A PORTFOLIO OF ACADEMIC, THERAPEUTIC PRACTICE, AND RESEARCH WORK

Including an investigation of

Opening up Pandora’s box:
Unintended harm in the consultation room

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To thine own self be true.

(Shakespeare, *Hamlet*, 1.3.78-8)¹

For Mum.
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To preserve the anonymity and confidentiality of clients, research participants, supervisors and placements, all names and identifying details have either been omitted or replaced with pseudonyms throughout the portfolio.
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RESEARCH DEVELOPMENT

Research abstract

This Research Development section presents a literature review and two qualitative research papers that explore the under-researched and under-reported topic of iatrogenesis (unintended harm). There seems no clear theory within Counselling Psychology which encompasses the notion of iatrogenesis. Therefore, this research draws upon relevant theories from other domains. The research in this thesis is underpinned by Merton’s (1936, 1968, 1972, 2016) sociological theory of unintended consequences, which supports a detailed exploration of what happens when two people meet in the social context of the consultation room.

Each of the three studies which form this research will explore a different aspect of iatrogenesis. This is intended to support an exploration of unintended harm from various epistemological and methodological positions, and different analytical perspectives. For a conceptual consistency across the research, harm is defined as, “a negative effect [that] must be relatively lasting, which excludes from consideration transient effects ... [such as in-session anxiety or between session sadness, and] must be directly attributable to, or a function of, the character or quality of the therapeutic experience or intervention” (Strupp, Hadley, & Gomes-Schwartz, 1977, pp. 91-92).

The theoretical grounding of the Literature Review is Merton’s (1936) theory of the Unanticipated consequences of purposive social action, which I have used to explore the dilemmas involved when the unintended consequences of actions expected to engender helpful change, can result in an unexpected or unexpected outcome. The research begins with a review of the literature that reports the prevalence of iatrogenesis as 10% of the public attending therapy. Therapists in the role of client report the greatest level of harmful experiences, at up to 40%. In the review, the process of iatrogenesis is explored from the perspectives of quantitative, qualitative and mixed methods research. Each method reveals
the strengths and weaknesses of the research approach when exploring the complex topic of iatrogenesis. The Literature Review concludes by suggesting there is a gap in the literature and indicates the relevance of qualitative studies as a means towards filling it.

The second study will present an Interpretative Phenomenological Analysis (IPA: Smith, Flowers, & Larkin, 2009), of the experiences of psychotherapists in the role of client. Merton’s (1972) distinction between ‘insiders-outsiders’ is applied, which in this study translates as ‘insider’ (client) and ‘outsider’ (therapist) roles, or positions. These positions help explicate potential mechanisms of change that are deemed to engender harmful experiences in psychotherapy sessions. A phenomenological approach was applied by interviewing counselling psychologists about their ‘insider’ experiences in their personal psychotherapy sessions.

As their philosophical training is rooted in phenomenological, reflexive and humanistic training, counselling psychologists were assumed to be able to speak from the dual focus of being an informed client, as well as being an informed practitioner. Therefore, counselling psychologists were considered the most suitable group who would be best placed to help me explore the research question. Semi-structured interviews were conducted with four participants, all qualified psychotherapists. The data was analysed using IPA’s methodology. The findings yielded three master themes: Competing world views: clashing epistemologies; How and by whom is therapy constructed?; and Making sense of an experience.

The third study builds upon the Literature Review and broadens the findings of the IPA, by applying a qualitative method of Thematic Analysis (Braun & Clarke, 2006). The Thematic Analysis utilises Merton’s (2016) distinction of the ‘manifest’ and ‘latent’ functions of purposive social actions. The notion of ‘manifest’ and ‘latent’ functions serves to explicate the experience of iatrogenesis from the perspective of psychotherapists delivering psychotherapy, who perceived their delivery of psychotherapy to have
engendered unintended harm. The notion of functions serves also to explicate potential latent processes that can be obscured, and also the more subtle influences within and beyond the therapeutic space that impact upon what happens within the consultation room.

The Thematic Analysis is framed by the increasing number of clients who are complaining to professional registration bodies regarding perceived harmful experiences during their psychotherapy. One response has been to introduce new codes of ethics. Applying Thematic Analysis, I conducted interviews with 20 practitioners from various modalities about their experiences of providing psychotherapy sessions. They reported their day-to-day experiences of ‘do no harm’. The Thematic Analysis indicated three themes; ‘Preparation for practice’; ‘Boundaries’; and ‘Issues of safety’. An overarching fourth theme was Professionalism. Transcending all the comments was the notion of tensions, which questioned: ‘Is therapy an art or a science’? Implications are drawn for training, supervision, practice and the future. Across the three studies, I practice and research from a stance which is critical realist, which is to say we each edit the reality we perceive to accord it with our beliefs. My research position is that of a reflective scientist-practitioner, and I identity strongly with counselling psychology’s philosophy and ethical value-base. The research stance is critical-realist.

Introduction to my Research Development

This research presents a literature review and two pieces of empirical research; both are qualitative, and apply a different method or methodology. The first empirical study provides an in-depth ideographic exploration of the topic of iatrogenesis. The second empirical study broadens the findings of the previous study by identifying patterns across a group of therapy practitioners. Each research piece was written to comply with the guidance provided for manuscript submissions from a journal relevant to counselling psychology. The choice of publications was guided by my intention to report on and inform the debate, within the UK and internationally. Within the UK there seems to be a
growing interest in the topic, evidenced by invitations to present and apply this research. This is creating international links, and is producing some offers to engage in collaborative research. Most recently, I have received invitations to apply the research at public healthcare policy level.

The research opens with a critical literature review exploring iatrogenesis. The review begins and ends with a consideration of whether iatrogenesis is a taboo topic in the field of counselling and psychology. The first empirical research paper is an Interpretative Phenomenological Analysis (IPA: Smith, 2015). Following a gap highlighted by the literature review, IPA was applied for an incisive personalised exploration of the lived experience of unintended harm. Some of the findings surprised me, and I had to review my own beliefs around the topic.

The surprises helped guide the design of a second empirical research paper to consider the topic from a different angle. I acknowledge that I have influenced the research, and been influenced by the research. To avoid repetition, this is addressed in the studies. Also in the studies, I critique issues of ontology, epistemology and my research designs. Plus, I make suggestions to address my critiques. Therefore, I will not repeat these here. Issues of philosophical underpinnings are also discussed within the context of the research.

