Wil*

The process of change can be interpreted as gradual and non-linear. The progression towards more positive feelings is intertwined with unpleasant experiences, which also suggests a complex relationship between feelings and change. Jo further described how the downs are a part of the learning process, and possibly necessary, in order to reach the ups:

*An initial period of difficulty, maybe staying the same, maybe some dips <yep>, and then maybe a little blip as you try something out. A few more, maybe a big sink at some point as you forget or you experience something completely different <mmh> and then maybe a gradual rise to something better.*

*Jo*

Participants alluded to difficulties they face in getting to the ups, often drawing on analogies to illustrate the point. Common descriptions included: “*climbing out the hole*” (Amy), “*it’s not going to be smooth sailing*” (Syed), “*I feel like I’m in a rollercoaster there are days that uh I’m really bad I’m really bad <mmh>, like I’m down here*” (Fola).

Thus, participating in change can be viewed as a non-linear continuous process that requires engaging with. The metaphors describe an active process that if stopped will result in a “*not just climbing out the hole, like you’re sliding back down*” (Amy). Participants talked about this feeling of being pushed downwards, suggesting the role of effort in the process and maintenance of change. Fola described this as having to “*do some work for it*” and further goes on to say “*it’s not going to be a day’s work*” implying it will take time.

Suaid described change in therapy as a “*slug race... it was like up the hill, and not only up the hill there were some hurdles in the way as well*”. In this reflection change was constructed as something to be achieved or won, but also lost. The concept of potential loss echoes other participants’ change experiences. Participants shared worries that if they stop ‘working’ they will not hold on to the change or there would be some kind of loss, thus highlighting the risk felt by participants of engaging in therapy:

*That was scary for me, I told my therapist that I’m going through this phase whereby things are really nice and then suddenly they go downhill.*

Fola

*You kind of feel like you’re back to square one because you tried like loads and then nah.*

Amy

The undoing of work and “*collapsing*” (Suaid) of the effort was talked about by participants as a form of sliding further down the hole which could get them back where they were at the start of therapy, or worse. The fear of this experience, along with the gradual process of positive change, can lead to difficulties in achieving it.

Positive changes were mostly depicted as “slow” (Fola) and time consuming, requiring immense effort. In contrast, negative or unwanted changes were conceptualised as something quick and sudden:

*That change happens a lot quicker and it was a lot easier to go from a good situation to a bad situation to then come out of a bad situation to a good situation. It's a lot easier I think to stay in that bad situation <mmh>, which I think is why a lot of people struggle with therapy. As well it's so much easier to stay there and stay, and stay anxious<mmh>. The process of the change, of getting better<yeh>, is so much harder and it's, it's a long process and a lot of hard work.*

Saba

Saba described the ongoing uphill challenge participants experienced to reach positive change. The struggle of the up and down process from participant accounts indicate that there is a certain threshold that needs to be reached in order to stabilise and be considered change:

*I think that's the main thing, my personal feeling towards the process of change in therapy is that there is like, it's like a threshold you have to get to.*

Jo

The processes of the ups and downs may accumulate and be considered change once it has reached this threshold. The language and analogies portray the process of change as a journey, potentially suggesting there are certain milestones of the change process that are significant. Using Syed's analogy these thresholds could be considered the docking ports for resting or restocking along a sailing route towards a destination, and these stops are a necessary part of the journey.

Furthermore, the use of language to describe change as something that is 'up' or implying it being high indicates the positive connotations participants may have towards change and the transformative possibilities to get to a place of feeling “free” (Fola, Lara, Amy). This suggests that although, as aforementioned, change seems to have been conceptualised as a process of continuous effort, participants explained

that once the threshold has been reached the change journey can be completed, they can get out of the hole or get off the boat, and the continuous journey of effort can end.

### 3.4.2 Change Leads to Change

As well as discussing the ups and downs of change, participants spoke about the accumulation amounting to a notable change and change itself causing further change. This subtheme highlights the ability of change to propel and promote further change in terms of increasing motivation to put the effort in and also in terms of differences within a person that allows further change to occur.

Participants illustrated that coming to therapy is doing something different, so a change in itself:

*Being somewhere that I could go every week um and show commitment and work through difficulties ...it was an example that I could do it.*

Jo

It struck the researcher that in the descriptions of their experience of therapy participants alluded to engaging in different behaviours (attending therapy itself) as an attempt to 'climb out the hole'. However, each action on its own seems to be discounted by participants as change. In speaking about change in this way there appears to be a process whereby participants slowly engage in small changes. When grouped together, these small changes are substantiated and significant to them, therefore are considered 'change'.

*I learnt you just like you need to make tiny little changes and them by making those tiny changes they turn into big changes.*

Amy

Participants described taking time at first and then after a certain point change started occurring. Participants spoke about the process of "opening up" (Lara), "talking" (Wil) and "feeling feelings" (Georgie) in therapy as the start of the change process. The initial steps to change appeared to be rooted in the thinking and

experiencing of difficulties within a safe enough therapy space as opposed to spending energy on what participants described as avoiding and trying to get rid of the problem:

*Change for me was just moving forward you know<okay>, just not staying in the same place, very much emotionally and mentally<okay>. That was the main change for me, then the physical changes came after.*

Amy

Participants suggested thoughts and emotions helped to create a context in which change could occur. Syed spoke about this as *“first and foremost you have to change your beliefs, so that it’s in itself manifests in your actions”*. From this change, participants indicated that motivation developed. *“You see the changes ...so I kept going”* (Izzy), which participants described as sufficient to carry them through the ups and downs in the change process previously discussed.

In discussing how they experienced the changes, participants spoke about the varied impact of social activities; physical, behavioural, relationship, mental, and work changes they experienced:

*The more I’ve done you know the more I could control, and then I start seeing changes little by little... I actually slept all night through.*

Lara

*I think it all comes hand-in-hand you know, when one things happen then another and another and another in a sense ... like a domino effect.*

Saba

Participants highlighted that change happens little by little and that the change in one facet impacts on another. Lara described a cycle of taking control of *“my breathing, my thoughts”* which led to a calming effect. Saba also talked about a relationship between change in one aspect (physical/behavioural) to another area (mental). Thus, change can be viewed as fostering further change.

Participants suggested that knowing and experiencing some change, even small, made change feel like a realistic possibility that “gives me hope” (Syed) and feels achievable:

*I started to feel like a I could get to that point because I'd done it a few times <okay> which is different from before.*

Jo

Jo went on to describe that the achievement felt “rewarding” and helped “dealing with feelings of discouragement”. Positive feelings and hope created from change experiences opened participants thinking and allowed them to believe it was possible to achieve a wanted outcome. This can be interpreted as a cycle of emotional, cognitive and behavioural changes. Additionally, this can play out in a negative cycle, whereby sad feelings described by participants led them to go to bed and pause their change efforts. These processes formulate initial small changes as a key factor in the process of progressing further and achieving the desired change.

### 3.4.3 Changing Expectations

In discussing how participants engaged in the change process and how it occurred, participants spoke about what they thought this would look like in therapy. Some came with expectations and hope, whereas others spoke about “not knowing” (Wil), “had no clue” “I didn’t really know how that works in therapy” (Saba), “literally hopeless” and “didn’t think it would work” (Izzy).

This suggests that the participants’ approach to change and their expectations changed over the course of therapy; some participants spoke of being content with it being different to how they had wanted.

*I wanted a a quick fix <yeh>, like it didn’t happen, but it does improve itself so like I said I’m very happy with, with of how you know it’s making a change.*

Lara

The change in expectations of therapy was experienced by participants and appeared to be facilitated by socialisation to therapy or direct conversations with

therapists. Participants described coming to therapy with certain ideas, however these were reconstructed through conversations and learning the boundaries of therapy during sessions. As Lara alluded to, she came to therapy wanting a quick change, and although this was not achieved, she was content with a different process of change as she felt there had been an improvement. As described by Georgie:

*My therapist said to me ... you don't wanna hear that but you wanna think there is gonna be something that can be quite quick <yeh> but yeah its being I think once you realistic with yourself, which is something that just sort of clicked.*

Participants suggested this helped them to reassess what was possible and what they wanted in terms of change from therapy. This process may function to minimise the limitations of the ability of therapy or the therapist to create change, and places onus on the individual. Perhaps it is also serving to protect the therapist from feelings such as failure or inadequacy, which are therapist fears the researcher has both experienced and heard anecdotally throughout her career.

This encounter nonetheless appears to form a shift in individuals' expectations. Fola's reflections suggest her experiences were helpful even though the focus of help had altered from "I wanted the nightmares to go" to "it has not changed <yeh> but <okay> I have a coping mechanism to help me through". Participants indicated experiencing a different, and at times unanticipated change, which they described as adequate. Some spoke of the change as better and farther reaching than they expected:

*No way did I think it would work the way it did... I hoped that I would develop normal relationships <mmh>, I hoped to understand myself which I hundred percent do now <mmh> and to not blame myself for everything <mmh, okay>, and I came out all of the above but more as well.*

Izzy

*I honestly didn't believe in therapy before that<okay>, and I didn't think I'd ever get better... I just I'd never thought I'd be like this [happy crying] I could never see it. I never thought I'd be okay ... I didn't realise it's not a part of me something that it can go.*

Saba

These extracts suggest that the emotional impact of the change and, subsequently, participants' positive experiences in parts of their life seemed to override the want for the specific change initially set out. Perhaps participants are signifying an acceptance of some of the difficulties. The change in expectations connects with a change in participants' relationship to their difficulties. Participants were able to identify with additional aspects of their identity, focus less on the things keeping them stuck and feel able to cope with the difficulties, which shaped different experiences and meaning for individuals. Maintaining a hook onto original expectations that were unable to be met would have interfered with participants' transformation.

Alternatively, some spoke about a tentative acceptance and appreciation of their therapy achievements whilst also holding onto the idea of their original expectations of therapy. This led to searching elsewhere for help, for example, in religion (Georgie) and in other therapies "*I will sign up for something different*" (Fola). Whereas therapists placed the change in the individual (e.g. in changing their expectations), the individuals appeared to place the ability to change at times outside of themselves and placed the responsibility on the therapy.

### **3.5 Theme 2: External Help**

This theme attends to the multiple factors that impact on the change process, as participants felt that "*life isn't just about one thing like there's so many aspects of your life that can have like negative or positive like impact on you*" (Amy). Therapist role and expectations of the therapeutic relationship is explored in relation to change during therapy.

### 3.5.1 The Therapist

Although the research was in the context of psychological therapy, the researcher remained open to ideas that other factors supported participants' identified changes. Thus, open questions were asked about change facilitators that did not encourage participants to look to therapy, and enquiries made about changes outside of therapy. However, participants overwhelmingly attributed change to therapists first and foremost.

Most participants described instantly having rapport with therapists and building "trust" (Lara, Saba) "comfort" (Wil, Suaid, Amy), a "sense of safety" (Fola, Suaid), providing some "stability" (Suaid), "having someone to talk to" (Wil) and "someone to hear you" (Saba). Participants described this experience as a valuable change:

*Instead of keeping it to myself for a change <yeh> I've actually been able to talk to people about it <mmh> which was the best bit.*

Wil

Wil described how the therapist meeting his needs provided a new experience which is most beneficial in the process of therapy. Participants also placed the therapist as responsible for success:

*I can't even explain what [therapist] has done to me, like she is literally transformed my life.*

Saba

*I didn't tell her but she knew.... she suggested that, that I'm it's like really unique thing that my mother used to do take some decisions for me.*

Suaid

Suaid suggested that the understanding that therapists develop helps them to care for and make helpful decisions for participants. Therapists were described as nurturing and giving. Their role can be viewed as supporting the change process for participants by providing a context in which participants can grow and develop.

The therapeutic relationship allowed participants to engage in change and use what was offered in therapy in a helpful way. Participants' accounts of the importance of connection and safety in therapeutic relationships are associated with positive emotions which participants described as transformative as they were then able to take different actions (e.g. talk to others about their difficulties). These experiences may have also led participants to engage more with therapeutic techniques.

Although participants highlighted the efforts required from them for the successful outcome of therapy, at times they credit the therapist, positioning them as the transformer and decider. This perhaps comes from participants wish for therapists to fix their difficulties and nurture them at a time where they could not do this themselves. Further to this, by placing these expectations on therapists, participants are able to externalise stuckness and attribute previous difficulties towards attaining change on therapists.

*I guess every therapist got his own techniques but there are all very good as well and I think if they're kind and caring then that would have a really big impact on the patient.*

Suaid

*What I didn't like about the other therapies before it was just me talking <mmh> and them listening <okay> whereas this one it was more about how we can cope with that, how you can do, like, and what made you think that <mmh> and it was very hands-on <okay> um so then I, I realise there was a lot of work that I also had to put in.*

Georgie

Participants described the importance of the therapeutic relationship, however, a good relationship itself was not sufficient for change to occur. These extracts show that therapeutic rapport created a safe environment within which change could start to take place and supported participants in using the tools and techniques discussed in therapy. It could imply that the trust and motivation created in the relationship supports participants to make initial changes which then can lead to further change. As Fola described "it's the techniques that will help me to be able to cope".

The therapist's role can be understood as *"motivating"* and providing the client with the strategies *"presenting me with the way out"* (Lara) and, as Georgie described, the change then occurs through participant hard work. This highlights that participants view therapists as knowledgeable and skilled which also emphasises power differences between therapist and client. Participants viewed the therapist as being there to guide them how to change or what to do and most described this as a helpful and welcome interaction. Georgie's reflection also shows the progression of the relationship from the therapist teaching, to collaboration, to participants taking the responsibility for change.

Although Jo described a *"jarring"* relationship with her therapist and felt *"the language that is used to ask for the change, and to point out that I need to change, it can feel quite invalidating and it can kind of play into the idea that you're wrong you're the problem"*, she too found that the strategies offered by the therapist started to help and explained that this led to an improved relationship with the therapist. Thus, representing a complex interaction between therapeutic rapport and therapeutic tools in the process of change.

### 3.5.2 Help Beyond Therapy

Participants spoke about what help was available and the timing of it in relation to change. Change may occur with the assistance of therapy, however, participants also described important change through other forms of support, and a link between the two. Consistent with the importance of change in multiple areas of participants' lives, participants discussed alternative services that were available to support change for them:

*In the background there was like a, social charities were like doing the social activities with me yes that really, like, because you cannot ask NHS to give you somebody to take you to park.*

Suaid

Suaid illustrated the lack of power participants may have in therapy to ask for support in actioning therapists' advice. He explained that therapy alone was not enough to create change *"I was unable to um implement the the techniques he was*

*telling me I was learning it but was unable to implement". Shared by Syed "I need some social engagements with some people which is like my recovery plan".*

Participants spoke about learning or being told to do something in therapy. However, to aid this transformation from something that was spoken about to being able to participants suggest needing support to motivate them to do it.

Further to participants shift in thought processes, when it came to following through with actions, some needed further motivation. Participants discussed this in terms of having someone there to help them at the time and also having an external reason to do it:

*Like having a reason to get up in the morning, and because otherwise when I'm stuck, I'd just sit there with the curtain closed the days.*

Amy

Participants' change experiences may not solely be facilitated through therapy, but other people, services and interventions may also offer equally helpful support to assist change. Again, reinforcing notions that there are many aspects to change. However, participants linked the support from other services with therapeutic support:

*It was joint I'd say more, more with therapy but like I'd have this really, I'd get very very anxious about death <mmh> and religion started to help me with that, but I think having that support network was really important so having the support from therapy.*

Georgie

These extracts imply that participants may attribute the change experiences to therapy; however, combinations of services and support facilitate the process. Participants spoke about their experience of therapy helping them engage in alternative support from the moment of their referral. Amy described how *"I'd waited so long like, and I sort of had to do a lot of change myself"*. The waiting for therapy may create a space where someone is readying themselves to change, and where

participants had long waits, they were able to try to make shifts themselves, perhaps feeling safer to do so knowing that therapy would be offered at some point.

On the other hand, participants also spoke about limitations of the availability of therapy and therapy modality *“when exposed to CBT and you are in not that great a mental space I think it’s easy to see the limitations of it the apparent fixedness of the structure”* (Jo). *“I waited so long”* (Suaid) getting in the way of them making progress at the time they felt it was needed.