I acknowledge that as a reflexive researcher I am ‘centring’ myself in the research (Etherington, 2007). In terms of axiology, this means I bring my own beliefs, morals, biases and worldview to the research. I also bring a relational stance that underpins my counselling psychology identity, and so I bring this way of viewing the world to the research. My epistemological stance and personality have influenced each research choice point, or my blind spots. I own my critical realist stance; “we create the world we perceive, not because there is no reality outside of our heads … [such as the superiority of one research approach, one therapeutic modality or that all are equal], but because we select
and edit the reality we see to conform to our beliefs” (Engel, 1987, p. vi). In terms of the topic explored within this portfolio about the complex issues surrounding unintended harm, I identify with counselling psychology’s competence to strive to do no harm (British Psychological Society, 2015). My intention has been to advocate for more awareness of the topic within the field of psychotherapy, not as a criticism but as a further step towards what constitutes good practice for both clients and practitioners alike.

Counselling Psychology

As philosophically trained reflective scientist-practitioners, counselling psychologists are adept at working with competing research approaches. We are trained to work with difficult issues, and the unknown. Our founding figures established a Division based upon the ethos of openness, curiosity and a philosophical base that places equal value upon different and sometimes competing narratives. I place a high value on being socially proactive, which is integral to my identity as a counselling psychologist. So, to that end, I hope this research will extend what we already do well.

References


Is Unintended Harm the Last Taboo of Counselling Psychology?

A Literature Review of Iatrogenesis

The topic of unintended harm within the consultation room, also known as iatrogenesis, is a widely-documented phenomenon in the field of medical practice and medical research (Illich, 1995; Makary & Daniel, 2016). Within the field of counselling, psychotherapy and psychology there has been a relative paucity of research into iatrogenesis when compared to the benefits of psychotherapy (Crawford et al., 2016; Lambert, 2013a; Lilienfeld, 2007). One way to understand what works in psychotherapy is to explore the reports of clients and practitioners who perceived their psychotherapy to not be beneficial (Barlow, 2010; Bystedt, Rozental, Anderson, Boettcher, & Carlbring, 2014; Cox, 2014; Flor, 2016). Therefore, increased understanding of iatrogenesis in psychotherapy research and practice could offer clinicians a way to improve how psychotherapy is practised.

Theoretical Grounding

There seems no clear theory within Counselling Psychology which encompasses the notion of iatrogenesis. Therefore, this thesis draws upon relevant theories from other domains. Within medicine, there is a body of literature on the theory of medicalisation (Illich, 1995). The notion of medicalisation discusses the side effects of medicine, and the notion of how well-intended physicians can cause unintended harm through inappropriate medical interventions. Szasz (1960) critiqued the role of psychiatry in relation to the unintended drawbacks of purposive actions within mental health care, which can similarly cause harm to patients. Less has been said about other mental health professions such as psychotherapy engendering unintended harm, or its consequences for patients or clients.

Within the social sciences, there is a broader literature, which looks at the theory of unintended consequences. The theory of unintended consequences originated in the work
of the philosopher John Locke (1632-1704), and was developed by the sociologist Robert Merton (1910-2003) in the 20th century. Merton’s (1936) paper, the Unanticipated Consequences of purposive social action, applied a systematic analysis to the problem of unintended consequences of purposive actions when intended to engender social change. Merton’s (1936, 1968, 1972, 2016) sociological theory of unintended consequences underpins this thesis’ exploration of what happens when two people meet in the social context of the consultation room.

Merton’s (1936) theory groups unintended consequences into three types: an unexpected benefit such as a positive therapeutic outcome; an unexpected drawback, defined as an unexpected detriment sometimes occurring in addition to the desired effect of an action; and a perverse result or effect that is contrary to what was originally intended. This thesis draws particularly upon Merton’s (1936) notion of drawbacks (unintended consequences of purposive action), and perverse results (effects opposite to the expected outcome), which I here term paradoxical outcomes. The concept of drawbacks and the concept of paradoxical outcomes both help explicate the topic of iatrogenesis within the context of psychotherapy. To construct his theory and its systematic analysis of the unintended consequences of purposive action, Merton (2016) sought empirical evidence to explore the complexity of a system within its naturalistic environment. Also, within a given environment and of relevance to this thesis, Merton (1936) considered self-deception and the failure to account for one’s own cognitive or emotional biases as potentially significant causes of unintended outcomes. Cognition and emotion are core to mainstream psychotherapies (Henton, 2016; Sanders, 2016). I therefore consider that Merton’s (1936) theory is particularly relevant for the purpose of exploring the topic of unintended harm in psychotherapy.

Merton (1936) highlighted two key difficulties with the development of his theory. Firstly, the diversity of contexts in which social actions occur has impeded a defined
identity of the problem of unintended consequences, with the result that no systematic, scientific analysis has been conducted. While the unintended consequences of purposive actions, “has been widely recognised and its importance appreciated, it still awaits systematic treatment” (Merton, 1936, p. 894). Secondly, the notion of unintended consequences of purposive action is known by a variety of terms, and the terms can impact on how Merton’s (1936) theory is applied. Both key difficulties parallel the topic of iatrogenesis. Within this thesis, I aim to address both limitations: the context of psychotherapy sessions provides a specific context for a formally organised activity where, “like-minded individuals form an association in order to achieve a common purpose” (Merton, 1936, p. 896); and in terms of competing interpretations the rationale for the selected conceptual definition of iatrogenesis is provided. Therefore, I believe that Merton’s (1936) theory of unintended consequences provides a solid theoretical thread to weave throughout this thesis.

Conceptual Definition of Iatrogenesis

‘Unintended consequences’ (Merton, 1968), is today the standard term which encapsulates Merton’s (1936) theory. The term is defined as “those elements in the resulting situation which are exclusively the outcome of the action, i.e., those elements which would not have occurred had the action not taken place” (Merton, 1936, p. 895). Within the context of medicine iatrogenesis is defined as ‘a disorder precipitated, aggravated, or induced by the physician’s attitude, examination, comments or treatment and which can have physical or psychological effects’ (World Health Organization, 1994, p. 54). This definition has been extended from its use by physicians and psychiatrists to encompass a professional intervention made with the intention of alleviating human distress (Caplan & Caplan, 2001).