Participants described the lack of choice in what and when therapy was offered. Perhaps suggesting that what services are offering may not be quite meeting them where they are at in their change journey:

*It really brings you down it just makes you feel like you’re not important at all it just makes you feel like our they’ve forgotten about me you know it’s sometimes a six-month wait, ...you know no one stepped up or cared so why should you bother...I feel like it impacts therapy a lot because it makes you feel like do these people care?*

Saba

These experiences may even lead to a decline *“I got a lot worse I think when I was waiting... I felt like it was really extreme <mmh> I was in the deep place”* (Amy).

Participants described feeling alone and questioning whether the help can be provided, reinforcing feelings of hopelessness, and also described worrying about how badly things could deteriorate. This captures the incongruence of the wish of participants in availability of help and what services offer. Indicating the importance of understanding the impact of waiting times on participants’ change process, in terms of possible declines as well as impact on the relationship and trust with therapists.

### 3.6 Theme 3: It's Not Magic

This theme explored the way participants spoke about engagement in change as passive and active. In discussing engagement in change, participants emphasised “*you got to find it within you*” (Izzy) and that “*you have to want the change to happen really, nobody can drive the change into anybody*”(Fola). They described the motivational impact of emotions and hope, which seems to have helped them persist and follow through with different actions to achieve significant shifts.

#### 3.6.1 A Hopeful Glimpse

Participants highlighted the importance of their acceptance and realisations; “*first you have to accept...if you don't accept you can't get help*” (Fola). Participants described gradual and sudden realisation as part of the change process. The role of realisation as motivational, helping participants to gain perspective and prepare for the process of change was explored:

*I was seeing the changes which then made me realise it's true what she's saying ... I realise the it's able to change <mmh> and although I'm so far away from where I want to be I know that I've got the capability to do it <yeh> just I realise it's gonna take me time.*

Georgie

*It's gradually like I think about something and then go back to it now, I wouldn't think about it for quite a while.*

Wil

*It all linked, like I said with my dad and then the confidence, and then it linked to me like going out and getting a job because I started loving myself and I wanted to do well.*

Saba

Participants suggested that the realisation of change aided a process of feeling capable of attaining change. This may enable participants to trust the process and continue taking steps in the direction of desired change, making further change,

even when there are not immediate results. Similarly, shared by Lara who described being “*more aware*” helped her to engage in the techniques introduced in therapy.

Participants linked their realisations to discussions with therapists. The skill may be attributed to explicit teaching and monitoring in sessions, as well as modelled in conversations with therapists:

*The behavioural experiments we did, it was it was based upon the facts that there was a change of attention <mmh hmm>. Where I wasn't focusing much on my condition, I was just focusing on doing other things in my life.*

Syed

Participants spoke about therapists helping them to reflect during sessions to bring their awareness and attention to other things that were happening as opposed to only seeing difficulties, which allowed realisations to occur. Jo described a similar process of realisation being enabled by a self-process of reviewing and reflecting on how things were different. Participants spoke about changes occurring without them acknowledging it, it was the shifting of their awareness that helped them form a new outlook.

Izzy also spoke of utilising therapy strategies and then looking out for changes:

*I'd go out and then try and use them ... and reflect about what was going on whether it was really a dangerous situation or whether it wasn't like<mmh> like it's just my anxiety, so like noticing small changes like it was nice.*

Izzy

Becoming aware may function as a shift of attention to notice and attend to other facets in participants' lives “*I had everything to live for... but didn't realise*” (Izzy). These experiences also suggest that shifting the spotlight of attention and separating from difficulties, enabled changes to be made in these areas which had in return had a positive impact on difficulties.

Participants described the process of this change taking time, and being in part unconscious. Most spoke about realising changes “*towards the end of therapy*” (Georgie). They described others (therapists, friends, family) as noticing differences and speaking about it with participants, however the shift was not felt. Participants talked about there being a time lag between others noticing and internal realisations; “*in the end I realised she is right*” (Suaid).

On discussing how they came to realisations; participants also spoke about sudden “*lightbulb moments*” (Izzy). This may link to gradual changes building up to a certain threshold that then become noticeable, just as for a lightbulb to work the elements and wires need to be connected:

*I suddenly realised but that's kind of how it's been I think it just like it sinks in at some point it's been like there's been, there's been moments where it's just collect ...my understanding is that probably my my brain is just taking some time to put things together and process*

Jo

Participants suggested that having a better grasp over difficulties or being able to shift attention away from them gave them the distance needed to be able to gain awareness. The researcher noticed that sudden realisations seemed to have a more remarkable impact on participants, and they described them as pivotal moments “*I was like oh shit*” (Izzy). This may imply that sudden realisations are epiphanies of self-discovery that connect elements of change and therefore have more weighting in participants’ change experiences.

### 3.6.2 Escaping Negative Emotions

Participants described how emotions, both positive and negative, impacted on how they engaged with change. They spoke about emotions as resistance to change. Saba felt that “*when I was depressed, I wanted to stay depressed*” and the fear of change and risk of the unknown was a deterrent: “*I don't really like taking too many risks <mmh hmm> because I'm used to what I know about my condition*” (Syed). The familiarity of what was known and unwanted felt more comfortable than the possibility of improvement that was unknown:

*Change is scary no matter what um but it's really scary when you when you are so comfortable in the sense um having, being a certain way um you're so comfortable feeling sad.*

Amy

Participants suggested that the experience of unpleasant feelings and fear of change was perhaps a reason for their stagnancy in the past. However, Izzy, Lara, Georgie, Wil, Amy, Saba, Syed and Suaid described that escalation in emotions, feeling desperation and needing something to be different led them to therapy, thinking they “*had nothing else to lose*” (Izzy). Intense distressing feelings increased participants’ thoughts of hopelessness and escape. Fola described having exhausted other attempts to cope and depicted therapy as a last resort:

*So negative <mmh> when I wake up with the nightmares and then dreams and I tried everything ...I'm not sure if it will work but it's worth a try because I don't know what else to do.*

Fola

Participants suggested that the emotions that they are trying to escape from become too trying to live with and so, escaping the feelings may become motivation for change. Participants used value laden terms such as negative and positive to describe emotions. Unpleasant emotions of distress were labelled as negative, perhaps signifying the adverse potential impact on the change process. However, at the point where emotions became overwhelmingly intense participants described emotions rising to the top of their hierarchy of difficulties:

*That's the horror for you if you don't if you don't move you'll be there forever ... you tell yourself enough is enough <mmh> and you're desperation is like at the highest levels.*

Suaid

*Change comes from being unhappy or sad because you that's why your that's why you're meant to feel sad<mmh> so that change will so you can change something.*

Izzy

The extracts suggest that participants viewed emotions as meaningful indicators that there was a need to change. The intensity of negative feelings seems to connect to experiences of feeling stuck and not being able to change, or feeling desperate to the point that the choice is between changing or ending their life, and for many the attempt to end their life had been unsuccessful. Although participants viewed the end goal of therapy as positive, they viewed the process of change as difficult and painful, *“what is change to me. I hate change”* (Izzy).

Participants suggested that feelings experienced during difficult stages in the change process created a context of resistance to change:

*Naturally people are going to find change difficult we're going to be resistant to changes.*

Jo

*She was asking me to do stuff and I wasn't, and I thought, and I started to get frustrated.*

Georgie

The complexity of the emotional impact is highlighted by Georgie, who conceptualised that low mood created negative unhelpful spaces in therapy which led to escape strategies of suicidal thoughts. Suaid shared that: *“I could not work on it because I was like really bad”*. However, through persistence, and continued engagement in the change process, participants noted their feelings became more positive.

*I'd had suicidal thoughts <mmh> that then there started to see, I started to see glimpses of better days<mmh> and then it started that the better days got more often, or the better times got more often and then yeah so I suppose during the week I started to see that.*

Georgie

*When you try and then you feel oh that felt good, then you try again a little bit, oh that felt good, until now your body is used to it.*

Fola

This could suggest that pleasant emotions help encourage participants to keep going through the more difficult times. As Jo illustrated, participants described needing to act against their distressed feelings to achieve change, which then helped to scaffold emotional change.

*Making change in a deeper emotional level is something that requires very great willpower, very, a willingness to change some logical thinking and some and good communication skills rights. And I feel like in the beginning I didn't have those because of the state I was in. So that was the very first barrier to change.*

Jo

Participants also suggested a connection between experiences and emotions. They noticed that their emotional state impacted on their perception of experiences, describing negative emotions as blocking their thinking and ability to engage in alternative ways of being. Linked to this, participants described both experiencing fewer unpleasant symptoms, as well as being less bothered by them due to attention shifts:

*When I'm positive and I'm happier the nightmares tend to reduce, so I I don't know what is the connection between the two but I feel like if I try to work on my happiness if I try to work on my positivity think positive there is a chance the nightmares will totally reduce.*

Fola

The reduction of unwanted and distressing symptoms was important to participants. However, seeking “*new feelings that were coming out that I hadn’t felt for a long long time*” (Georgie) was also valued.

This indicates the importance of emotions as barriers and motivators to participants’ change process; as well as deterring or pushing them to engage in change initially. Participants’ descriptions suggest that unpleasant feelings are not necessarily ‘negative’ in terms of the change process, as they can construct the basis for change and motivate the individual to do something different. Participants suggest that action needs to be taken contrary to emotions. Change was considered to take place on other levels (e.g. thoughts and behaviours), with emotions being intricately linked and ultimately leading to feelings shifting.

### 3.6.3 Control

Participants identified wanting therapy to change them automatically without effort “*I just expected it yeah you know a magic wand to make me better*” (Lara) “*to be hypnotised*” (Georgie). They described wishes that the change process would be fairly passive, and something done to them rather than them being in control of change. Suaid described this as harmonious with the therapist “*given me confidence*” and Jo shared tense interactions with therapists “*I’ve been told what to change and that there is a need to change*”. This indicates the power imbalances, and possible disempowerment, between therapist and participant. Initially participants spoke about therapists being in control, which possibly is constructed through the referral process and availability of help. Syed utilised an analogy to depict the client role in change:

*Some people have to be thrown into the water to learn how to swim <mmh  
hmm> others have to, have to take lessons by an instructor.*

Syed

This can mean that participants feel they are being ‘done to’ initially in therapy and need to become a “*fighter*” (Suaid) actively engaging in the therapist’s ‘lessons’. Through “*realisations*” and “*therapist told me*” (Fola), participants increasingly spoke

about being more “*in control*” (Lara). They discussed learning that they had control and “*power within yourself to like get better*” (Amy):

*I had my sense of autonomy and that I was in control, and whereas I feel this condition is in control most of the time... it's all about control really.*

Syed

*If I don't change me self, then change won't happen will it.*

Wil

*When someone is coming for therapy they must want the therapy to help them. If you're coming to therapy expecting that the therapist will change things for you it might not work because the therapist is there to lead you to give you a path from where you're gonna go through, it's up to you to go through that path or to stand and look at the path.*

Fola

This can mean the change is a feeling of taking back control over symptoms. Participants spoke about gaining the feeling of control through seeing the result of change. Syed described spending “*less time in the toilet*” and “*I do less of my unhealthy coping behaviours*”.

For change to occur, participants described making choices and deciding to take control as a conscious action. Participants described that taking some control over the direction of thoughts and their perception created change:

*I'll decide to choose to be positive not negative. Just the thinking of it brings that shift even it if it's a little bit. It's not always <yeh> or sometimes just to close the eyes and imagine I'm on the beach I can see the sun and I'm free, I'm free and with that brings the shift.*

Fola

*If I'm doing, if change is happening it's cos I'm making it.*

Izzy

To take control, participants highlighted the need to want to change and matching this with “*effort for it to change*” (Fola). They also discussed change as something that happens “*unpredictably*” outside of their control “*I think change can just happen like without your control and then you have to um like adapt*” (Amy). Participants spoke about negative change as occurring to them and impacting on them, whereas, having to actively seek out positive change. Positive change could also be understood as wanted changes. Participants spoke about the change not automatically occurring and requiring active effort. Participants expressed that once actively engaging in positive change there is a natural process where change develops:

*I would say that each change was a mixture of deliberate and is then some progress like natural progression<mmh>. So, I would say that yes, initially the decision to try out, the deliberate decision to try it out was the main push factor<mmh>. And then the natural consequences were in time then your responses that came more frequent<okay>. My self-esteem started to increase because I was doing things differently<okay> yeah, and then I suppose better relationships were kind of a a con-, like a natural development.*

Jo

*You have to work on yourself to make things change. I mean,<mmh> it's with therapy I think the changes happened from both sides, changes would never have happened if I didn't put in what she put in as well.*

Saba

These extracts highlight the complexity of control in the change process. Participants construct control as key for creating change; they emphasised their role, albeit with an initial wish to be passive, also explaining that nature and therapists control impact on their journey. As Lara suggested “*I mean it's not like a magic wand <yeh okay> but it does give me lots of tools*”, which empowers and positions participants as more in control.

### 3.6.4 Pushing Through

Participants described notions of motivation, will power and wanting change “*it’s just that I want, want more for myself*” (Wil), as well as hope and belief that change was possible as a premise for shifts to occur:

*I think the belief that it’s possible, <mmh> yep a belief that it will be beneficial <okay> yeah. I think those two things that it will be possible and that it will be beneficial... I had to really want to, I will, actually have an underlying desire for it.*

Jo

*A lot of motivation, and because I was still like in such an anxious like state anyway, I still hadn’t had like help. But I knew I just knew that if I didn’t make that change then I’m just gunno be stuck in the same old cycle...like your hope in the future of like where you want to be.*

Amy

*What helps me, me wanting to get better<okay> yeah that’s what helps me to to do all these things.*

Lara

They suggested that these elements were needed to be able to persist through the hurdles of the change journey. Thus, implying the process of change was effortful and needed strength from participants to push through. This connects to others’ experiences :

*To have that resilience to to defy your own mind and your mind tells you’re okay at home <mmh> but you say to yourself no I want to go out and it’s not really easy.*

Suaid

*When you have rigid beliefs you will only stick to certain uh practices or regimens and that you, that you're accustomed to <mmh> when you break out of it you begin to discover new things about yourself.*

Syed

This suggests participants become familiar with, and stuck in, ways of being, which connects with previously discussed concepts of comfort in the familiarity of negative emotions. These patterns then inhibit participants' connection to incongruent information. For example: participants may dismiss information that is positive or outside their negative expectations, and this may further confirm their negative expectations. Participants' language in these extracts portray feelings of constraint, they depict notions of 'breaking out' and becoming "free" (Saba, Amy, Fola, Georgie, Syed, Jo, Suaid).

Change may mean going against their current norm; Fola described this as "you have to reprogram". This was associated with being able to do something different despite the pull against it from feelings and effort involved:

*Fear of change, because what you're used your comfort zone... you have to do it anyway, you just have to do it despite the facts that you just have to keep on telling yourself you're good at is you can do it, you can do it... I used to say myself no I can't, I can't do it I can't do it, but it started to sink you know the brain started to adjust yes you can do it, yes you can do it until it becomes something that I'm able to do.*

Fola

This is significant in terms of change, as participants noted that action contradicting thoughts was able to create change and mental shifts. Further supported by Amy who expressed "you've got to start doing something different for that the change tale".

Participants spoke about these differences being external or internal, although focus was on internal shifts as this is where they described having control. To create change they described "getting on with it" (Wil) and "the intention and action <yeh>

*you know so if you intend to change you know, and then you actually do it, then it's going to happen"* (Lara). Participants spoke about pushing through:

*Just get up, jump straight out of b- out of bed, get ready get dressed get on the bus, and then as soon as you know it you're there and you're alright.*

Amy

*There are days that I don't even wanna get up from bed <yeh> but I've just started to push myself.*

Fola

*It was quite a forceful as well for me to tell myself no do it, no listen, you know take this on board try it and it was quite a deliberate forceful thing.*

Jo

The way participants spoke about the impact of following through with action indicates an overall sense that although change occurs on a myriad of levels, ultimately their sense of change was in the doing. Participants suggested that making the decision to act and persisting with it in the face of difficulties bridges the gap between intention and action which fosters change.

## 4. DISCUSSION

### 4.1 Chapter Overview

This final chapter considers the results of the research in relation to existing literature and research questions. Implications of the study are suggested and considered within the context of a critical review of the study. The researcher shares final reflections, and a conclusion is provided.

### 4.2 Findings in Relation to Research Questions and Literature

Previous researchers have advocated that, as the site of change (Greenberg, 1991) clients' perspective, is imperative to understand better the process of change in therapy (Carey, *et al.*, 2007; Carey, Griffiths, Dixon, & Hines, 2020; McLeod, 2001). This study asked the research questions:

- 1) How do clients define change in therapy?
- 2) How do clients describe their experience of 'psychological change' in therapy?

Three main themes were identified through thematic analysis: 'Change as changeable', 'External help' and 'It's not magic'. These themes will be considered in relation to research aims and existing literature.

#### 4.2.1 How Do Clients Describe their Experience of 'Psychological Change' in Therapy?

Through describing their experiences of CBT, participants offered insight into the dynamic processes of change, their understanding of what engenders change and participation in the process. Participants' understanding of how change occurs is reflected throughout all the themes: 'Change as changeable', 'External help' and 'It's not magic'. These themes, as detailed in chapter three, encapsulate the process of change as dynamic, other's role in change experiences, and the individuals role, respectively.

#### 4.2.1.1 Conceptualisation of the change process

##### 4.2.1.1.1 Nonlinearity

Participants described being on an up and down journey that gradually led to change. It seemed that getting to a desired destination required continuous active effort which participants spoke about as an uphill challenge. Participants voiced that their efforts could be easily dismantled and pushed back down until they reached a “threshold” of change (as described by Jo). Ups and downs were also described as unpredictable, thus implying that change is a non-linear process (Hayes, Laurenceau, Feldman, Strauss, & Cardaciotto, 2007). This somewhat contrasts the idea of individuals systematically progressing through predictable sequela of change as posited in TTM (Prochaska & DiClemente, 1983; Prochaska & Nocross, 2001; Prochaska & Velicer, 1997) and Clarke, Rees and Hardy’s (2004) findings. Non-linearity of change is aligned with recovery literature (e.g. Jacob, 2015) and is an important finding as it contradicts widely accepted assumptions about the linearity of change. The assumption of linearity influences the development of services, how the effectiveness of therapy is measured and the direction of research. For example, the effectiveness of CBT in Tolin’s (2010) meta-analytic review is measured using outcome scores on pre, post and follow-up measures. These measurements do not account for the up and down process of change, nor do they account for the multiple variables that influence the therapeutic change process, which may explain the stuckness in literature to identify and explain therapeutic processes of change (Hofmann, Curtiss, & Hayes, 2020).

The non-linearity and unpredictability resulted in participants’ description of embarking on the journey of change as a risk. They feared that experiencing downs after an up would be demotivating and undo the work they had put into change, and perhaps risk being worse off than when they commenced therapy. The risk also acted as a deterrent to change because of the uncertainty of the change process. As discussed in chapter 1.4.1 therapy can be unhelpful for some clients (Wiles, et al., 2013), Jarrett (2008) discussed that approximately 10% of clients deteriorate from therapy, thus, participants fears are substantiated. However, whilst participants described the resistance as a deterrent, it was not a barrier to change. This aligns with literature showing that resistance is unrelated to outcomes in therapy unless it is

extremely heightened (e.g. Schwartz, Chambless, McCarthy, Milrod, & Barber, 2019).

Participants explained that a key process in motivating them to take the risk is their desperation to escape intense negative emotions. As such these intense emotions are not necessarily viewed as a hindrance to change but possibly a motivator when it is felt there are no other options. Thus, linking to traditional models and measurements of change in therapy which look to alleviate distress for clients (e.g. Tolin, 2010). Participants did not describe going through distinct precontemplation, contemplation or preparation stages in deciding and acting on change as the TTM posits (Krebs, Nocross, Nicholson, & Prochaska, 2019). However, participants suggested unwanted emotions are meaningful indicators that change is needed. Thus, there is possibly a relationship between unwanted emotions and change that is worth exploring. This is similar to the process described in the pre-contemplation stage of TTM. Although, the experience described could be viewed as a goal to move away from negative emotions within Synder's (2002) hope framework, participants lacked the hope thoughts; pathways and agency, which are suggested to be a key mechanism in the model.

Power's (2005) offers a further explanation within Perceptual Control Theory (PCT) which aligns more closely with participants' descriptions than the previous theories discussed in Chapter one. Although as outlined the theories discussed offer an in-part explanation for some of the change process experiences participants described they are not entirely compatible. Whereas PCT offers a more complete explanatory framework for participants' experiences shared in this study. Therefore, although there was not an indication of its' relevance in the introduction of research in chapter one the findings have highlighted the importance of PCT. The researcher now introduces a summary of the theory to consider in relation to findings and continues to highlight examples of PCT concepts throughout the presentation of findings. Powers (1973) developed principles of control theory as a framework to understand human behaviour. PCT posits that control is a core process and that behaviour is one component of this (Carey, 2008). Alsawy, Mansell, Carey, McEvoy and Tai (2014) describe that individuals have internal reference points (desired or wanted experiences) and so will attempt to control their perceived experiences to reduce the

discrepancies between what is wanted and what is experienced. Homeostasis of this balance is maintained through an internal feedback loop. Furthermore, Powers, Clark and McFarland, 1960; Powers, Clark, & McFarland, 1960a) propose that systems of control are organised hierarchically whereby higher-level systems (which are more abstract) inform the lower level reference values (which are more specific and concrete). Conflict is considered a manifestation of loss of control experienced due to incompatibility of two reference points. Individuals attempt to control one without the awareness that this may conflict with the other, which results in feelings of psychological distress (Mansell, 2005).

Conflict can be resolved by enhancing control and by a process of reorganisation (Mansell & Huddy, 2020). Reorganisation is understood as a process of trial-and-error learning which re-establishes control as it is mediated by the process of awareness (Alsawy, Manswell, Carey, McEvoy, & Tai, 2014). Ultimately, individuals gain insight and adapt their perception of experiences or alter what they value as important to them.

PCT conceptualises that perhaps in this research the negative emotions would indicate a state of goal conflict and error which would trigger a reorganisation (change) until conflict is resolved (e.g. Mansell, 2005). The role of positive emotions is considered later in this chapter.

The up and down process described by participants can be understood as the process of trial-and-error in PCT to reduce conflict and realise goals (Mansell, 2005; Powers, 2005). Participants' experiences of reaching thresholds in change may relate to the reorganisation process whereby the error between conflicts has reduced. Although change models discussed in chapter one account for setbacks in the change process, (for example, TTM posits clients can revert to previous stages), client description of change as an up and down process has not been mentioned in the change-process literature. This is an important consideration as TTM would indicate that clients need to progress and work through each stage again after a setback. Whereas, understood as a trial-and-error process, perhaps participants experiences suggest that continuing with further strategies, or trying out different techniques, tools or approaches would better facilitate change.

#### 4.2.1.1.2 Awareness

Participants also reflected that there were gradual and sudden changes that felt somewhat unpredictable. This again contrasts the ideas brought by Clark, Rees and Hardy (2005) that clients progress through predictable sequela of change, however, is in line with Carey et al.'s (2007) conclusions that change is both gradual and sudden. Hayes, Laurenceau, Feldman, Strauss and Cardaciotto (2007) contend that change can be unintentional, unexpected, unpredictable and sudden, possibly reflected in participants' descriptions of both changing their expectations and sudden realisations as part of the change process.

Realisations were described as shifts in perspective which were directed through awareness. For some this involved self-discovery through reflection, a process of feeling capable of attaining change and forming a new outlook. TTM acknowledges becoming aware of the difficulty in the contemplation stage of change. Although this resonated with participants as demonstrated by Fola: *"first you have to accept...if you don't accept you can't get help"*, the model posits this is a distinct stage, whereas, participants described awareness paralleling and being part of change as a process throughout. Awareness was facilitated through discussions with therapists, which links to previous findings of therapeutic alliance as a common factor (Crits-Christoph, Connolly Gibbons, & Mukberjee, 2013), and through behavioural experiments (Bennett-Levy, 2003) which is specific to CBT. Participants shared that behavioural experiments and therapist modelling helped them to shift the focus of their attention which they described as a change. This relates to CBT literature which proposes that behavioural experiments and therapeutic relationships support change (Gilbert, 2017). It is noteworthy that participants did not refer to altering dysfunctional thinking (Lemmens, Muler, Arntz, & Huibers, 2016) as a means to shift their attention which supports Burns and Spangler's (2001) findings that change can occur outside of challenging 'dysfunctional' thoughts. Interestingly, participants described attention, perspective and awareness processes in these interactions which seem to map onto common core-processes (e.g. Beitman & Soth, 2006; Elliott, 2001) and is aligned with contextual transdiagnostic approaches such as Mindfulness (Kabat-Zinn, 2011) and Method of Levels therapy (MOL, a cognitive therapy approach (Carey, 2008; Powers, 2005)).

Participants described “lightbulb moments” (Izzy) where they suddenly realised change had occurred or suddenly realised that it was possible. These experiences were pivotal as awareness enabled change. According to PCT these lightbulb insights can be understood as a process of reorganisation linked to awareness (Mansell & Huddy, 2020). Reorganisation is hypothesised to be the reordering and change in control systems at the level of awareness (Carey, 2008). The shift in awareness described by participants is possibly facilitated through a shift in perception to higher level goals which can be considered to produce change in behaviour, and at lower level goals to reduce conflict.

Additionally, participants described experiences of awareness and realisations as hopeful. This supports Snyder et al. (2000) and Gallagher et al.’s (2020) ideas that hope is a dominant change mechanism of therapeutic change. Participants suggested that realisations aided participants belief and hope that they are capable of change, and so they developed more agency and generated pathways to change and achieve goals. As posited in hope theory, participants described their learning within interpersonal relationships with therapists and received positive emotional feedback which helped them make changes towards their goals (e.g. Shorey, Snyder, Rand, Hockemeyer, & Feldman, 2002). The role of positive feelings of change was also found by Clark, Rees and Hardy (2004) which linked to participants’ sense of positive feedback from achieving change. Similarly, Fitzpatrick and Stalikas (2008) theorise that experiences of positive emotions are change generating as they open the mind to a wider array of possibility and action which individuals can then build upon.

#### 4.2.1.1.3 Evolution

The concept in Hope theory of generating further pathways also offers an explanation for participants’ descriptions of change developing and changing. Cheavens, Heiy, Feidman, Benitez and Rand (2019) posit that people with high hope generate more pathways towards goals and are able to problem solve or generate alternate route to goals. Participants’ accounts supported this notion as they shared “*tiny changes they turn into big changes*” (Amy) which could be viewed as more pathways being created. In support of CBT theory (Beck, 2011) participants

elaborated on how change created change through cyclical patterns, for example a change in behaviours helped to create an emotional change.

However, somewhat contrasting previous ideas discussed in change literature, participants described their goals and expectations of change differing over the course of therapy. The previous literature discussed goals being agreed, and then if there was a change, clients consciously reassessing as goals were thought to be driving and motivating behaviours (e.g. Prochaska & Nocross, 2001; Synder, 2002). Yet, participants described that goals and expectations of therapy were altered over therapy through discussions about realistic expectations with therapists about what was possible in therapy, discussions about what resources would allow and through realising alternative change with which they were content. For some this reflected a socialisation to therapy and the CBT model which Daniels and Wearden (2011) posit develops from the therapeutic alliance. The development and changes of goals can be understood within PCT to be a result of resolution of conflicts and reorganisation which would then inform new reference points (goals) or bring to attention different ones. Participant accounts spoke of the safety they felt with therapists which enabled this change. For others, this reflected a shift in acceptance where participants acknowledged that difficulties would not necessarily change, however, they felt they had tools to cope with challenges. Both therapeutic alliance and skill acquisition has been highlighted in the literature as processes in change (e.g. Olofsson, Oddli, Hoffart, Eielsen & Vrabel, 2020). These can be considered as common and specific therapeutic factors, respectively.

#### 4.2.1.1.4 Active participation

Participants described taking control and having an active role in making change occur, as has been referred to in literature (e.g. Bohart and Tallmans, 2010). Although at the start of therapy participants described wanting a passive role where therapy provided a quick fix, during therapy they transformed through actively engaging in sessions and took control. Clarke, Rees and Hardy (2004) and Olofsson, Oddli, Hoffart, Eielsen and Vrabel (2020) also referred to findings of participants taking charge and responsibility for their recovery. Participants described themselves as needing to make the changes, similar to Greenberg's (1991) concept that clients are the site of change.

Participants described losing control or something being done to them which took away their control as the cause of their difficulties, and that the change experienced was them taking back control. This concept has been discussed widely in recovery literature as agency, the recovering of a sense of personal control (e.g. Boardman & Shepherd, 2012) and again can be explained within PCT. Alsawy, Mansell, Carey and McEvoy (2014) propose that control is the sense that individuals can keep their perception as close as possible to desired outcomes. Lack of control would be where there is an enlarged gap between the wanted and experienced value. PCT places the self as the agent of change and describes therapists as facilitators, much as participants in this study have described. Participants felt the following were necessary components of control which led to change: Awareness, having tools to cope, effort and action. Aligning with previous research (e.g. Wampold, 2015), participants also expressed that although there are other factors that play a role in change, as outlined above, they believe that they play the biggest role “if changes happening its cos I’m making it” (Izzy).

Thus, with growing agency, participants described taking the action of ‘pushing through’ as a mechanism of change. Motivation, as has been referred to in motivational interviewing techniques (Rollnick, Miller, & Butler, 2008), helped participants move from thinking to doing. The TTM posits contemplation and action as distinct stages, whereas participants described a fluid movement that combined aspects of the stages, for example they reverted to contemplating further whilst still following through with action. Although participants described internal changes, they attributed change to behaviour changes. Just as Burns and Spangler (2001) highlighted that change can occur prior to challenging ‘dysfunctional’ thinking, so too participants spoke about pushing through and “*doing something different for that the change tale*” (Amy) rather than trying to challenge thoughts to change the tale and the acting. However, as discussed, participants did acknowledge that to get to this point cognitive changes, for example gaining awareness had occurred.

*4.2.1.2 Summary of clients’ experiences:* Participants demonstrated cognitive and behavioural processes of change. Although some specific factors of CBT (behavioural experiments, maintenance cycles and skill acquisition) were

highlighted, participants placed emphasis on the common factors of therapy such as therapeutic alliance and gaining awareness and control. This is in line with Cujipers, Reijnders and Huibers (2019) suggestion that therapy is a complex multifactorial process that possibly effects change through both common and specific factors. Overall participants felt that they themselves were the largest contributor of change.

Participants' understanding of how change occurs in therapy fits into some of the change process research proposed in the literature (e.g. Crits-Christoph, Connolly Gibbons, & Mukberjee, 2013). However, key aspects of participants understanding of mechanisms of change are spread through other areas of research, for example ideas of non-linearity of change and participants taking control. Interestingly, PCT integrates and offers the closest match of theoretical explanations, as well as researcher and therapist accounts of change, to understand and connect with the findings of participants experience of change in this study. Although the development of PCT has progressed recently, these understandings of change mechanisms are yet to be incorporated within mainstream clinical psychology.

#### 4.2.2 How Do Clients Define Change in Therapy?

In describing their experience of change, participants reflected difficulties in explaining and articulating their understanding "*I can't explain what mentally changed but what I do know it did change.... it's hard to explain*" (Syed). After interviews, participants expressed that this was the first time that they had reflected on the process of change. Unlike Carey et al.'s (2007) study where participants were unable to discuss what change is, participants in this study were able to reflect on this. They spoke about finding it tricky to find the words to explain, yet also appreciated the opportunity to talk about change explicitly. Participants shared that they found it helpful to identify what had made a difference to them and hoped they would be able to continue focusing on these factors to maintain and progress their changes.

Participants offered descriptions of change which are reflected predominately through themes one and two: 'Change as Changeable' and 'External Help. The way change is defined by participants naturally connects to their insights of change experiences. Therefore, there is overlap in how clients define change and how they

experience it. For example, change was conceptualised as a dynamic non-linear process resulting in a meaningful difference as this was participants' experience of it.

*4.2.2.1 Change as a journey:* Participants described change as a journey that is liberating. Metaphors of taking trips were used to explain the ups and downs, non-linearity, effort, sudden and gradual changes discussed in chapter 3 and 4.2.1. Participants' use of metaphors is consistent with the construction of change as a process with a destination that develops or restores wellbeing as postulated by Evans (2013). Change was spoken about as moving towards becoming free from the stuckness of distress which connected to a change in control, awareness and attention. For some, not all, change was the reduction of symptoms. Although none of the participants felt they had experienced a complete remittance of symptoms, they described having a different relationship with symptoms. Following therapy all participants described feeling capable of coping with symptoms and expressed this was a change for them which resulted in less distress.

Participants defined change as something different that was moving in the wished-for direction "*change for me was just moving forward*" (Amy). This was described as mental, emotional and behavioural changes.