In contrast to the use of any single term, Parry, Crawford, and Duggan’s (2016) scoping review of the literature concerning iatrogenesis, located 14 common terms. I
discuss the use of these terms in this study’s literature review section under the subheading data reduction. Parry et al. (2016) note the, “[f]ailure to agree the most appropriate terms and definitions to describe harm associated with psychological treatments...” (p. 210), hampers efforts to build a bridge between research and practice (Kazdin, 2008). Here, the point is that as yet, there is no single, systematic way to define or describe iatrogenesis within psychotherapy. Strupp, Hadley, and Gomez-Schwartz’ (1977) seminal work, Psychotherapy: For better for worse considers the systematic study of how one client improves and another gets worse as “an absolute necessity if the field is to advance ... [and] a challenge that must be met in years to come” (p. 12). Four decades later, it seems the challenge has yet to be met. A step towards meeting Strupp et al.’s (1977) challenge is the aim of this thesis.

Definitions of iatrogenesis vary and so impact upon research choices and findings. For example, some quantitative research has reported client experiences of unintended harm within sessions (Bystedt et al., 2014; Parker, Fletcher, Berk, & Paterson, 2013). However, within sessions it is likely that clients may experience increased distress precisely because difficult issues are explored (Boisvert & Faust, 2002). What happens within psychotherapy sessions or once therapy is completed, may impact also upon others in the client’s social world. For instance, a client may gain the confidence to become more assertive with a partner, and so change the dynamics of the relationship, leading the partner to feel harmed (Lilienfeld, 2007). Therefore, in this review of the literature a suitable definition of harm is, “a negative effect [that] must be relatively lasting, which excludes from consideration transient effects ... [such as in session anxiety or between session sadness, and] must be directly attributable to, or a function of, the character or quality of the therapeutic experience or intervention” (Strupp et al., 1977, pp. 91-92).

Potential Underlying Mechanisms of Iatrogenesis

The underlying mechanisms associated with the generation of unexpected
consequences include ignorance, errors and a clash of values (Merton, 1936). Allen-Scott, Hatfield, and McIntyre (2014) conducted a scoping review of unintended harm associated with public health interventions. The authors aimed to gather data to develop typologies of unintended harm related to outcomes, and describe the potential underlying factors of well-meaning, yet harmful actions. The objective was to inform further systematic syntheses of research through theory development and clinical evaluation. Of the reported psychosocial harms, a significant number of interventions were shown to lead to stigmatisation. Within the field of psychotherapy generally and the literature relating to iatrogenesis specifically, there is much debate over what causes harm, or if therapy can even cause harm. The process of stigmatisation may offer one mechanism to explore iatrogenic practices.

**Potential mechanisms for harmful therapy.** Parry et al’s (2016, p. 211) highlight possible mechanisms for harmful therapy, which include: (a) damaging interactions between therapist and patient, and unresolved ruptures in the therapeutic alliance; (b) therapist factors such as using an inappropriate therapeutic method or a lack of skill in noticing and repairing ruptures in the therapeutic alliance; and (c) patient factors that increase the risk of iatrogenesis such as people diagnosed with a borderline personality disorder. Boisvert and Faust’s (2002) “theoretical exploration of the potential impact of labels, language and belief systems” (p. 245), which are arguably mechanisms underpinning iatrogenesis, added: (d) the way clients may be socialised into therapy through use of terms and labels suggests the therapist, or researcher, has specialised knowledge.

Each of the three studies which form this thesis will explore a different aspect of the therapeutic relationship to explore the unintended consequences of purposive interventions, and unintended harm, from various angles and different levels of analysis. This first study will review the literature through consideration of various research
paradigms, research methods and how they relate to the risk and experience of harm in routine practice. The review will consider also the current national provision of psychotherapy. The second study in this thesis will present an Interpretative Phenomenological Analysis (IPA: Smith, 1996; Smith, Flowers, & Larkin, 2009) of the experiences of psychotherapists in the role of client. The third and final study in this thesis will present a qualitative Thematic Analysis (Braun & Clarke, 2006), of the perceptions of psychotherapists in their day-to-day practices of delivering therapy which are perceived to have engendered harm.

**Positioning counselling psychology to explore the topic.** The UK government’s evidence-based practice (EBP) programme, Improving Access to Psychological Therapies (IAPT: Layard, Clark, Knapp, & Mayraz, 2007) treated 1 million people (2009-2012), with a recovery rate of 45% (Department of Health, 2012). Socio-political powers are rapidly extending the current programme with a three-fold budget increase to £1.2 billion, to treat 1.5 million people annually (Clarke, 2016). From the 97% of completed outcome data, IAPT reports the current national deterioration rate (adverse effects of therapy) as 6%, or 54,000 people (Clarke, 2016). The wider literature suggests this is an underestimate of harm engendered by attending psychotherapy. As critical reflective scientist-practitioners, counselling psychologists are trained to compare competing research paradigms, and apply multiple therapeutic modalities. Counselling psychologists are therefore trained to mediate what is known from the research, and balance the tensions of EBP with a personalised “complex, intersubjective process” such as psychotherapy (Henton, 2016, p. 141).

Therefore, counselling psychology is well-positioned to explore the topic of unintended harm.

**Organisation of the Review**

The organising principle of this literature review is the different research methods applied to explore iatrogenesis. The role of therapists in relation to iatrogenesis is an
approach which I consider can transcend the methodological differences of the reviewed papers. This means we can explore the therapist’s role across the multiple research papers at the level of ontology (where human nature sits on a biological-relational continuum), and epistemology (a continuum of whether the knower can know the truth or constructs it). Ontological and epistemological stances shape what is considered a legitimate object of enquiry as well as the scope of enquiry. Research paradigms offer different philosophical and conceptual frameworks. They ask different research questions based upon the ontological and epistemological assumptions that are often unstated. These assumptions also shape the philosophy that underpins the research, the tools applied, which participant samples are recruited and the methodologies used (Denzin & Lincoln, 2000). These assumptions are explored within this review because they may impact upon the way unintended harm is understood.

Wendt and Slife (2007) consider that the epistemological assumptions that underpin the debate around EBP, “are not based on evidence or rationale and that this violates the very spirit of evidence-based decision making” (p. 613). This, if accepted, would have profound implications for the topic of iatrogenesis because EBP underpins the reported safest empirical treatments (APA: American Psychological Association, 2012). Within counselling psychology this represents the tension between relational practice and the drive towards clinical competencies based on the increasing use of outcome measures (American Psychiatric Association, 2013; BPS: British Psychological Society, 2015). This review considers EBP, or what counts as evidence, to assess whether the shift in the field towards outcome measurements is justified clinically or could potentially exacerbate the issue of unintended harm in the consultation room. Merton’s (1936) theory of the unintended consequences of purposive social actions theoretically underpins this this review of the literature by drawing upon his concept of drawbacks and paradoxical outcomes. These questions are of high relevance to clients, clinicians, researchers and the public because the
discourse of what counts as EBP is actively shaping public healthcare policy, and policy is being shaped by EBP research (Clarke, 2016; NHS, 2016a; Parry et al., 2016). To my knowledge this circular argument and the tensions inherent in the process have yet to be explored in the literature relating to iatrogenesis.