Largely, change was referred to as meaningful if it made a difference to the person. Similar to definitions discussed in chapter 1.7. participants considered change to be a literal difference that is observable. However, unlike Evans (2013) definition participants did not refer to the worth of change to society or societal values. Instead they focused on their feelings and personal satisfaction with the change. Furthermore, the end of therapy did not mark a final point in the change journey, it was considered a stage at which participants were able to continue their change journey without the guidance of therapists.

*4.2.2.2 The role of others:* As mentioned, therapists played a key role in the process of change for participants. Further to this, external support was also instrumental in achieving change from therapy. For example, participants described using support workers from charities to assist them in carrying out behavioural experiments which were set up in therapy sessions. Additionally, participants sought support and

motivation from their social environments (e.g. religious groups). Therefore, participants' definition of change in therapy is also reliant on external resources. This connects to literature which shows that change happens outside of therapy (e.g. Pfeiffer, Heisler, Piette, Rogers, & Valenstein, 2011) and also links to therapies which place importance on systemic factors (Spink & Blow, 2004).

4.2.2.3 Summary of participants' definition of change in therapy: Findings suggest that characteristics of change are changeable, and as such change can look different and mean different things to different individuals. Significantly, the findings offer a working definition of participants understanding of change, which is clearly lacking in the literature. The following definition is offered for researchers and clinicians to utilise and develop:

Change can be understood as:

- A risk.
- An individual journey which is nonlinear process with different timescales.
- A difference in emotions, sense of agency and awareness that is meaningful to the individual which results in doing something different.
- Dynamic and multifaceted.
- Being supported by external factors
- A sense of being able to continue the journey of change without therapeutic support.

### **4.3 Clinical Implications**

The study's findings highlight the complexity of the change process in therapy and emphasises the importance of clients' perspective within this. Implications at individual, service and wider system levels are considered.

#### **4.3.1 Individual level**

*4.3.1.1 Expectations and meaningful change:* Participants felt they were the largest contributor of change. They indicated that although remittance of symptoms is wanted, there are more meaningful aspects of change for them. For example, being able to engage in other activities, a shift in their relationship to symptoms and a

change in perspective. This indicates that remittance of symptoms should not be the primary focus of mental health support, and that finding meaningful change for individuals may be more valuable. Furthermore, talking to clients about how therapy works and engaging them in a dialogue about what change means to them throughout therapy may be valued. To do so the researcher recommends listening further to clients' viewpoints.

Additionally, participants experience of their expectations changing over the course of therapy is an important consideration in relation to goals. Although in clinical practice goals are often tracked throughout therapy, revisiting what the goals are is not common practice. Therefore, the researcher suggests that goals are revisited during therapy to ensure clinician and client continue to work towards meaningful change.

The nonlinearity, dynamic and multifaceted aspects of change in therapy is important to consider with individuals as unmet expectations in therapy could add to increased resistance to change and hinder individuals' ability to notice differences. Therefore, the researcher suggests that clients are asked about their ideas and expectations around change during therapy. Understanding that there are not necessarily noticeably distinct phases of change may help both client and therapist trust the process to transform stuckness rather than viewing setbacks as signs of ineffectiveness. Normalising downs as part of the process may help individuals to move away from self-blame and maintain motivation on their change journeys. Thus, therapists can also offer psychoeducation to socialise clients to an understanding of how change occurs. Furthermore, individuals could be supported by sharing other clients' experiences and the working definition of change from this research.

*4.3.1.2 Engendering change:* The suggestion that change creates change through hope, positive emotions and through changes in one area leading to changes in another is important to consider. For individuals this may mean that change in any aspect of their life could be a gateway into areas of desired change. Therefore, individuals could be supported to make any small changes that appear to be manageable either at the start of therapy or times of apparent stuckness, similar to ideas of introducing the difference that makes the difference (Bateson, 1972). The

researcher offers an example of this where they supported a client with academic work which resulted in positive feedback for the client and enhanced belief in their control and capabilities, this had a domino effect and led to further changes in the targeted areas.

The findings suggest that CBT may be tapping into core cognitive and behavioural processes of change. Agency and awareness were suggested as important facilitators of change which indicates that it may be helpful for therapists to promote individuals' awareness of what is meaningful to them and enhance their agency in being able to make changes to reduce the conflict between values. Although CBT may enable this reorganisation, other modalities or foci within CBT may enhance the process of change. It is important to acknowledge that agency is dependent on many factors, for example, having the external resources to change and therefore careful consideration should be taken not to place blame on individuals for stuckness.

*4.3.1.3 Facilitating active participation:* Finally, it may be helpful for both therapists and clients to reflect on the client role in these processes as the doer, having agency, and others' role as the facilitator. This may reduce power differentials between client and therapist and support the process of change, to be focused on what is meaningful to them rather than therapist or societal values. Furthermore, it may reduce the pressure felt by therapists to make changes or 'do' to the client, providing more opportunity to build therapeutic alliance and work alongside each other with therapy being client led. Considering PCT postulates reorganisation occurs at individual level of awareness (Carey T, 2008), it is important to support individuals to redirect awareness to higher levels rather than to the therapists agenda.

#### 4.3.2 Service Level and Wider Systems

As well as redirecting individuals' focus on key aspects of change in therapy, this study findings draw attention to the importance of the role of services in change processes. Participants noted the positive effects of having wider support to facilitate change for example with charities and religious groups. Building on this clients and services may benefit if more community links were built to provide a context that is more conducive to change. This suggestion is in line with the No Health Without

Mental Health Policy (HMG/DH, 2011) which emphasised recovery and the building of stronger social relationships along with potential to facilitate the policies' other key objectives such as greater sense of purpose. Having links with community resources may increase individual's external help resources and also offer them opportunities to facilitate others.

A further consideration of services and of wider level systems such as commissioners should be how services measure and monitor the effectiveness of services. Change processes as non-linear and dynamic suggests that individuals may be re-referred to services which relates to the up and down nature of change and does not indicate therapy was ineffective which is currently not reflected within services. Furthermore, it may be helpful for services to evaluate the measuring of change in services; from participants' accounts it seems as though meaningful change may not be captured in current outcome measures as proposed by Green (2016). The researcher suggests further attempts are made to capture client's change outcomes and processes whilst accounting for idiographic journeys. In the long term this will support services to tailor support and better their outcomes. Although current outcome measures are driven by service, policy and NHS priorities this research suggests that they are not capturing the intended information and patient-led outcomes may be more informative, transformative and cost-effective in the long term.

Additionally, although there are common and specific factors that support change within CBT, the findings suggest core processes of change which offers support for transdiagnostic approaches to mental health and indicates that treatment does not necessarily need to be led by diagnostic labels. The current findings do not suggest that CBT should be abandoned, indeed, participants accounts have praised the support offered and services would require radical restructuring to offer transdiagnostic led services. However, services and commissioners could consider the focus of provision of resources on the core aspects of therapy which promote change for individuals, which as the findings of this study suggest would indicate using client perspective and PCT to guide theoretical understanding of the active ingredients in therapy. Suggestions of using CBT active ingredients informed by PCT

and MOL to maximise change are offered by Alsawy, Mansell, Carey, McEvoy and Tai (2014).

Lastly, the researcher suggests that services give more agency to clients through the construction of user-led services (Braye, 2000). Although there has been movement over the past decade to consult with service-user groups, this is inconsistent across services. This can be seen at government level, for example, the exclusion of service-user led groups in the mental health summit (NSUN, 2018). Not only could this shift give clients the opportunity to shape services and policy to better meet their needs, it potentially maximises their control and motivation to engage in change. The findings of this study indicate that taking control and having an active role in change can be transformational. Furthermore, participants shared that having external responsibilities and focus outside of therapy can be helpful motivators to 'do anyway' instead of getting stuck in distress. The researcher acknowledges that this may require a reform of services and challenge previously held beliefs about the clinicians' position of power. However, the question can be asked "is it really within services' or professionals' power to decide to give the client choice?". Carey and Spratt (2009) highlight the benefits and ethics of clients leading on decisions about their care, for example deciding the frequency of sessions. Practices such as client-led appointment scheduling for MOL have already demonstrated benefits to clients and services (Carey, Tai, & Stiles, 2013) these practices could be maximised and implemented within secondary care.

## **4.4 Research Implications**

### 4.4.1 Review of the Literature

The findings indicate that psychological change is a complex multifactorial process which is dynamic and non-linear. This may explain the varied use of the term and lack of definitions of change in the literature as discussed in chapter 1.7. In this study participants offered a working definition of change which could be used to review the literature to examine whether similar constructs of change are being discussed.

A noteworthy consideration is that findings in this study of change have linked to recovery literature. As discussed in chapter one, change process research is

dominated by researcher and therapist views (e.g. Olivera, Braun, Gomez Penedo, & Roussos, 2013). However, recovery based research is dominated by client perspective and lacks health care professionals' views (Le Boutillier, et al., 2015). It may be interesting to review the literature in parallel to explore whether potential insights can be offered to each area of research.

#### 4.4.2. Further Research

The support from participants for core concepts (e.g. awareness and control) as active ingredients in CBT has implications for research and the development of talking therapies. As discussed, one possibility is that the data could be showing ideas conceptualised in PCT. Therefore, it would be interesting to explore whether this focus indeed increases effectiveness in therapies in terms of client reported outcomes and in terms of timescales of change. Additionally, the findings suggest it would be valuable to explore the process of hope in CBT.

The study used a qualitative design which provided important understanding of key processes of change from the participants' perspective. It may be valuable to build on these findings using mixed-method approaches to further investigate these processes. It would be interesting to replicate further this research by looking at the completion of standard service outcome measures to understand what the measures are capturing and are not, in relation to clients' qualitative accounts.

Further to this as discussed, research and development of individualised outcome measures that capture meaningful change from client perspective and monitors the process of change would be a valued tool to monitor services and therapeutic effectiveness to enhance therapies offered in the long term.

### **4.5 Critical Review**

The research contains a critical evaluation of the research guided by Yardley's (2015) principles: Sensitivity to context, commitment and rigour, coherence and transparency, and impact and importance. Limitations of the research are also discussed.

#### 4.5.1 Sensitivity to Context

This study was grounded in relevant theoretical literature and the socio-cultural setting as demonstrated in chapter one. Additionally the researcher continuously reflected on her position and interactions with participants to consider the social context and influence on the study through journaling and supervision, furthermore relevant aspects of the researchers identity have been shared in chapter two for the readers consideration.

Although some power imbalances are unavoidable within this context the researcher aimed to reduce researcher-participant power differences (Rappaport & Steward, 1997). Examples of this are through remuneration for participants time, through the co-construction of interview schedules, through participant consultation to shape the research, and through positioning of chairs for the interview. Therefore, service user groups and participants had an active and valued role in the development of the research. Participants described these efforts as impactful and shared this without prompt in the interviews. Additionally, most participants offered further ideas for the research at interviews and told the researcher they felt able to do this because they felt that their voice would be heard and their ideas properly considered.

#### 4.5.2 Commitment and Rigour

The researcher reviewed multiple resources, reviewed thematic analytic approaches (Braun & Clarke, 2006) and utilised supervision to ensure rigour in the design and implementation in this research. The researcher was fully committed to gaining client perspective and therefore completed thorough in-depth interviews with ten participants to gain a rich understanding of participant's experiences. As discussed, service users were included as much as possible in the construction of this research and attempts were made to be as inclusive and representative as possible to access a range of viewpoints across social context (Mays & Pope, Quality in qualitative health research, 2006). Additionally, the researcher was careful to use direct quotes from participants to support themes and represent a balanced selection of participants perspective.

#### 4.5.3 Coherence and Transparency

Coherence and transparency have been demonstrated through the clear documentation of process and development of the argument and findings of the study in this thesis. In particular, methodology and interpretation of the data are outlined in chapters two and three, with participant extracts and stages of the development of themes presented in the appendices for transparency. The researcher used a reflective journal and supervision to attend to their responses and influences on the study. Indeed, through the process of this study the researchers' feelings towards CBT have been challenged and adapted through her openness to participants' experiences.

#### 4.5.4 Impact and Importance

This study achieved its aim of gaining clients' perspective of the process of change in therapy and their understanding of change. It offers valuable insights into change experiences and calls into question the prioritisation of quantitative research methods and the privileging of therapist and researcher perspective. The findings presented offer valuable avenues for the enhancement of therapeutic interventions as discussed in section 4.3 above.

#### 4.5.5 Limitations

Participation was voluntary and participants self-selected. Although effort was made to be inclusive as possible by advertising the study through multiple platforms, having wide inclusion criterion and offering interviews in close by bases, it is likely that only those who felt comfortable to share their experiences and therapy journeys opted to participate. This could mean that participants understood or engaged in therapeutic change differently to individuals who chose not to participate and so their experiences are not captured within this research. Additionally, the use of lone interviews to capture participants' experiences offers insight into their construction of change in that time period (Lyons & Chipperfield, 2000) which limits the understanding of how participant's perspective on their experience changes following discharge. However, the current findings offer valuable insights at this stage in therapy, interviews at further time points were not possible due to ethical and time constraints.

Whilst the present study sample encompassed a range of ethnicities it is unlikely to be reflective of the general population according to the latest UK census (ONS, 2011). The sample is also unlikely to be representative of the general population as three of ten participants were male, whereas Baker (2020) shared statistics that in the U.K 4.7% of males access mental health services compared to 5% of females. Furthermore, those above the age of 80 are more likely to access services and those between the ages of 20-79 have similar rates of contact with services (Baker, 2020) , yet, this study sample has a mean age of 33.4 with a range of 21-57. Perhaps an explanation for this was the style of advertising materials such as posters, it is possible that elders may have volunteered to participate had the materials been adapted. This is likely to limit the generalisability of findings. It is important to acknowledge that generalisability is not the aim of qualitative data (Willig, 2008). These findings offer important insights into understanding complex and unknown processes and represent one potential understanding of participants' experiences that is shaped by the researchers' lens (Reissman, 1993).

Counter to initial plans, due to COVID-19 restrictions, the researcher was unable to re-consult with the service user group to review and co-construct interpretations of the analysis. Nonetheless, the researcher was careful to hold in mind feedback from the consultations that did occur prior to analysis, reviewed interviews following the construction of themes and included multiple extracts to centralise participant's perspective. Careful consideration and respect was attributed to service users and participants to achieve non-tokenistic active participation and collaboration (Romsland, Milosavelijevic, & Andreassen, 2019). As discussed, the researcher acknowledged the impossibility of removing herself from her position and influence on the data (Stratton, 1997) and used various platforms to remain reflexive. The researcher is committed to following through with user involvement and aims to go back to the group when Covid-19 restrictions allow.

#### **4.6 Research Reflections**

A contributing factor which instilled the researchers' interest in this study was their engagement in clinical psychology training at UEL, as alluded to in chapter 2. Taking the critical lens encouraged by educators the researcher began to question the

differences and similarities between therapeutic modalities leading to thoughts around 'how does therapy work?', which intersected with awareness of power in 'who says that?'. The researchers position as a clinician undoubtedly influenced the decision to explore these ideas further and conduct this research.

The researcher noted that many participants felt that this was their first opportunity to reflect on their experiences and processes as an individual who partook in therapy. Participants conveyed an eagerness to share their experience to normalise and validate therapeutic experiences for others. In doing so, there was a sharing of previously untold, unheard experiences (Pearce, 2007) with various emotions arising. The researcher felt conflicted in their position as researcher and her role as a clinician, this has been referred to as 'interrole conflict' as part of challenges of the clinician-researcher position (Yanos & Ziedonis, 2006). The researcher attempted to manage this by clarifying their role as a researcher in supervision. She also wrote a reminder at the top of the interview schedule and it was helpful to spend time setting up the space with participants to explain their position. Additionally, debriefing at the conclusion of interviews alleviated the researcher's feelings of guilt for evoking participants' memories of sadness. Participants shared that they valued partaking in the research and the researcher is hopeful that contributions will help to progress and improve the process of change in therapy. Perhaps if participants had not found therapy helpful the researcher would feel differently about this.

The role of the researcher and their engagement in prospective and retrospective reflexivity in qualitative research has been highlighted as an integral and crucial factor in conducting ethical research (Attia & Edge, 2017; Patton, 1990). Through their reflections the researcher noticed their identification as a 'partial-insider' and the impact of this positionality on the study (Chavez, 2008). Discussions held in supervision facilitated conscious decision making and an evolving awareness on the choices taken in relation to the research, the researcher was also aware that not all decision making is conscious (Ross, 2017). Given that this thesis will be available to the public as an online document the researcher has chosen to maintain the privacy and intricacies of reflections journaled and shared in supervision. Participants have been afforded this same consideration; participants made the decisions as to what was shared with the researcher. At the end of interviews participant and researcher

reviewed whether there was anything shared that participants did not want discussed in the study, personal or identifying information has been carefully anonymised and participants had the option to withdraw from the study if they wished.

#### **4.7 Conclusion**

This study explored clients' experience and understanding of how change occurs in therapy. Three themes were identified using TA: 'Change as changeable', 'External help' and 'It's not magic'. Although some findings were in line with previous research, the participants' experiences challenge widely accepted assumptions about the processes of change (e.g. linearity of change).

Findings highlighted the nonlinear, dynamic, complex and individualised process of change in therapy. This thesis also contributed to the literature by offering a working definition of participants' understanding of change which can be utilised in research, policy and practice.

While some CBT specific factors were highlighted, participants emphasised the role of common factors in facilitating change. These include hope, emotions, awareness, control, agency and therapeutic alliance. A PCT framework was considered as one possible explanation of participants' experiences as it was able to account for descriptions of change more than other theories.

Therapy and services need to put further effort into gearing support towards more meaningful change for clients and hand over some of the control to clients to do so. Overall, participants identified themselves as the leading contributor of change, thus suggesting that clients' perspective is crucial in advancing understandings of change mechanisms.

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## APPENDIX A: Stages of Change Model

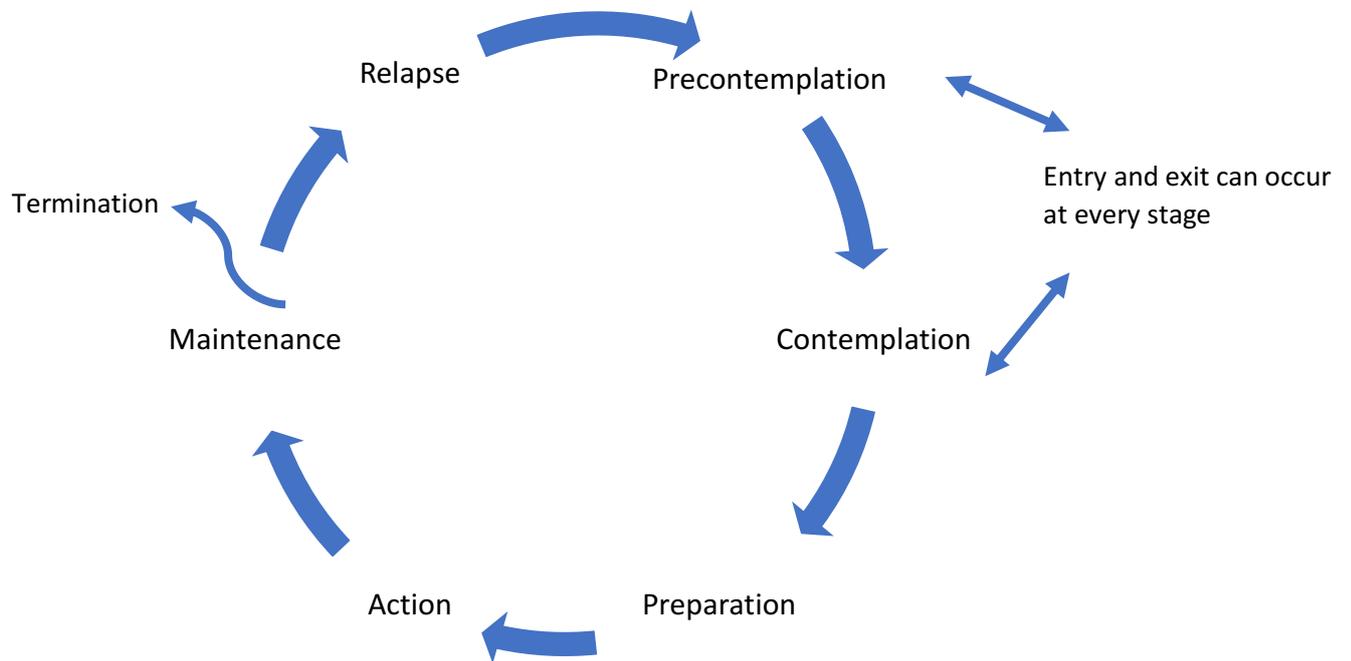


Figure 1. Prochaska & Nocross (2001) Stages of Change Model

***Table 1: Summary of Change Processes from Prochaska and Velicer (1997) Research:***

<b>Change Process</b>	<b>Associated Interventions</b>	<b>Stage in which the change process is considered most effective</b>
Consciousness Raising. This is increased awareness of the problem behaviour.	Feedback, education, confrontation, interpretation, bibliotherapy, media campaigns.	Pre-contemplation and contemplation stage
Dramatic Relief. The individual experiences increased affect associated with the behaviour followed by a decrease in felt emotions if action is possible.	Psychodrama, role playing, grieving, personal testimonies and media campaigns.	Pre-contemplation and contemplation stage
Self-revaluation. The individual evaluates (emotionally and cognitively) their self-image with and without the problem behaviour.	Value clarification, healthy role models and imagery.	Contemplation stage
Environmental Revaluation. Evaluates the impact of their behaviour on the social environment.	Empathy training, documentaries, and family interventions.	Pre-contemplation and contemplation stage
Self-Liberation. The belief on can change and the commitment to do so.	Public testimonies, multiple options, motivational interventions and advocacy.	Preparation stage.
Counter conditioning – alternative actions to the problem behaviour.	Relaxation techniques, grounding, assertiveness training and alternative coping mechanisms.	Action and maintenance stage
Stimulus control- this is the removal of cues for the problem behaviour	Avoidance, change to environment, self-help groups.	Action and maintenance stage
Contingency Management- punishment and reward for behaviours. Rewards are more effective for self-change.	Self-affirmations and group recognition.	Action and maintenance stage
Helping Relationships- support from others	Therapists and buddy systems.	Action and maintenance stage

## APPENDIX B: Key Terms and Concepts of Change

### Key Terms and Concepts

**Cause:** A variable or intervention that leads to and is responsible for the outcome or change.

**Mediator:** An intervening variable that may account (statistically) for the relationship between the independent and dependent variables. Something that mediates change may not necessarily explain the processes of how change came about. Also, the mediator could be a proxy for one or more other variables or be a general construct that is not necessarily intended to explain the mechanisms of change. A mediator may be a guide that points to possible mechanisms but is not necessarily a mechanism.

**Mechanism:** The basis for the effect (i.e., the processes or events that are responsible for the change; the reasons why change occurred or how change came about).

**Moderator:** A characteristic that influences the direction or magnitude of the relationship between an independent and a dependent variable. If the relationship between variables x and y is different for males and females, sex is a moderator of the relation. Moderators are related to mediators and mechanisms because they suggest that different processes might be involved (e.g., for males or females).

(Kazdin A. , 2009)

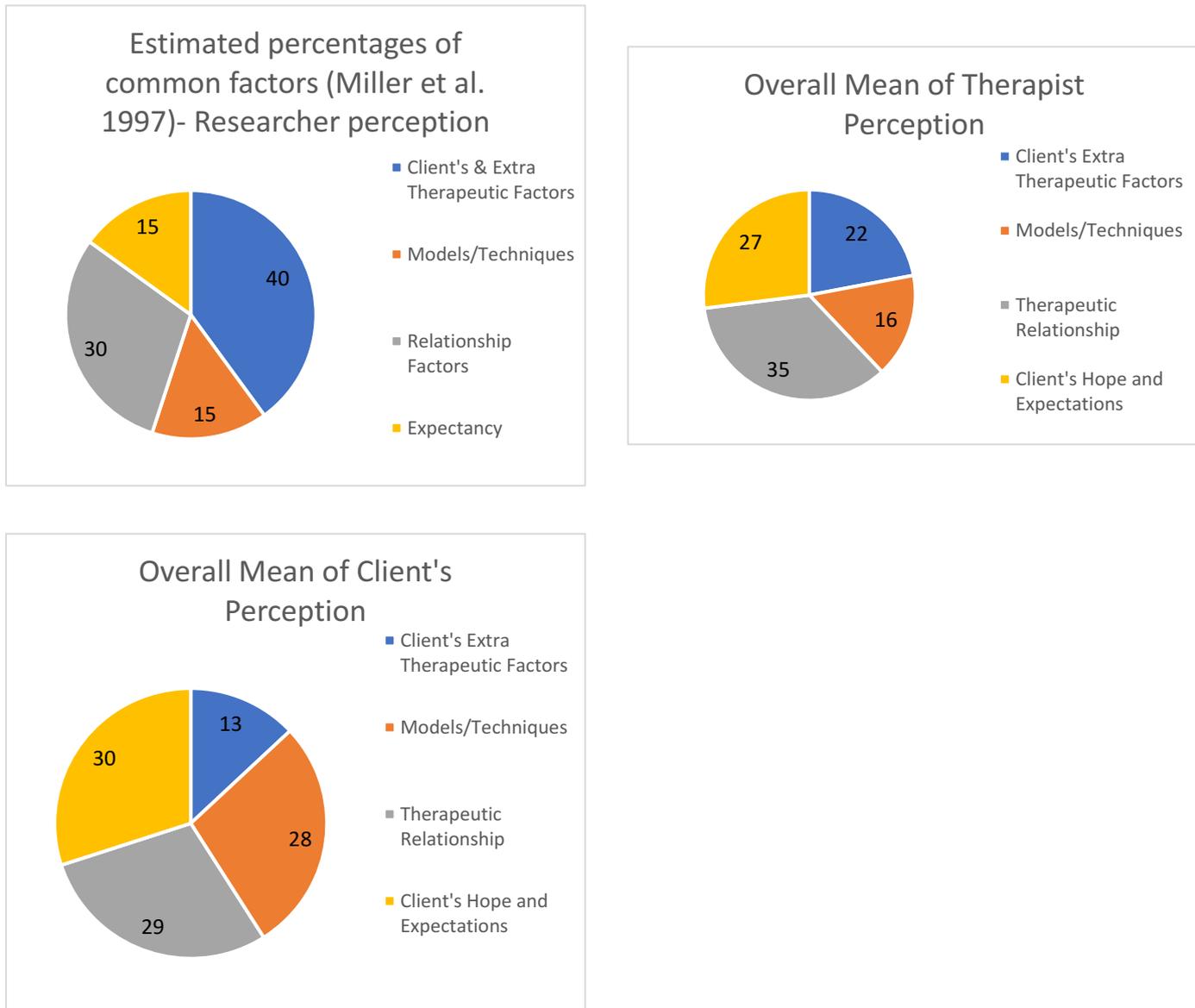
## APPENDIX C: Therapy Common Factors

**Table 2** Overview of common factors in psychotherapy outcomes\*

Common factors		
Support	Learning	Action
Catharsis	Advice	Behavioural regulation
Identification with therapist	Affective experience	Cognitive mastery
Mitigation of isolation	Assimilating problematic experiences	Encouragement to face fears
Positive relationship	Cognitive learning	Taking risks
Reassurance	Corrective emotional experience	Mastery efforts
Release of tension	Feedback	Modelling
Structure	Insight	Practice
Therapeutic alliance	Rationale	Reality testing
Active participation of both therapist and client	Exploration of internal frame of reference	Experiencing success
Therapist expertise	Changing expectations of personal effectiveness	Working through
Therapist warmth, respect, empathy, acceptance, genuineness		
Trust		

(Cuijpers, Reijnders, & Huibers, 2019)

## APPENDIX D : Percentages Attributed to Variables from Different Perspectives



**Figure 2: Perception of the Percentages of Change Attributed to Each Variable**

(Miller, Duncan, & Hubble, 1997; Thomas, 2006)

## APPENDIX E: Search Criteria

The guiding question in the literature search regarding change process was: how has service user perspective of change process been directly investigated in the literature?

The following search terms of key words were used to search the literature using Boolean operators 'AND' and 'OR':

- Client
- Service User
- Patient
  
- Perspective
- View
- Experience
- Account
- Attitude
- Outlook
- Thought
- Viewpoint
- Point of view
- Stance
  
- Change process
- Process of change
- Therapeutic change
- Change mechanism
- Therapy outcome
- Symptom reduction
- Value based change
- Theory of change
- Difference
- Psychological change
- Transformation
- Improvement
- Modification
- Shift
- Variation
- Revision
- Psychotherapeutic process
- Cognitive Behavioural Therapy
- CBT

Limiters included:

- English language only
- Title, Keyword and Abstract only.
- Human only.
- Adult only (>18)

Inclusion criteria

All literature was considered regardless of:

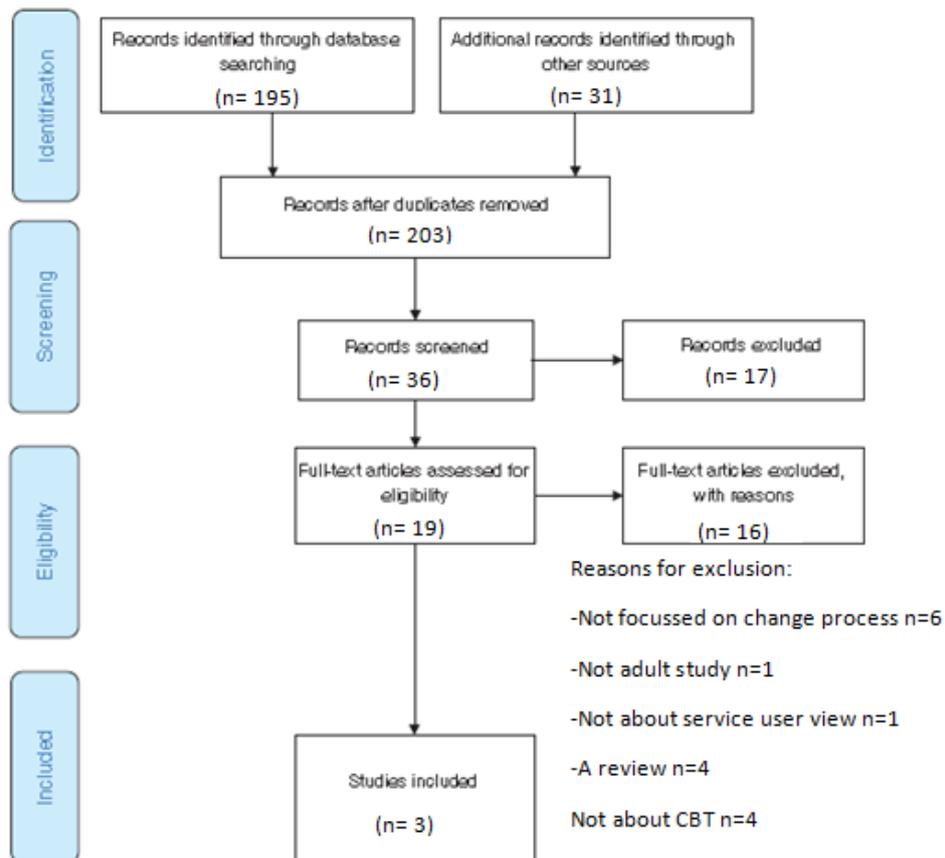
- The date of publication
- The country of origin
- How service user perspective was investigated

Exclusion Criteria:

- If service user perspective wasn't the main focus of the research
- Not related to CBT
- Not related to change process (focused on change outcome)
- Not related to therapy (e.g. spontaneous change).
- Poetry, fiction or other artistic literature

## APPENDIX F: Literature Review

### Narrative literature review



## APPENDIX G: Ethics – IRAS, HRA, REC, UEL Approval and Letter of Access for NHS Researchers

### REC Favourable Opinion



*Health Research Authority*

West Midlands - Coventry & Warwickshire Research Ethics Committee

The Old Chapel  
Royal Standard Place  
Nottingham  
NG1 6FS

**Please note:** This is the favourable opinion of the REC only and does not allow you to start your study at NHS sites in England until you receive HRA Approval

12 March 2019

Miss Amanda Mount  
Trainee Clinical Psychologist  
Camden and Islington NHS Foundation Trust/ The University of East London  
School of Psychology  
University of East London  
Water Lane, London  
E15 4LZ

Dear Miss Mount

<b>Study title:</b>	<b>The change process: clients' perspectives and understanding of change during psychological therapy</b>
<b>REC reference:</b>	<b>19/WM/0088</b>
<b>Protocol number:</b>	<b>N/A</b>
<b>IRAS project ID:</b>	<b>243364</b>

The Proportionate Review Sub-committee of the West Midlands - Coventry & Warwickshire Research Ethics Committee reviewed the above application on 11 March 2019.