**Literature Search Strategy**

I conducted literature searches of PsychINFO, The Web of Knowledge, SciVerse and EBSCO between 1963, when Bergin (1963) published a seminal study, to date. This broad search applied combinations of the terms iatrogenesis, unintended- or unintentional harm, therapist-caused harm, deterioration, negative effects, negative events, negative outcomes, adverse effects, adverse events, or adverse outcomes. These search parameters yielded an unmanageable level of data. I undertook further international electronic searches of *The Counseling Psychologist, The Journal of Counseling Psychology, The European Journal of Counselling Psychology, The Journal of Psychotherapy and Counselling Psychology Reflection’s, Counselling Psychology Quarterly* and *Counselling Psychology Review* (CPR). Through my network, I obtained some older copies of CPR (the UK Division of Counselling Psychology’s publication) not yet transferred to pdfs. Within these counselling psychology journals, no results were found with iatrogenesis or its associated descriptors, except for ‘harm’, in the article titles or abstracts. Those located with ‘harm’ in the title were nearly all published in America. Parry et al.’s (2016) scoping search reported 14 search terms relating to iatrogenesis. This wide focus arguably evidences the difficulties of working with a concept that is ill-defined in the literature, and reflects the complexity of the topic (Sarkozy, 2010).

The strategy did however identify the application of different research methods in the 1963-to date publications. These were research methods regarding the client’s feedback and the therapist’s role, and typically situated within the quantitative paradigm. Additionally, the exploration of the therapist’s role situated within the qualitative research
paradigm was identified. A third and more recent mixed-methods approach was located, with particular relevance to public health care provision. Epistemologically the papers were overwhelmingly quantitative, so from an overview perspective I made several decisions to narrow the next phase of the search.

Relevant to this review are the current trends in research relating to iatrogenesis and the potential impact of the research upon applied research, clinical practices and UK health care policy. The Division of Counselling Psychology was formed in 1994. Since the mid-1990’s there is an international trend for a quantitative research focus on EBP. Compared to the quantitative research, the number of qualitative studies was relatively sparse, and these tended to be mostly anecdotal reports of personal experiences within therapy sessions. Whether quantitative results or qualitative results are reported, one aspect of the topic was rarely mentioned; the actions of researchers or practitioners.

Data reduction was implemented as multiple literature search decisions were made: i. to narrow the search dates from 2007 to date when interest in the debate was reignited (Lilienfeld, 2007); ii. to search using the most current terms used across mental health disciplines, which are ‘deterioration’ (Bergin, 1963; Flor, 2016), ‘negative effects’ (Barlow, 2010; Rozental, Kottorp, Boettcher, Andersson, & Carlbring, 2016), and ‘adverse effects’ (Bystedt et al., 2014; Ladwig, Riefa, & Nesoriuc, 2014; O’Hara et al., 2011; Parker et al., 2013). The term ‘adverse events’ was discarded because it relates to events such as hospitalisation or illness, rather than harm attributable to the process of psychotherapy. It is recognised that the terms may be considered divisive when translating research across paradigms and clinical practices, yet arguably the field of psychotherapy needs a common reference point to address this important topic of harmful therapy; and iii. to review quantitative and qualitative papers based on reported negative effect sizes, or negative personal experiences.
Epistemological Position

An epistemological theme weaves throughout this review; “we create the world we perceive, not because there is no reality outside of our heads… [such as the superiority of one paradigm or therapeutic modality over another], but because we select and edit the reality we see to conform to our beliefs” (Engel, 1987, p. vi.). Therapists who lack the ability to reflect upon their practice errors, which Merton (1936) considers an important aspect of unintended consequences, may be unable to see the dilemmas inherent in any practice, and so unwittingly seek out ‘evidence’ to support personal beliefs (Gambrill, 2012). Development beyond perception-determining beliefs or what Bateson (1987) called ‘epistemological premises’ (p. 314), requires awareness and acceptance that reality is negotiable and malleable (Merleau-Ponty, 2002). This philosophy underpins the Division of Counselling Psychology’s professional practice guidelines; to ‘negotiate between perceptions and world views but not to assume the automatic superiority of any one way of experiencing, feeling, valuing and knowing’ (BPS, 2014, pp. 1-2).

Research so Far: Parallel Development of Iatrogenesis Research and EBP

To situate the topic, Bergin’s (1963, 1966) early research reported that a consistently significant proportion of participants in experimental groups reported that their symptoms improved or became worse, than in the comparison groups. During the mid-1990’s these statistical outliers at the poles of the benefit-deterioration continuum were included in Empirically Validated Treatment research (EVTs: efficacy vs. effectiveness; see Seligman, 1995). EVT’s developed into EBP research. In 2006, the APA Presidential Task Force (2006) was established “to promote effective psychological practice” (p. 253). Lilienfeld’s (2007) subsequent paper, Psychological treatments that cause harm, re-ignited the debate around iatrogenesis. Today, the debate is shifting from normative group level analyses towards the development of outcome measures to improve the performance of individual therapists through perceived practice performance outcome measures. It is of
note that some UK leading figures and research departments, such as Michael Barkham’s
team (O’Hara et al., 2011), which shaped the UK development of EBP practice and
research, is now positioned at the vanguard of the debate and research developments
regarding iatrogenesis (Parry et al., 2016).

Prevalence

Lambert argues (2013a), “the prevalence and causes of unintended harm have been
inadequately researched” (p. 206). Reports regarding the prevalence of iatrogenesis range
from ‘does not exist’ or ‘so small it does not merit exploration’ (non-significant in House,
2008; 2% in Fleischer & Wissler, 1985), to 40% (Lambert, 2010; Macaskill & Macaskill,
1992). Current quantitative research suggests a prevalence of 5%-6% (Clarke, 2016;
Crawford et al., 2016; Parry et al., 2016). The phenomenon of iatrogenesis is apparent in
the literature irrespective of Western nationality, therapeutic modality or research
methodology applied. The APA’s (2012) psychotherapy effectiveness report noted that
some client populations are at greater risk of greater levels of iatrogenesis than the general
population, and for this aspect of iatrogenesis the reader is directed to: young people
(Rhule, 2005); addiction (Moos, 2005); black and minority ethnic groups (BME; Bhui,
Aslam, Palinski, McKenzie, & Bhugra, 2015), and for the LBGTQRI community
(Semlyen, King, Varney, & Hagger-Johnson, 2016). While the specific issue of identifiable
sub-groups is not the topic of this review, how they may be marginalised by general EBP
research is considered. Across the literature, the most commonly reported figure of
unintended harm hovers around the 10% mark (Barlow, 2010; Boisvert & Faust, 2003;
Lambert 2013b; Lilienfeld, 2007; Scott & Young, 2016). Therefore, the effect size for
psychotherapy outcome in the negative direction is here applied at a conservative
benchmark figure of 10%.

Trends in the Field

While the topic of iatrogenesis is gaining traction (Berk & Parker, 2009; Jarrett,
over the last decade there has been a clear trend towards EBP and outcome measures (Bystedt et al., 2014; Ladwig et al., 2014; Parry, 2015; Rozental et al., 2016).

This shift in the research has implications for the field of psychotherapy. One implication is that psychotherapists, who have traditionally considered that increased distress within sessions is to be expected because problems are discussed (Boisvert & Faust, 2002), are now more open to looking at how the impact of what occurs within the consultation room may have a lasting and negative effect beyond the consultation room. Of interest in this review is how harm is conceptualised and measured because this impacts upon what is considered good or poor practice. Evidence that any key aspect of the debate remains obscured, for instance that the trend in the research omits consideration of other equally important aspects of iatrogenesis, could support an argument that some research may exacerbate the issue. Pope, Sonne, & Greene (2006) suggest that when an important issue is rarely or not directly discussed it becomes reasonable to talk of a taboo topic.

**The Hierarchy of Science: Investigating Iatrogenesis in Research**

To achieve breadth and depth, this review will drill down through the traditional hierarchy of scientific evidence (Kuhn, 1962), which is underpinned by the concepts of reliability and validity. These concepts are the *sine qua non* of rationality (rules of logic). This strategy will support consideration of how different research approaches are applied to investigate iatrogenesis. The strategy will also be applied to investigate the strengths and weaknesses of the research methods applied to support EBP, which shapes how therapy is practised and delivered.

**Random Controlled Trials**

Meta-analyses and randomised controlled trials (RCT) sit at the pinnacle of the hierarchy of research evidence. Yet research is not neutral and research approaches have implications for what is, or is not, considered as evidence. Between 1995-2013, none of the 82 UK National Institute of Health Research (NIHR) funded psychological health trials
mentioned the occurrence of an adverse (iatrogenic) event in psychological treatments (Duggan, Parry, McMurran, Davidson, & Dennis, 2014). In 2014, and for the first known time, the Trial Steering Committee of a UK psychotherapy trial halted recruitment due to the adverse effects reported by participants in one of the treatment arms (Duggan et al., 2014). The study was of personality disorders, a common category applied in quantitative research (Parker et al., 2013). Crawford et al. (2016) also listed some American trials that were halted, and which correlate with Lilienfeld’s (2007) critique of psychotherapy.

Further, Crawford, Barnicot, Patterson, and Gold (2016) consider, “the high failure rate in recent trials [phase III testing effectiveness in clinical settings] of complex mental health interventions is a concern” (p. 6). To address such concerns, Parry et al. (2016) suggest that the solution is for more systematic research. Yet any systematic research founded on or using pre-2014 data regarding adverse effects or unintended harm seems open to question as pertinent data was not reported. This review will now explore the topic of unintended harm across quantitative research, qualitative research and mixed-methods research.

**Research Approach 1: Quantitative Research**

Identifying the Frequency of Risks and Side Effects of Psychotherapy and their Correlates for the Therapist and Patient, Ladwig, Rief, and Nestoriuc’s (2014) review of the literature regarding the risks and side effects of psychotherapy confirmed the findings of the broader extant literature, that psychotherapy is effective (APA, 2012). Relative to effectiveness studies, their review of the literature published up to 2012, located few studies reporting iatrogenesis. Ladwig et al.’s (2014) central argument is that within this underrepresented research topic there is even less research of the comparisons between efficacy research and effectiveness research. To explore this gap, the authors recruited 586 participants through an online survey website; 319 agreed to participate, of whom 200
completed the survey (61%). The sample comprised 90% German nationals. Ladwig et al. (2014) defined negative effects as changes that had a direct or indirect detrimental effect upon well-being and functioning. The effect measured needed to have occurred during the period of therapy, immediately after therapy or be due to a delay that could be attributed to the therapy. The latter speaks to Merton’s (1936) concept of ‘drawbacks’, and extra-therapeutic influences (the 40% non-specifics factor; Lambert, 2013b).

From their analysis Ladwig et al. (2014) developed the Inventory for the Assessment of negative effects of psychotherapy (INEP), a self-report instrument capable of analysing the frequency of negative effects and their correlates. The INEP is measured in terms of 21 items (Cronbach’s α of 0.86). Of the 195 participants: 93.8% (n = 183) reported an experience of negative effects in their psychotherapy. As this is nearly the entire sample it suggests a broad definition of harm, and therefore caution in interpretation is advisable. The individual mean frequency of significant negative changes ranged from 6.8% to 15.8%, which is broadly consistent with the literature. The confirmatory 7-factor solution (Cronbach’s α = 0.93) showed the three highest iatrogenic areas as: i. intrapersonal (15.8%; α = 0.93); ii. the experience or fear of stigmatisation, (14.9%, α = 0.79); and iii. a 12% negative effect in intimate relationships and 9.6% negative effect regarding family and friends (α = 0.67). The sample comprised: gender (74.9% female, 25.1% male); 66.7% of patients had a female therapist; actual gender pairings were not stated, and self-identified sexual orientation or religious affinity were not collected; 18% (35) reported a negative therapeutic alliance; negative inpatient care (25.1%) and negative outpatient care (74.9%). Predominant diagnoses were depression (62.1%) and anxiety disorders (52.8%). The internal consistency of the full questionnaire (k = 52), had a Cronbach’s α of 0.94, which is high.