We plan to publish your research summary wording for the above study on the HRA website, together with your contact details. Publication will be no earlier than three months from the date of this favourable opinion letter. The expectation is that this information will be published for all studies that receive an ethical opinion but should you wish to provide a substitute contact point, wish to make a request to defer, or require further information, please contact [hra.studyregistration@nhs.net](mailto:hra.studyregistration@nhs.net) outlining the reasons for your request. Under very limited circumstances (e.g. for student research which has received an unfavourable opinion), it may be possible to grant an exemption to the publication of the study.

## Ethical opinion

On behalf of the Committee, the sub-committee gave a favourable ethical opinion of the above research on the basis described in the application form, protocol and supporting documentation, subject to the conditions specified below.

### Conditions of the favourable opinion

The REC favourable opinion is subject to the following conditions being met prior to the start of the study.

1. Amend the study adverts to include the title of the study and the university logo.
2. Amend the consent form so boxes to be initialled and not ticked.

**You should notify the REC once all conditions have been met (except for site approvals from host organisations) and provide copies of any revised documentation with updated version numbers. Revised documents should be submitted to the REC electronically from IRAS. The REC will acknowledge receipt and provide a final list of the approved documentation for the study, which you can make available to host organisations to facilitate their permission for the study. Failure to provide the final versions to the REC may cause delay in obtaining permissions.**

Management permission must be obtained from each host organisation prior to the start of the study at the site concerned.

Management permission should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements. Each NHS organisation must confirm through the signing of agreements and/or other documents that it has given permission for the research to proceed (except where explicitly specified otherwise).

Guidance on applying for HRA and HCRW Approval (England and Wales)/ NHS permission for research is available in the Integrated Research Application System, [www.hra.nhs.uk](http://www.hra.nhs.uk) or at <http://www.rdforum.nhs.uk>.

Where a NHS organisation's role in the study is limited to identifying and referring potential participants to research sites ('participant identification centre'), guidance should be sought from the R&D office on the information it requires to give permission for this activity.

For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.

Sponsors are not required to notify the Committee of management permissions from host organisations.

### Registration of Clinical Trials

All clinical trials (defined as the first four categories on the IRAS filter page) must be registered on a publicly accessible database. This should be before the first participant is recruited but no later than 6 weeks after recruitment of the first participant.

There is no requirement to separately notify the REC but you should do so at the earliest opportunity e.g. when submitting an amendment. We will audit the registration details as part of the annual progress reporting process.

To ensure transparency in research, we strongly recommend that all research is registered but for non-clinical trials this is not currently mandatory.

If a sponsor wishes to request a deferral for study registration within the required timeframe, they should contact [hra.studyregistration@nhs.net](mailto:hra.studyregistration@nhs.net). The expectation is that all clinical trials will be registered, however, in exceptional circumstances non registration may be permissible with prior agreement from the HRA. Guidance on where to register is provided on the HRA website.

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

#### Ethical review of research sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion").

#### Extract of the meeting minutes

##### Recruitment arrangements and access to health information, and fair participant selection

The PR Sub-Committee agreed the study adverts should include the title of the study and the university logo.

##### Informed consent process and the adequacy and completeness of participant information

The PR Sub-Committee agreed the consent form boxes should be initialled and not ticked.

#### **Approved documents**

The documents reviewed and approved were:

Document	Version	Date
Copies of advertisement materials for research participants [Interview Advert XXXX]	Appendix C	05 December 2018
Copies of advertisement materials for research participants [Interview Advert XXXXXX]	Appendix C	05 December 2018
Copies of advertisement materials for research participants [Leaflet XXXXXX]	Appendix D	12 December 2018
Copies of advertisement materials for research participants [Leaflet XXXXXX]	Appendix D	12 December 2018
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [Insurance]	1	18 July 2018
Interview schedules or topic guides for participants [Interview Schedule]	Appendix F	05 December 2018

IRAS Application Form [IRAS_Form_25022019]		25 February 2019
Other [Employers Liability]	1	01 August 2018
Other [Professional Indemnity]		01 August 2018
Other [Peer Review]	Appendix H	11 January 2018
Other [Approval for research]	1	22 January 2018
Other [Demographic Info XXXXXX]	Appendix G	05 December 2018
Other [Demographic Info XXXXXX]	Appendix G	05 December 2018
Other [Debrief XXXXXX]	Appendix B	05 December 2018
Other [Debrief XXXXXX]	Appendix B	05 December 2018
Other [Proposal amendments following Peer Review]	1	21 February 2019
Participant consent form [Consent Form XXXXXX]	Appendix E	12 December 2018
Participant consent form [Consent Form XXXXXX]	Appendix E	12 December 2018
Participant information sheet (PIS) [Information Sheet XXXXXX]	Appendix A	30 January 2019
Participant information sheet (PIS) [Information Sheet XXXXXX]	Appendix A	30 January 2019
Research protocol or project proposal [Research Proposal]	1	26 December 2018
Summary CV for Chief Investigator (CI) [CV]	1	26 December 2018
Summary CV for student [AM CV]	1	26 December 2018
Summary CV for supervisor (student research) [Supervisor CV]	1	21 February 2019

#### Membership of the Proportionate Review Sub-Committee

The members of the Sub-Committee who took part in the review are listed on the attached sheet.

#### Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

#### After ethical review

##### Reporting requirements

The attached document "After ethical review - guidance for researchers" gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

Notifying substantial amendments

Adding new sites and investigators

Notification of serious breaches of the protocol

Progress and safety reports

Notifying the end of the study

The HRA website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

User Feedback

The Health Research Authority is continually striving to provide a high quality service to all applicants and sponsors. You are invited to give your view of the service you have received and the application procedure. If you wish to make your views known please use the feedback form available on the HRA website:

<http://www.hra.nhs.uk/about-the-hra/governance/quality-assurance/>

HRA Training

We are pleased to welcome researchers and R&D staff at our training days - see details at

<http://www.hra.nhs.uk/hra-training/>

With the Committee's best wishes for the success of this project.

19/WM/0088 Please quote this number on all correspondence

Yours sincerely

Dr Ronald Jubb Chair

Email: [NRESCommittee.WestMidlands-CoventryandWarwick@nhs.net](mailto:NRESCommittee.WestMidlands-CoventryandWarwick@nhs.net)

List of names and professions of members who took part in the review

Enclosures: 'After ethical review - guidance for researchers' [[SL-AR2](#)]

Ms Catherine Hitchens

XXXXXXX

Copy to: England: [HRA.Approval@nhs.net](mailto:HRA.Approval@nhs.net)

**West Midlands - Coventry & Warwickshire Research Ethics Committee Attendance at PRS**

**Sub-Committee of the REC meeting on 11 March 2019**

Committee Members:

Name	Profession	Present	Notes
Ms Yasumati Damodar	Pharmacist	Yes	
Dr Ronald Jubb (Chair)	Retired Consultant Rheumatologist	Yes	
Dr Rebecca Keyte	Lecturer in Psychology	Yes	

Also in attendance:

Name	Position (or reason for attending)
Mr Tad Jones	REC Manager



Miss Amanda Mount  
Trainee Clinical Psychologist  
Camden and Islington NHS Foundation Trust/ The  
University of East London  
School of Psychology  
University of East London  
Water Lane, London  
E15 4LZ

Email: [iraapproval@nhs.uk](mailto:iraapproval@nhs.uk)

29 March 2019

Dear Miss Mount

HRA and Health and Care  
Research Wales (HCRW)  
Approval Letter

Study title: The change process: clients' perspectives and understanding of change during psychological therapy  
IRAS project ID: 243364  
REC reference: 19/W/M/0088  
Sponsor: University of East London

I am pleased to confirm that [HRA and Health and Care Research Wales \(HCRW\) Approval](#) has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications received. You should not expect to receive anything further relating to this application.

Please now work with participating NHS organisations to confirm capacity and capability, in line with the instructions provided in the "Information to support study set up" section towards the end of this letter.

How should I work with participating NHS/HSC organisations in Northern Ireland and Scotland?  
HRA and HCRW Approval does not apply to NHS/HSC organisations within Northern Ireland and Scotland.

If you indicated in your IRAS form that you do have participating organisations in either of these devolved administrations, the final document set and the study wide governance report (including this letter) have been sent to the coordinating centre of each participating nation. The relevant national coordinating function/s will contact you as appropriate.

Please see [IRAS Help](#) for information on working with NHS/HSC organisations in Northern Ireland and Scotland.

How should I work with participating non-NHS organisations?

HRA and HCRW Approval does not apply to non-NHS organisations. You should work with your non-NHS organisations to [obtain local agreement](#) in accordance with their procedures.

What are my notification responsibilities during the study?

The document "*After Ethical Review – guidance for sponsors and investigators*", issued with your REC favourable opinion, gives detailed guidance on reporting expectations for studies, including:

- Registration of research
- Notifying amendments
- Notifying the end of the study

The [HRA website](#) also provides guidance on these topics, and is updated in the light of changes in reporting expectations or procedures.

Who should I contact for further information?

Please do not hesitate to contact me for assistance with this application. My contact details are below.

Your IRAS project ID is 243364. Please quote this on all correspondence.

Yours sincerely,

Juliana Araujo

Assessor

Email: [hra.approval@nhs.net](mailto:hra.approval@nhs.net)

## List of Documents

The final document set assessed and approved by HRA and HCRW Approval is listed below.

Document	Version	Date
Copies of advertisement materials for research participants [Interview Advert XXXXXX]	2	13 March 2019
Copies of advertisement materials for research participants [Interview Advert XXXXXXs]	2	13 March 2019
Copies of advertisement materials for research participants [Leaflet XXXXXX]	2	13 March 2019
Copies of advertisement materials for research participants [Leaflet XXXXXXs]	2	13 March 2019
Copies of advertisement materials for research participants [Interview Advert XXXXXXs]	Appendix C	05 December 2018
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [Insurance]	1	18 July 2018
HRA Schedule of Events [HRA Schedule of Events Validated]	1	27 December 2018
HRA Statement of Activities [HRA Statement of Activities Validated]	2.0	08 March 2019
	Appendix F	05 December 2018
Interview schedules or topic guides for participants [Interview Schedule]		25 February 2019
IRAS Application Form [IRAS_Form_25022019]		25 February 2019
Other [Employers Liability]	1	01 August 2018
Other [Professional Indemnity]		01 August 2018
Other [Peer Review]	Appendix H	11 January 2018
Other [Approval for research]	1	22 January 2018
Other [Demographic Info XXXXXX]	Appendix G	05 December 2018
Other [Demographic Info XXXXXX]	Appendix G	05 December 2018
Other [Debrief XXXXXX]	Appendix B	05 December 2018
Other [Debrief XXXXXX]	Appendix B	05 December 2018
Other [Proposal amendments following Peer Review]	1	21 February 2019
Participant consent form [XXXXXX]	2	13 March 2019
Participant consent form [XXXXXX]	2	13 March 2019
Participant information sheet (PIS) [PIS with GDPR approved wording (XXXXXX)]	2.0	29 March 2019
Participant information sheet (PIS) [PIS with GDPR approved wording (XXXXXX)]	2.0	29 March 2019
Research protocol or project proposal [Research Proposal]	1	26 December 2018
Summary CV for Chief Investigator (CI) [CV]	1	26 December 2018
Summary CV for student [AM CV]	1	26 December 2018
Summary CV for supervisor (student research) [Supervisor CV]	1	21 February 2019
243364 19WM0088 (PRS) Application valid 28.02.2019.pdf		28 February 2019
243364 19WM0088 (PRS) Docs received following FOWC 18.03.2019 (reissue).pdf		18 March 2019
243364 19WM0088 (PRS) FOWC 12.03.2019.pdf		12 March 2019

IRAS project ID	243364
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### Information to support study set up

The below provides all parties with information to support the arranging and confirming of capacity and capability with participating NHS organisations in England and Wales. This is intended to be an accurate reflection of the study at the time of issue of this letter.

Types of participating NHS organisation	Expectations related to confirmation of capacity and capability	Agreement to be used	Funding arrangements	Oversight expectations	HR Good Practice Resource Pack Expectations
This is a multi-site study undertaking the same research activities. There is therefore one site type.	Participating NHS organisations should formally confirm their capacity and capability to undertake the study.	A statement of activities has been submitted and the sponsor is not requesting and does not expect any other site agreement to be used.	No application for external funding will be made for the study.	As per the Statement of Activities provided a Principal Investigator will be in place at each participating NHS organisation.  No assistance to identify potential Principal Investigators is required from the participating NHS organisations	It is unlikely that letters of access or honorary research contracts will be applicable, except where external staff employed by another Trust (or University) are involved (and then it is likely that arrangements are already in place). Where arrangements are not already in place, external staff would be expected to obtain a Letter of Access based on standard DBS checks and occupational health clearance would be appropriate.

**Other Information to Aid Study Set-up**

*This details any other information that may be helpful to sponsors and participating NHS organisations in England and Wales in study set-up.*

The applicant has indicated that they do not intend to apply for inclusion on the NIHR CRN Portfolio.



4<sup>th</sup> April 2019

Dear Amanda,

<b>Project Title</b>	<b>The change process: clients' perspectives and understanding of change during psychological therapy</b>
<b>Researcher</b>	<b>Amanda Mount</b>
<b>Principal Investigator</b>	<b>Amanda Mount</b>

I am writing to confirm that the application for the aforementioned NHS research study reference 243364 19/WM/0088 has received Research, Research Degrees and Ethics Sub-Committee (RRDE) ethical approval and is sponsored by the University of East London.

The lapse date for ethical approval for this study is **4<sup>th</sup> April 2023**. If you require RRDE approval beyond this date you must submit satisfactory evidence from the NHS confirming that your study has current NHS R&D ethical approval and provide a reason as to why RRDE approval should be extended.

Please note as a condition of your sponsorship by the University of East London your research must be conducted in accordance with NHS regulations and any requirements specified as part of your NHS R&D ethical approval.

**Please ensure you retain this approval letter, as in the future you may be asked to provide proof of ethical approval.**

With the Committee's best wishes for the success of this project.

Yours sincerely,

Catherine Hitchens  
 Research Integrity and Ethics Manager  
 For and on behalf of  
 Research, Research Degrees and Ethics Sub-Committee (RRDE)  
 Email: [researchethics@uel.ac.uk](mailto:researchethics@uel.ac.uk)

## Letter of Access for NHS Researchers

Human Resources Department  
XXXXX

Ms. Amanda Mount Psychology  
Regional Trainee St. Paneras  
Hospital 4 St Pancras Way  
London NW1 OPE

Date: 05 June 2019

Dear Ms. Amanda Mount Letter

of access for research

As an existing NHS employee you do not require an additional honorary research contract with this NHS organisation. We are satisfied that the research activities that you will undertake in this NHS organisation are commensurate with the activities you undertake for your employer. Your employer is fully responsible for ensuring such checks as are necessary have been carried out. Your employer has confirmed in writing to this NHS organisation that the necessary pre-engagement check are in place in accordance with the role you plan to carry out in this organisation. This letter confirms your right of access to conduct research through XXXXXXXX for the purpose and on the terms and conditions set out below. This right of access commences on [13/5/19] and ends on [25/9/19] unless terminated earlier in accordance with the clauses below.

You have a right of access to conduct such research as confirmed in writing in the letter of permission for research from this NHS organisation. Please note that you cannot start the research until the Principal Investigator for the research project has received a letter from us giving permission to conduct the project.

You are considered to be a legal visitor to XXXX premises. You are not entitled to any form of payment or access to other benefits provided by this organisation to employees and this letter does not give rise to any other relationship between you and this NHS organisation, in particular that of an employee.

While undertaking research through XXXX, you will remain accountable to your employer [**Camden and Islington NHS Foundation Trust**] but you are required to follow the reasonable instructions of your nominated manager [XXXX] in this NHS organisation or those given on her/his behalf in relation to the terms of this right of access.

Where any third party claim is made, whether or not legal proceedings are issued, arising out of or in connection with your right of access, you are required to co-operate fully with any investigation by this NHS organisation in connection with any such claim and to give all such assistance as may reasonably be required regarding the conduct of any legal proceedings.

You must act in accordance with XXXX policies and procedures, which are available to you upon request, and the Research Governance Framework.