The participants self-rated post-therapy symptom changes as worse (15.9%) and better (51.9%). Also, the level of conflict in general relationships was greater (18.4%), and
lesser (21.9%). This may indicate a link between the frequencies of negative effects with their relational correlates. Caution with the 93.8% \((n = 183)\) reporting of negative effects is advised because one interpretation is that negative effects are intrinsic to psychotherapy. Ladwig et al.’s (2014) study arguably adds breadth in terms of frequency data, yet lacks depth in terms of the quality of the therapeutic relationship or cultural influences. This could have serious implications for EBP, ranging from face validity to the applicability of the findings in relation to therapy as it is practised and/or experienced in naturalistic settings. For instance, in some cultures therapy would take place outside and within the community, rather than in relatively isolated small rooms (Ade-Serrano & Nkansa-Dwamena, 2016).

Ladwig et al. (2014) propose that to lower the frequency of negative effects, therapists have a moral duty and ethical obligation to advise patients of the range of negative effects possible in therapy. Unfortunately, the authors do not say how this could be put into practice. They also omit what would seem a moral duty and ethical obligation to advise of potential drawbacks within- or post-therapy (Merton, 1936). Ladwig et al (2014) also suggest that their research aim cannot yet be achieved because there is a lack of scientific evidence regarding which negative effects are experienced, and their frequency. The authors omitted to factor into their conclusion that intrapersonal changes may occur through conflict within the therapeutic relationships, and how relational difficulties are worked through may be a central factor in therapeutic practice.

A serious ethical concern within this paper is the number of patients (14.9%) who experienced suicidal thoughts for the first time during treatment. Curiously, this figure is very close to the number who also reported feeling stigmatised by their therapist (15.8%). In Allen-Scott et al.’s (2014) scoping review to develop typologies of unintended harm, a significant number of interventions led to client report of feeling stigmatised. This may be significant as minority groups are at greater risk of stigmatisation as a mechanism of
negative change (Meyer, 2003), and so unintended harm is a potential risk in therapy (APA, 2012). Unfortunately, there was no reference to the ability of practitioners to self-assess their role or to identify individuals or social groups at greater risk of experiencing harm by attending psychotherapy. In addition, patients diagnosed with a personality disorder tended to report more experiences of negative effects, which is what halted the RCT previously mentioned.

**Differences among Therapeutic Approaches**

Of note, and particularly when placed within the context of the wider literature, was the result that more patients in Cognitive Behavioural Therapy (CBT) than non-directive or psychodynamic therapy reported feeling coerced by their therapist to engage with specific interventions. Although unnamed, these were likely behavioural experiments or homework tasks, which are the cornerstones of CBT. Patients in psychodynamic therapy reported the highest frequency of feeling offended by their therapist. Again, unnamed, part of psychodynamic therapy is to work with deep and difficult emotional issues, and therapeutic interpretations. It is notable that Merton’s (1936) theory described how the failure to account for cognitive or emotional biases within purposive actions, which here includes researchers, psychotherapists or clients, can act as a mechanism that can lead to significant drawbacks.

**Limitations and strengths.** Ladwig et al. (2014) concluded that there is an ethical and legal imperative to further understand and discuss the negative effects of psychotherapy treatment. Yet the authors excluded the experiences of five participants from the data analysis because their negative experiences of therapy took place more than 14 years before the study. This study design decision encapsulates the issue within this particular study. For no apparent reason, other than being statistically 2 standard deviations from the mean (Z value > 3.29), the client-participants were categorised as outliers (Bergin, 1966). Despite the contribution of their experiences to the research and the crucial
information they might hold due to being at the statistical extremes, their knowledge of harmful therapy was excluded from the analysis; they might be ‘left feeling they hadn’t been included in the analysis’ (Cox, 2014).

I suggest that these outliers may have much to tell us regarding iatrogenic practices. Indeed, Ladwig et al. (2014) state they subsequently conducted qualitative interviews with a section of their sample ($n = 35$). Those results were not reported. The point is that this study seems representative of the trend towards measurement tools of negative experiences. However, the authors latterly recognised the value of extending a quantitative study design with qualitative data, as their next research stage to capture personal experiences through the application of a qualitative perspective. Without this flexibility, Ladwig et al.’s (2014) INEP risks reducing artful therapists keen to explore and learn from errors openly to technicians (Ogden, 2016).

**Towards understanding iatrogenesis.** Ladwig et al.’s (2014) study points towards several pathways to develop our understanding of unintended harm in the consultation room. While the INEP yields useful data such as the potential relationship between stigmatisation and suicidal thoughts, “demonstrating a causal relation does not necessarily provide the construct to explain why the relation was obtained” (emphasis original; Kazdin, 2008, p. 152). The authors acknowledge their study omits consideration of how clients experienced the negative effects of their psychotherapy, which indicates a need for a more personalised qualitative-oriented research. Ladwig et al. (2014) applied constructs such as depression, anxiety disorders and personality disorders, which can limit what is considered to be an appropriate object of research study. (For an argument against the categorisation of clients and the medicalisation of therapy through such constructs, see Douglas, 2010).

Boisvert and Faust’s (2002) theoretical exploration of iatrogenesis and the potential impact of the labels, language and belief systems applied by professionals suggests, “when the client’s behaviour and experiences are categorised ... the client’s window of normality
may be narrowed” (p. 252). Ladwig et al. (2014) omitted to consider that categorisation can lead to changes in self-perception, which can then lead clients to refine their experiences through a process of normalisation and become the person the category describes. For instance, clients labelled as being depressed or portrayed as having a personality with characteristics assumed by the descriptor of psychiatric language (Kazdin, 2008), may be treated as such and so respond with difficulty to the treatment. This would risk the creation of a circular process. When this appears in the research process it impacts how the research results are understood, and applied.

The risk can also have an impact in the consultation room, where there may be a potential for the paradoxical outcome (Merton, 1936) of limiting what it means to be well. In such a scenario, marginalised individuals and groups seem at greater risk of experiencing iatrogenic practices in the consultation room. Curiously, these participant-clients, whose experiences of being within the therapy room were left outside of the research analysis, may also be those most likely to shed light upon drawbacks or paradoxical outcomes; it is possible that these may occur within research, therapy or a space in-between. I believe this limitation may be of significance for the individuals or groups whose experiences in turn, could assist professionals in gaining a deeper insight into iatrogenic practices. This may be particularly relevant for marginalised participants.

**Developing the Review**

To determine what constitutes a negative effect is a highly complex issue. However, several suggestions on how to monitor and report negative effects have recently been presented in the literature (Linden, 2013). Parker et al. (2013) have developed a questionnaire intended to probe for negative effects among patients undergoing psychological treatments.

**The Development of a Measure Quantifying the Adverse Components of Psychotherapy: the Therapist**
Similar to Ladwig et al. (2014), Parker, Fletcher, Berk, and Paterson (2013) consider there has been little systematic research of iatrogenesis. Additionally, Parker et al. (2003) consider that there are, “no tools specifically quantifying adverse aspects of psychotherapy” (p. 294). The authors’ base their claim upon Berk and Parker’s (2009) respected review of the literature. In their present study, Parker et al. (2013) continued with their focus on what the client perceives the therapist contributes (the ingredients), to the therapeutic interaction. To explore this gap in the literature, Parker et al. (2013) developed the Experiences of therapy questionnaire (ETQ), to measure what they term the therapeutic ‘ingredients’. Their premise was that non-specific factors of therapy have been shown to support positive and beneficial therapy (Duncan, Miller, Wampold, & Hubble, 2010), and so they concluded that their absence should influence therapy in an adverse way.

Parker et al. (2013) recruited participants via the Australian Black Dog Institute website, where they were invited to complete the questionnaire anonymously. Based on their earlier literature review, Parker et al. (2013) identified constructs that when present, enhance psychotherapy and which when absent risk adverse outcomes. These were defined as: factors effecting the formation and maintenance of a therapeutic alliance; the extent of an in-session therapeutic structure; and the extent to which the therapist encourages dependency or enmeshment. From the data, the authors captured the following descriptive items in eight domains including: client efficacy; the quality of the therapeutic relationship; the impact of therapy; the treatment-rationale fit; treatment as restorative; therapist factors; and the therapeutic setting. The method yielded 103 items that were weighted towards a negative component or attribute.

Parker et al’s (2013) presentation of their results can be sub-divided into two categories: participants still in therapy (n = 707), of whom 360 (50.9%) completed all questions; and participants who had finished therapy (n = 680), of whom 356 (52.3%) completed the questionnaire. In this literature review I made a choice to focus on the group
in therapy. The rationale was that by narrowing the scope, this review can focus on any fundamental flaws in the way the topic of iatrogenesis was explored, and therefore how the data was interpreted to support EBP. Parker et al.’s (2013) study is relevant because Berk and Parker’s (2009) Elephant on the couch review of iatrogenesis was instrumental in helping the topic gain theoretical traction, yet the authors’ method in this study seems a poor fit with their theory. One key flaw is to include the 263 (73.3%) participants taking medication. This was not well-conceived; in this context, this is a confounding variable that makes it difficult to isolate and so explore a potentially key ingredient: the therapeutic relationship (Jones Nielsen & Nicholas, 2016).

A second key flaw is a conceptual definition of harm because the research approach focused on increased client distress within sessions. This is a good example of Merton’s (1975) concept of drawbacks because the research design decision omits a consideration of therapeutic models that value engaging with distress and how clients develop coping skills in order to alleviate long-term distress. This gap seems particularly unfortunate as the participants were professional psychotherapists in the role of client. With their dual focus, as ‘insiders’ and as ‘outsiders’ (Merton, 1968), they could perhaps have added further insights to the topic of iatrogenesis beyond the ability of non-professional clients to do so. Clients tend to have less professional insight into acceptable processes within a therapeutic space. Sadly therefore, within this important study, we know little, if anything, of how unintended consequences may have impacted the participants’ social world within or beyond the consultation room. I believe this is problematic. As social beings, we live in a complex interpersonal social world where each aspect of life tends to impact upon other aspects of life. Using the therapeutic relationship to work through such distress is considered to be the therapy in certain schools of thought (Clarkson, 2003).

Similar to Ladwig et al. (2014), Parker et al.’s (2013) main therapy types were CBT, 120 (33.3%), and general counselling, 17 (29.2%). The main presenting problems
were depression, 201 (55.8%), and anxiety, 39 (10.8%). Time in therapy was: more than 2 years, 141 (39.2%), and 1-2 years, 76 (21.1%); weekly therapy, 114 (31.7%) and monthly therapy, 56 (15.6%). Other potentially relevant patterns included an increase in the treatment of substance abuse/dependence, which is beyond the scope of this study (see Moos, 2005; White & Kleber, 2008). The political, cultural and social implications in the field of psychotherapy’s trend toward the quantification of distress is of key importance in this study. It is important to note, Merton (1936) considers the failure to account for cognitive biases or emotional biases, core to each of the therapeutic modalities applied by Parker et al. (2013), may possibly engender unintended consequences. For clarity, I am not claiming the results are thereby biased, merely that this is a theoretical possibility. To claim more would require further evidence.

It is important to note that Ladwig et al.’s (2014) study and Parker et al.’s (2013) study are situated within the post-positivist paradigm. This means they carry implicit values and a priori assumptions. One key assumption underpinning both studies is that the method of factor analysis can construct useful categories to explore negative experiences, and highlight potential themes within the data. Parker et al.’s (2013) factor analysis yielded five factors, which explained 53.4% of the total variance, or otherwise put little better than chance. Each factor was retained if the loading exceeded .4. No explanation was offered for this threshold. However, of interest to a study regarding iatrogenesis within psychotherapy, the following factors apply: Factor 1 ‘Negative Therapist’, which accounted for 40% of the variance; Factor 2 ‘Pre-occupying Therapy’ (excessive inwards focus and powerlessness), which accounted for 5.6% of the variance; Factor 3 ‘Beneficial Therapy’ (therapy did not address the client’s issue, 4% of the variance); and Factor 4, ‘Idealisation of Therapist’ (items such as dependency), accounted for 2% of the variation.

What may be attributed to a negative therapist may be the well-intentioned therapist’s belief in their own model, an inability to be flexible, or it may arise because of
self-deception (Merton, 1936). This is may be more pertinent to therapists trained in
general counselling or a single modality, who unlike counselling psychologists, may not be
trained to select from a range of interventions and to purposively apply one selected EBP
modality (treatment-rationale fit). Additionally, clients who received 12 sessions or less
rated their therapist as significantly more negative than those who received 100+ sessions.
This result is important for two reasons. It seems counter-intuitive to the popular argument
that longer-term inward (intra-personal insight) focusing therapies are more likely to evoke
difficult material, and so have more time for interpersonal, or negative therapist difficulties
to emerge (Denman, 2016). Also, 12 sessions maximum of CBT is the bedrock of the NHS
evidence-based national health programme (Layard et al., 2007; NHS, 2016b). The authors
are in effect questioning the evidence upon which the quantitative EBP trend is based.