You are required to co-operate with XXXXX in discharging its duties under the Health and Safety at Work etc Act 1974 and other health and safety legislation and to take reasonable care for the health and safety of yourself and others while on XXXXX premises. Although you are not a contract holder, you must observe the same standards of care and propriety in dealing with patients, staff, visitors, equipment and premises as is expected of a contract holder and you must act appropriately, responsibly and professionally at all times.

If you have a physical or mental health condition or disability which may affect your research role and which might require special adjustments to your role, if you have not already done so, you must notify your employer and the XXXXX Research & Development Department (XXXXX), prior to commencing your research role at the Trust.

You are required to ensure that all information regarding patients or staff remains secure and *strictly confidential* at all times. You must ensure that you understand and comply with the requirements of the NHS Confidentiality Code of Practice (<http://www.dh.gov.uk/assetRoot/04/06/92/54/04069254.pdf>) and the Data Protection Act 1998. Furthermore you should be aware that under the Act, unauthorised disclosure of information is an offence and such disclosures may lead to prosecution.

XXXXX will not indemnify you against any liability incurred as a result of any breach of confidentiality or breach of the Data Protection Act 1998. Any breach of the Data Protection Act 1998 may result in legal action against you and/or your substantive employer.

You should ensure that, where you are issued with an identity or security card, a bleep number, email or library account, keys or protective clothing, these are returned upon termination of this arrangement. Please also ensure that while on the premises you wear your ID badge at all times, or are able to prove your identity if challenged. Please note that this NHS organisation accepts no responsibility for damage to or loss of personal property.

We may terminate your right to attend at any time either by giving seven days' written notice to you or immediately without any notice if you are in breach of any of the terms or conditions described in this letter or if you commit any act that we reasonably consider to amount to serious misconduct or to be disruptive and/or prejudicial to the interests and/or business of this NHS organisation or if you are convicted of any criminal offence. You must not undertake regulated activity if you are barred from such work. If you are barred from working with adults or children this letter of access is immediately terminated. Your employer will immediately withdraw you from undertaking this or any other regulated activity and you MUST stop undertaking any regulated activity immediately. Your substantive employer is responsible for your conduct during this research project and may in the circumstances described above instigate disciplinary action against you.

If your circumstances change in relation to your health, criminal record, professional registration or suitability to work with adults or children, or any other aspect that may impact on your suitability to conduct research, or your role in research changes, you must inform the NHS organisation that employs you through its normal procedures. You must also inform your nominated manager in this NHS organisation.

Yours sincerely

XXXX Human Resources Department

cc: R&D office at XXXXX  
HR Department of substantive employer

## APPENDIX H: Participant Information Sheet

### Change in Therapy: Clients Perspective

#### Information Sheet

**Researcher:** Amanda Mount (Trainee Clinical Psychologist)

**Email:** [U1622889@uel.ac.uk](mailto:U1622889@uel.ac.uk) **Telephone:** (to leave a message). **Address:** [Department of Clinical Psychology, University of East London, Water Lane, London E15 4NZ](#). **Thesis supervisor:** Dr Trishna Patel (email: [t.patel@uel.ac.uk](mailto:t.patel@uel.ac.uk))

I would like to invite you to take part in a research study. My name is Amanda and I am a Doctoral student in Clinical Psychology at the University of East London. Before you decide to participate, it is important that you understand why the research is being done and what it would involve. **Please read through the following information carefully before deciding whether you would like to take part in the research.** You can talk to others about the study if you wish. Please do not hesitate to contact me via email or phone if you have any questions.

#### **What is the purpose of the study?**

I will be interviewing individuals who have completed Cognitive Behavioural Therapy (CBT) with the XXXXXX I would like to hear about your understanding of how you experienced psychological change during therapy. There is very little information available on clients' understanding of how things change in therapy. Your perspective is vital in terms of informing how and what type of therapy is offered and delivered in services. Your contribution will help professionals think about how psychological interventions such as CBT help people achieve meaningful change and how therapists can facilitate this.

#### **Will taking part impact on my access to services?**

XXXXX will not be involved in data collection or analysis of this study. They will receive an anonymised copy of the completed research and will use this information to think about improving how therapy success is evaluated by the service. I am not a staff member or volunteer in the service.

Taking part in this research will not impact on the services you receive or the involvement you continue to have with the service.

**What will you be asked to do if you agree to take part?**

It is entirely up to you whether you participate or not. If you would like to participate, I will invite you to attend an interview lasting about an hour, where I will ask you questions about your experiences of therapy. You can take breaks during the interview and can choose at any time during the interview to stop and/or withdraw your consent to participate. You do not need to provide a reason for doing so and this will not impact on the care you continue to receive from the service.

**Where will the interview take place?**

I can arrange to meet you at The University of East London Stratford Campus, or at XXXXXX at a time that is convenient for you. If you would like to meet at XXXXX, please be aware that staff may see you and therefore know that we are meeting. However, I would not talk to them about the information you have shared with me in your interview.

If you would prefer, I can arrange to do the interview over the telephone or via Skype.

**Compensation:**

Participants who complete the interview will be offered a £10 Love2Shop voucher for their time. Public transport costs to and from the interview will also be reimbursed .

**Will the information I provide be confidential?**

Your privacy and safety will be respected at all times. All the information discussed in the interview will be kept confidential, unless I am concerned that you, or someone else, is at risk of harm. In this case I would need to speak to someone else as it is my duty of care to keep you, and others, safe from harm. If I felt this was necessary, I would always try to discuss this with you first.

All interviews will be audio-recorded. The researcher will write-up the audio recordings and anonymise identifiable information. All data will be stored on password protected devices only accessible to the research team. The written information will be anonymous, and for the purpose of the study the information you have provided will be under a false name. Short extracts of the

interviews may be used in the research study report. The researcher's supervisor and examiners may read anonymised full transcripts.

When the research study is complete it will be used as part of a doctoral research submission. This means that it will be accessible to the public and that you can read it too if you would like. It will be available on UEL's online library. Hopefully this research will also be published in Psychology journals so that more people can gain from the findings.

Names, contact details, and anonymised reports of the interviews will be held electronically on a password protected device for three years after the study completion date (estimated 2022).

### **Can I change my mind?**

Yes! You can change your mind without giving a reason at any point until the interviews have been analysed. Analysis will begin two weeks after our interviews. If you would like to withdraw your information completely from the research, please contact me before this. If you would like to withdraw your data from the study after this date, I may still use your fully anonymised data in the final analysis; however, you can request that no extracts are used from your interview.

### **Are there disadvantages to taking part?**

Taking part in these interviews may remind you of experiences that you found difficult. You have the right not to answer questions that you do not wish to and will have the opportunity to discuss any difficult feelings that emerge at the end of the interview. You will also be provided with a list of supporting agencies should you feel that you would like to talk to someone after the interview is completed.

### **Who has reviewed the study?**

All research in the NHS is looked at by an independent group of people called a Research Ethics Committee to protect your safety, rights, well-being and dignity. This study has been reviewed and given favourable opinion by [to be inserted post REC decision]

### **Complaints procedure:**

If you have concerns about any aspect of this study, you can contact the researchers on the numbers provided and we will do our best to answer your questions. If you remain unhappy and wish to complain formally, you can do this through the NHS Complaints Procedure. Details can be obtained at XXXX

### **Is my data affected by the General Data Protection Regulation (GDPR)?**

All your data will be handled to follow GDPR guidelines and maintain your privacy. The University of East London is the sponsor of this study. The University of East London and their staff will not have access to any of your personal information.

XXXXXX will use your name and contact details to tell you about the research study XXXXX will not breach NHS Confidentiality when identifying patients for research.

Amanda Mount is working with XXXXXX to organise the research. She will not have access to your medical records. To protect your rights Amanda Mount will not use any identifiable information in the final written work or on anything the University of East London may see. Amanda Mount will act as the data processor for this study, this means that she is responsible for looking after your information. She will not keep any identifying information after the research is completed (estimated December 2019).

Your rights to access, change or move your information are limited, as we need to manage your information in specific ways in order for the research to be reliable and accurate. If you withdraw from the study, we will keep the information about you that we have already obtained. To safeguard your rights, we will use the minimum personally-identifiable information possible. Regulatory organisations may look at your research data to check the accuracy of the research study. You can find out more about how we use your information by contacting [researchethics@uel.ac.uk](mailto:researchethics@uel.ac.uk).

### **Who can I contact following the study if I have any questions?**

If you would like further information about this study, please do not hesitate to contact me or my supervisor Dr Trishna Patel.

**Thank you for taking the time to read this information,** please keep this page for your reference.

IRAS ID: 243364

## APPENDIX I: Consent Form

### Change in Therapy: Clients Perspective

#### Consent form

**Researcher:** Amanda Mount (Trainee Clinical Psychologist)

**Email:** [U1622889@uel.ac.uk](mailto:U1622889@uel.ac.uk) **Telephone:** (to leave a message). **Address:** [Department of Clinical Psychology, University of East London, Water Lane, London E15 4NZ.](#)

**Thesis supervisor:** Dr Trishna Patel (email: [t.patel@uel.ac.uk](mailto:t.patel@uel.ac.uk))

If you agree to participate, please initial all the boxes below indicating your understanding of what is involved in the study and your consent to participate.

I confirm that I have read and understood the information sheet for this study and have saved a copy for my reference.

I have been given the opportunity to ask questions, to which I have received satisfactory answers.

I give my consent to the interview being audio-recorded.

I understand that I can ask to receive a copy of the transcript of the interview.

I understand that my participation in the interview is voluntary and that I am free to withdraw at any time without giving any reason and without my medical care or legal rights being affected.

I give permission for anonymous quotations to be used, as appropriate, in written and verbal reports of the study.

I understand that the information I share will be confidential between the researcher and her supervisor.

If I withdraw from the study, I agree that the information already collected about me during the interview can be retained and used. I also understand that should I withdraw, the researcher reserves the right to use my anonymous data.

I understand that all information about the study will be destroyed after 3 years.

Participant's Name (BLOCK CAPITALS)	Participant's Signature
Researcher's Name (BLOCK CAPITALS)	Researcher's Signature

**I hereby fully and freely agree to take part in the research, which has been fully explained to me.**

Please indicate your consent by signing below:

Date:

## APPENDIX J: Debrief Information

### Change in Therapy: Clients Perspective

#### Debrief Information

**Researcher:** Amanda Mount (Trainee Clinical Psychologist)

**Email:** [U1622889@uel.ac.uk](mailto:U1622889@uel.ac.uk) **Telephone:** (to leave a message). **Address:** [Department of Clinical Psychology, University of East London, Water Lane, London E15 4NZ.](#)

**Thesis supervisor:** Dr Trishna Patel (email: [t.patel@uel.ac.uk](mailto:t.patel@uel.ac.uk))

The aim of this research study is to understand clients understanding of how things change in therapy. Everybody comes to therapy for different reasons; often people are looking for some kind of change. Researchers believe therapy helps people go through similar processes to achieve change. There's plenty of research which tells us what therapists/researchers think about it; however, very little is known about client's views. This study is important as it asks the people it effects most, clients.

This research is important in understanding what clients think because this helps therapists and researchers to develop more effective and meaningful therapies. It can also help services to think about how psychological interventions such as CBT help people achieve meaningful change and how therapists can facilitate this.

If you have any **questions** relating to this study, please contact us using the contact information above.

If you have felt any discomfort or distress related to this research you can contact a number of services. For example:

- Your General Practitioner (GP)
- If you are still being cared for by XXXXX, you can contact the team.
- The Samaritans: Call 116 123

The findings of this study will be available online via ROAR. If you are interested in journal articles published from this research, please contact me and I will keep you updated. **I would like to thank you again for your time and contribution to this research.**

Amanda Mount

# APPENDIX K: Consultation Presentation

**How does therapy work for you?**

Amanda Mount- Clinical Doctorate Research Project  
2019

Amanda Mount [U1622889@uel.ac.uk](mailto:U1622889@uel.ac.uk)

1

**Your input at every level**

2

- ▶ **The Research**
  - ▶ What you think is important/not about it
  - ▶ Language
- ▶ **Research Interview Questions**
  - ▶ What do you want to know?
- ▶ **Participation poster**
  - ▶ What would make you read it?
- ▶ **Information Sheet**
  - ▶ Does it make sense?
- ▶ **Consent Form**
  - ▶ Any questions / what else is important?
- ▶ **Debrief Form**
  - ▶ Anything to add?
  - ▶ Anything else?

**The Research**  
**Change in Therapy: Client's Perspective**

- ▶ Psychological therapy revolves around ideas of making change, and thinking about how change works.
- ▶ **Change process research** is the study of the process of how change occurs (Elliott, 2010).
- ▶ We are interested in asking clients not 'what' changed in therapy, but the '**how**' did it change.
- ▶ Research has been informed by quantitative approaches (Binder, Holgersen, & Neilsen, 2010), yet there is limited understanding of how this change occurs (Wein & Elliott, 2006). It is important to acknowledge that clients' views are yet to catch up with the breadth of research from the researcher's and therapist's perspective (Clivea, Braun, Gomez Penedo, & Rousos, 2013).

**What is Change?**

It is common for people to talk about change in research before they define what change actually is (Carey et al., 2007).

- ▶ When I say change in therapy- what comes to mind?
- ▶ How would you describe it? What words would you use?

5

**What is Change?**

It is common for people to talk about change in research before they define what change actually is (Carey et al., 2007).

- ▶ Carey, et al. (2007) unsuccessfully asked client's to define change, so it is clear further research is needed in this area.
- ▶ It is difficult to know whether research is talking about a shared understanding of the term. The term 'psychological change', primarily a professional term, is laden with meaning. We would like to find out more about what it means to clients.

6

**Cognitive Behavioural Therapy (CBT)**

- ▶ **Talking therapy**
- ▶ Targets a problem by looking at the way you think and what you do
- ▶ Collaborative approach considered integral to the effectiveness of CBT (Hibide, Byrne, & Fries, 2013).
- ▶ However, little attention is generally given to client's viewpoint of what happens in therapy (Hodgetts & Wight, 2007). This is worrying given that, clients' views are crucial, and that research shows that clients' expectations of therapy shape the experiences of process and outcome, a likely mechanism underlying good outcomes (Marin, Armin, Barnes, & Angus, 2010).
- ▶ This is concerning given that widely used models such as Cognitive Behavioural Therapy (CBT) although shown to be effective, having a significant number of clients do not respond to treatment, and there is a common rate of relapse (Wiles, et al., 2013)

7

**Research Questions**

Aim: to gain the service user's perspective/understanding of how things change in the app.

- ▶ What do you want to know?

8





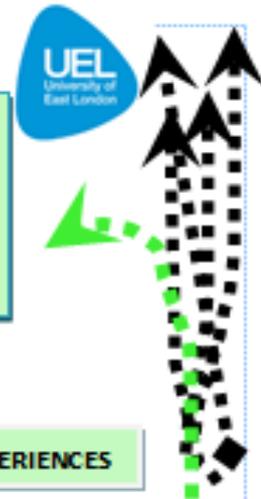
## APPENDIX L: Poster

Participation advert- Version 2.

13/3/19 IRAS ID: 243364

Change in therapy: clients' perspectives

# HOW DOES THERAPY WORK FOR YOU?



Have you had Cognitive Behavioural Therapy (CBT)?

I would like to find out more about how you understand change in therapy.



**I'M INTERESTED TO HEAR YOUR EXPERIENCES**

- Psychological therapy revolves around ideas of making change.
- There's plenty of research which tells us what therapists think about it, but I'm interested in clients views as these are the people that it affects the most.
- I would like to find out more about how you understand/make sense of change in therapy.

It will be an opportunity to share your thoughts and we hope will contribute to more meaningful and effective therapy interventions.



I'm Amanda, a trainee Clinical Psychologist studying in the University of East London (UEL), and have also experienced therapy myself. I am passionate about hearing what you have to say.

### **£££:**

Everyone who attends will be offered a £10 Love2Shop Voucher for their time, and public transport cost compensation \*

\*receipts needed

### **HOW:**

1 hr conversation with me

### **WHERE:**

At your preference xxx Services OR UEL Water Lane, Stratford.

**Please contact me for further information if you are interested. Thank you**

## APPENDIX M: Leaflet

Leaflet– Version 2. 13/3/19. IRAS ID: 243364

Change in therapy: clients' perspectives



### HOW DOES THERAPY WORK FOR YOU?

Have you had Cognitive Behavioural Therapy (CBT)?