Further, higher Factor 4 ‘Idealisation of Therapist’ “scores were returned by
females” (Parker et al., 2013, p. 298). I suggest that Parker et al. (2013) have replicated a
fundamental issue with the quantitative paradigm’s research of iatrogenesis, and
undermined their own central argument. The authors assumed that the common ingredients
of an interaction can be identified and so taken at face value, through the completion of the
ETQ. Yet other unstated factors were potentially impacting upon the scores. For instance,
the ‘Idealisation of Therapist’ is a theoretical construct and its interpretation epitomises the
heart of the issue of unintended harm; if researchers and practitioners do not consider the
wider social contexts and social norms, biases risk creeping into the research process as
well as the therapeutic relationship.

If shown to be apposite or paradoxical, this might elicit at least an alternative
argument for the prevalence of unintended harm. This issue is explored below. It could
also support an argument that unintended harm is considered a taboo topic in
psychotherapy (Pope et al., 2006). Paradoxically, the very measures developed and applied
to avoid adverse effects could inadvertently overlook vulnerable populations (Watts,
2016), and thereby engender adverse effects (Bystedt et al., 2014). This would result in a paradoxical outcome for research where the manifest (conscious) intention was towards well-being, and yet the latent (unconscious) function of the research resulted in people being marginalised within the realm of clinical practice (Merton, 2016).

From Parker et al.’s (2013) conclusions, interesting data emerged regarding the higher ‘Idealization of Therapist’ scale scores. The authors concluded that further studies could clarify the influence of therapeutic bonding and transference issues. Superficially, this seems to accord with Parker et al.’s (2013) belief that poor therapy can make clients worse by “triggering latent pathology” (p. 300). Yet, for EBP generally and CBT specifically, which is the largest modality applied by one of the world’s largest free psychotherapy providers (NHS), the concept of transference is not typically applied. The theory and the research seem mismatched. The authors acknowledge that adverse outcomes, “are likely best judged experientially and subjectively [however] ... We did not ask for feedback from participants regarding whether the items selected adequately captured the different aspects of their psychotherapeutic experience” (emphasis added; Parker et al., 2013, p. 299-300).

**Limitations and strengths.** The categorisation, potential marginalisation of some people and gender issues, limit the value of Parker et al.’s (2013) study because the work is arguably unrepresentative of the world in which the study is situated. There is no explanation regarding the test-retest reliability sample of 89.1% females, when females formed 84.7% of the total sample. The difference seems small, but it is worth noting that males formed 15.3% of the total sample yet only 10.9% of the reliability test. In absolute terms the difference is only 4.4%, yet relatively or subjectively rather than objectively, we do not know how this could have skewed the results or any assumptions built upon them. Parker et al.’s (2003) key claim is that the ETQ, “may be used to evaluate differing psychotherapies and psychotherapists, particularly in terms of contribution to unsuccessful
outcome ... and to determine actual adverse risk outcomes associated with each factor” (p. 300). Within this review, the claim seems at best only partially supported. As Foa and Emmelkamp (1983) note, it seems “almost taboo to admit that sometimes the expected results were not obtained” (p. 3), not that this unexpected outcome holds the potential to lead to methodological creativity.

Towards understanding iatrogenesis. Parker et al.’s (2013) comment that poor therapy triggers latent pathology shifts the focus away from researchers or practitioners, and towards the client. This risks blaming the client for reacting to poor therapy. It risks also shifting the gaze away from qualitative explorations of mechanisms of change that potentially engender iatrogenesis. For instance, the understanding of iatrogenesis could be better postulated by exploring which patient, researcher, psychotherapist, treatment-orientation, and contextual factors either moderate or are correlated with positive, negative or neutral outcomes. Kazdin (2008) considers, the “processes within or during [research or] treatments are responsible for (not just correlated with), outcome (mechanisms of therapeutic change)” (p. 150). Research that ties in with Kazdin’s (2008) concerns, has the potential to shift this literature review away from formally structured quantitative research, and towards reflective semi-structured qualitative research. Such a shift might broaden our understanding of iatrogenesis by bridging the gap between research and psychotherapy, as it is practised in the real world, and thereby move beyond the statistical inferences that attempt to interpret unique lived experiences (Smith, 2017).

A Critique of the INEP and ETQ Measurement Scales

Rozental, Kottorp, Boettcher, Andersson, and Carlbring’s (2016) critique of Ladwig et al.’s (2014) INEP and Parker et al.’s (2013) ETQ is briefly offered to illustrate how the EBP approach can in some contexts, seem fractured. Within the scientific hierarchy these post-positivist studies are the essence of scientific advancement. Yet paradoxically, such studies may hinder client development because studies purporting to
show efficacy over the naturalistic effectiveness of therapy as practised in the field, pose a risk of causing harm. I believe that Rozental et al.’s (2016) critique is a vital addition to this literature review due to the questions that arise from it. In their critique of the Ladwig et al.’s (2014) INEP, Rozental et al. (2016) consider the INEP difficult to assess because it lacks a clear and coherent scale.

Also, some INEP questions such as, ‘My therapist physically attacked me’ (Item 19), focused on malpractice. Prohibited behaviours are not a general feature of treatment interventions, and yet this was the focus of the INEP study. Curiously, Rozental et al. (2016) similarly criticised Parker et al.’s (2013) ETQ for a lack of item clarity, and for including negative and positive effects. Interestingly, Duggan et al.’s (2014) critique of the recording of adverse events from psychological treatments in clinical trials, considered that to increase our understanding of iatrogenesis, both positive and negative effects must be reported. Rozental et al.’s (2016) conclusion that only reporting prohibited or negative effects inhibited the development of a measure to assess adverse effects, which was Parker et al.’s (2013) aim, seems to apply equally to Rozental et al.’s (2016) critique. Additionally, the ETQ was critiqued for making post hoc comparisons, which Rozental et al. (2016) consider increases the risk of reporting spurious findings. Spurious findings were exactly what Lilienfeld, Ritschel, Lynn, Cautin, and Latzman (2014) identified as a major problem in the debate regarding iatrogenesis.

Towards understanding iatrogenesis. Arguably researchers, whether quantitatively-oriented or qualitatively-oriented, are unsure exactly what to measure because the topic of iatrogenesis is under-theorised and mechanisms of change, in either