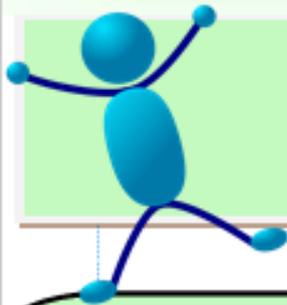
I would like to find out more about how you understand change in therapy.



### I'M INTERESTED TO HEAR YOUR EXPERIENCES

- ♦ Psychological therapy revolves around ideas of making change.
- ♦ There's plenty of research which tells us what therapists think about it, but I'm interested in clients views as these are the people that it affects the most.
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#### HOW:

1 hr conversation with me

#### WHERE:

At your preference ~~xxxx~~ Services  
OR UEL Water Lane, Stratford.

Please contact me for further information if you are interested. Thank you

**Amanda Mount. Email: [U1622889@uel.ac.uk](mailto:U1622889@uel.ac.uk). Telephone:**

## APPENDIX N: Demographic Information Form

### Change in Therapy: Clients Perspective

#### Demographic Information

**Researcher:** Amanda Mount (Trainee Clinical Psychologist)

**Email:** [U1622889@uel.ac.uk](mailto:U1622889@uel.ac.uk) **Telephone:** \_\_\_\_\_ (to leave a message). **Address:** [Department of Clinical Psychology, University of East London, Water Lane, London E15 4NZ.](#)

**Thesis supervisor:** Dr Trishna Patel (email: [t.patel@uel.ac.uk](mailto:t.patel@uel.ac.uk))

To begin, I would like to ask you some questions about yourself. The information you provide will remain confidential.

Age: \_\_\_\_\_

Gender: \_\_\_\_\_

How would you describe your ethnic origin? \_\_\_\_\_

Have you ever received a mental health diagnosis/ diagnoses (e.g., depression)?

Yes  No

Have you ever experienced or do you currently experience psychological difficulties but have not received a diagnosis? Yes  No

If you answered yes to either question:

What diagnosis have you received or how would you describe your psychological difficulties? \_\_\_\_\_

\_\_\_\_\_

Do you take any medication for the psychological difficulties you experience? Yes  No   
If you answered 'yes', what medication are you currently taking?

\_\_\_\_\_

How many sessions of psychological therapy have you received? \_\_\_\_\_  
What type of therapy did you receive? \_\_\_\_\_

When does/ did your current therapy end? \_\_\_\_\_

How many sessions have you attended to date? \_\_\_\_\_

Have you received psychological therapy in the past?

Yes  No

If yes, how many times have you sought therapeutic help (e.g., twice)? \_\_\_\_\_

## **APPENDIX O: Interview Schedule**

### **Interview Questions**

#### **Preamble:**

- Who am I
- Put person at ease
- Review and receive consent
- Check when psychological therapy ended.

Broad **Interview questions** following consultation with service user group:

1. Did you experience any change in therapy?
2. What brought you to therapy?
3. What is change to you?
4. How did you know this was change?
5. What has changed since starting therapy?
6. Is it what you had expected?
7. What is your understanding of how change occurs?
8. What facilitates/hinders your engagement in change?
9. How difficult was therapy?
10. Has there been any change outside of therapy?

#### **Prompts**

What helped/didn't help that? What is/was that like? What effects does that have? How did you come to that conclusion? Negative and positive change? Could you say more about that? What would count as change? Did you experience any change? how do you experience it? What were your expectations about change in therapy? Was therapy challenging? Were you expecting it to be challenging?

#### **Closing**

- Check in to make sure interviewee feels okay following interview
- Check consent again
- Link to support
- Debrief sheet

## APPENDIX P: Transcription Key

(.)	Pause
(2)	Two second pause
[inaudible]	Inaudible section of transcript
<u>emphasis</u>	Word spoken with more emphasis than others
[laughter]	Laughter during the interview

Where an interruption by another speaker is brief it is placed in parentheses <>

Other interruptions and overlapping talk are marked with /

[cough]	Cough during Interview
[xx-]	To indicate unfinished word
[Text]	Contextual information is included if a part of the extract is ambiguous

Words in brackets () replace potentially identifiable information Extracts are punctuated to facilitate reading Pseudonyms are used in place of all names

Adapted from Bannister et al. (2011).

## APPENDIX Q: Initial Codes Generated and Transcript Example

Name	
acceptance	hope for change
awareness	how therapy helped
being believed or understood	ignoring symptoms to move on
can't see it yourself	inner strength
change is unknown	instability of change
change leads to more change	internal change
change takes time	lasting change
choice	learning to cope
comparison to old self	making the most of the change
comparison to others	mix process of change
confidence to change	monitoring it
control	negative change
description of change	negative thoughts
desperation	no control, passive
different beliefs to therapist	not magic
different therapies	noticeable change
disappointment	opportunity- therapy is limited
doing something different, stopping the cycle	options in therapy help
distraction	other change
effort	other therapy working or not
escape, hopelessness	others negativity and stigma
expectations	patience
experience of change	perspective
external changes	preparation
faith things can change	process of change
fear	pushing self, motivation
fear so came to therapy	realisation
feeling safe	reprogram
feelings barrier to change	seeking help
getting rid of symptoms- reason for coming	service user perspective
goals change	small things lead to change
Golden- measuring change	some change but not complete
	specific techniques

## Transcript Example

Interviewer: so you notice that, so it sounds like you're saying the you therapy led to changes that gave you kind of it gave you coping <yeh> things to cope <Yeh and it has given me hope> and it's given new hope <yeh> and it sounds like it's also um giving you, you want to more do things <yeh> and go out more.

Ppt 1: um it has bought a positive per-person in me. Before I was very negative, everything I was hearing was negative negative negative <mmh> I still hear them they never stop but I've chosen to be positive <okay> it's it never it will never stop me that's what I've decided. My nightmares will not stop me from doing things <yeh> yeah and when you look at other people they they everyone has a struggle their own <mmh> it's just that we don't know it's just the when you see someone you don't know. You have your own struggle <mmh hmm> could be collecting this information can be a struggle for you <mmh hmm> or something or just.

Interviewer: Ok so you you've noticed that everybody has a struggle <yeh> and that for you that's not gunnno stop you <yeh> okay <yeh>. And what what is changed to you so I've been asking about change and saying the word change what does that mean to you?

Ppt 1: change <yeh>. Change. Seeing things differently <mmh> thinking differently starts from all in the mind. change can be anything really. Can be how you see life how you view things <mmh>

Interviewer: okay and if you are going to explain it to someone who is just starting therapy haven't had any therapy or would you say?

Ppt 1: to them <about change> you will see change you will you will experience new things in your life it's just how you decide to take them, it can be a positive change or a negative change. There are people who start therapy and finish the 20 sessions and they remain the same or even become worse <mmh>. It the therapist cannot change you you just has to a ccess some things and take whatever they tell you and put them to practice. Or now what they give you every day cannot change you if you don't accept the change in yourself <mmh> it's not gonna do like this and everything will disappear <mmh> you have to put some things into practice. So it depends on what the person is really expecting when they come for therapy

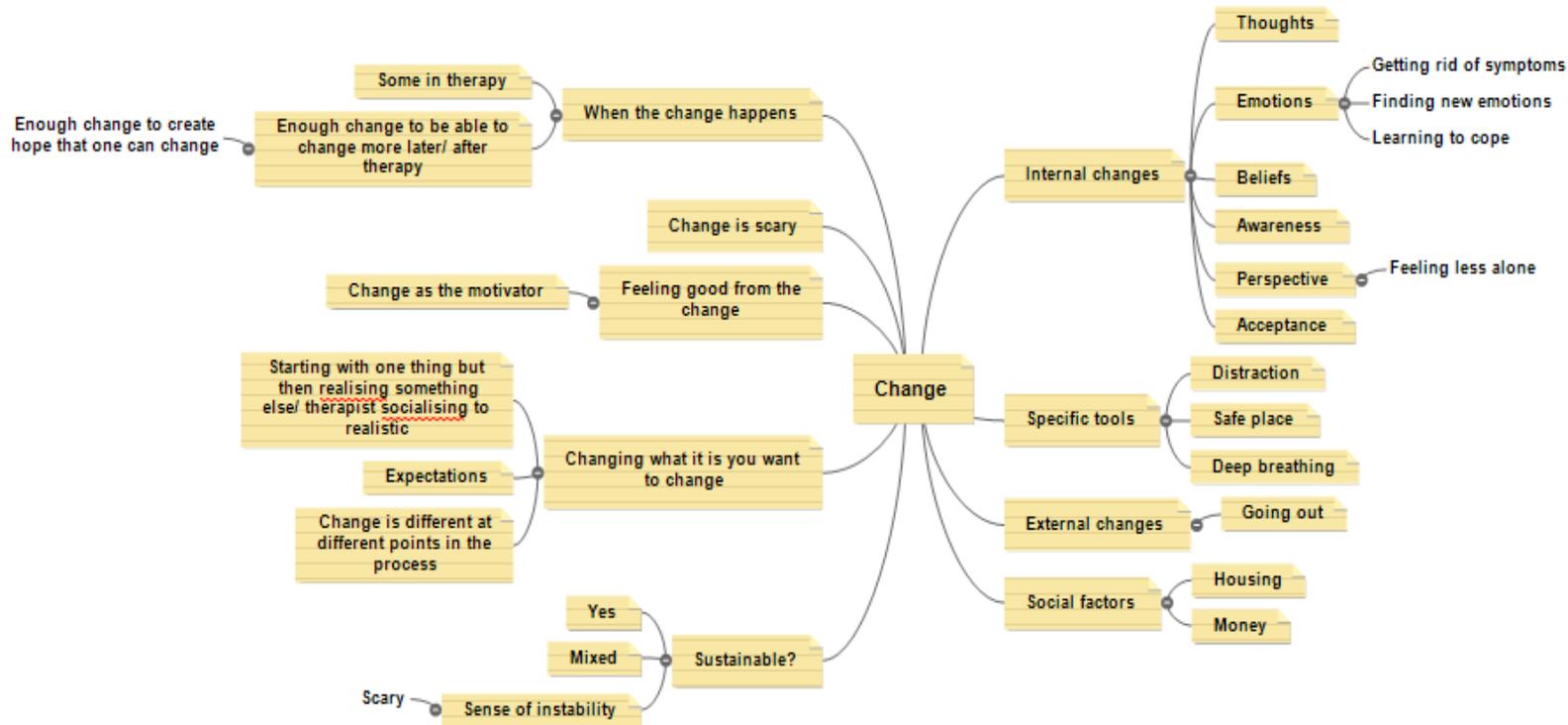
Interviewer: so it's about practice and acceptance <yeh, yeh>. Do you have an ideas of what helped someone accepts?

Ppt 1: um for someone who is nightmares you have to accept that it's not going to go overnight <mmh hmm> if it's something that you're struggling with that you had for a long time you have to accept that it's not going to change overnight, you have to put in some effort for it to change, for it to even budge a little bit <mmh>, you

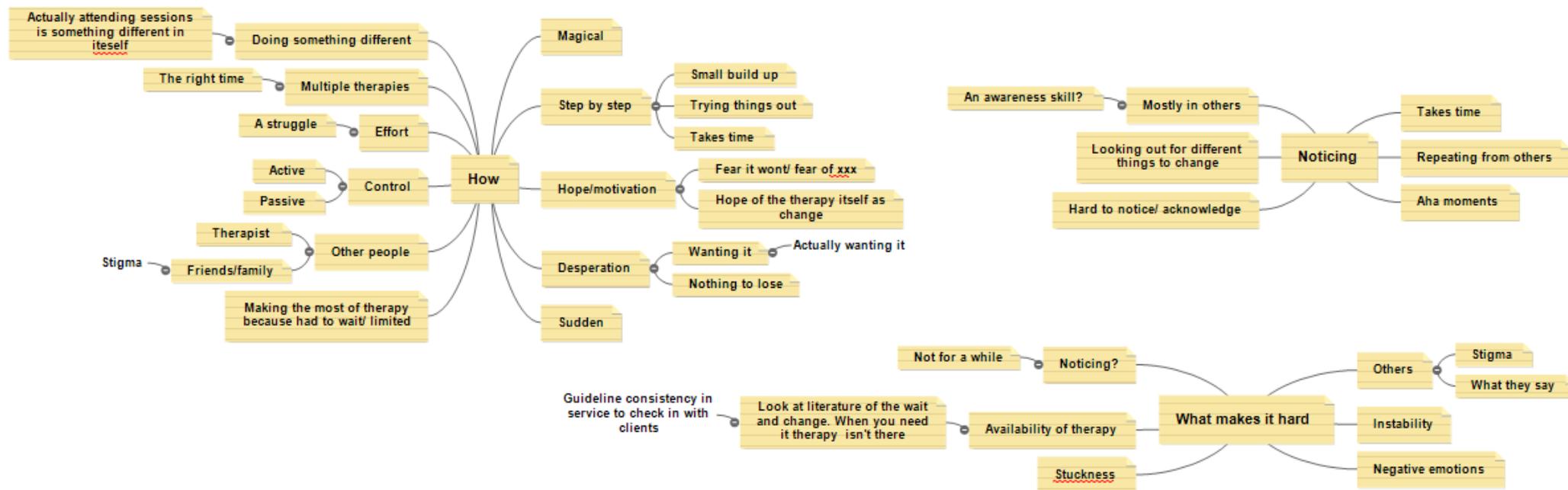


## APPENDIX R: Theme Development

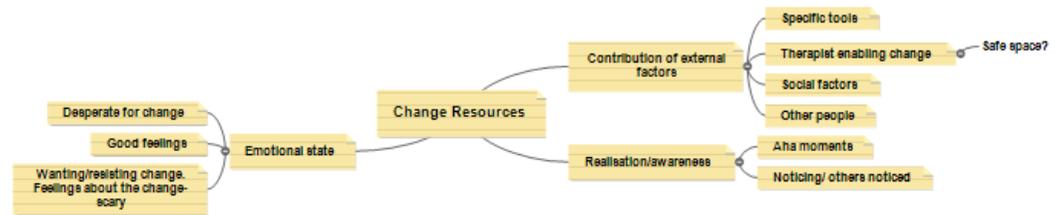
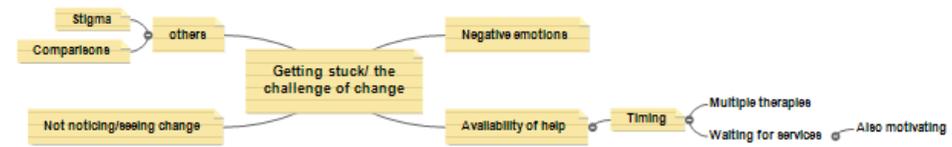
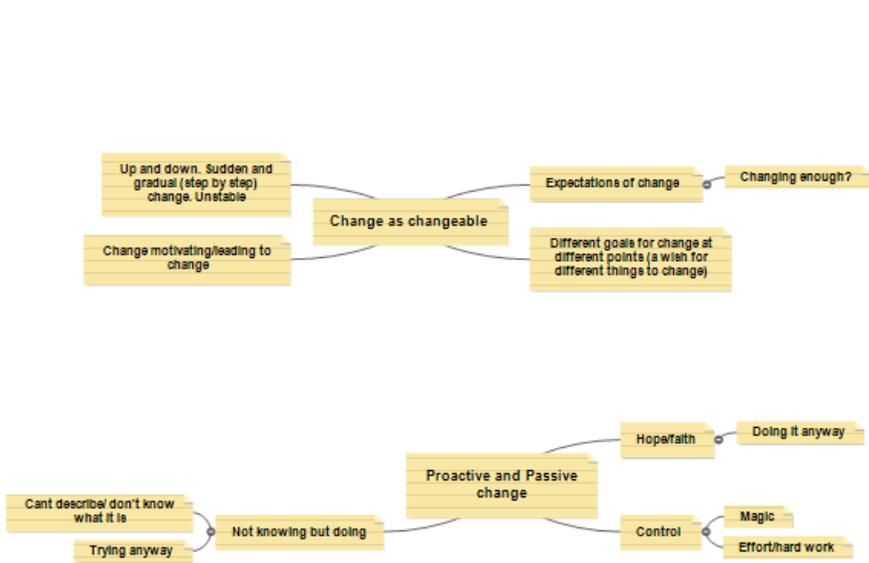
### Initial Stages of Themes:



## Development of Themes:



## Further Development of Themes:



## Final Thematic Map:

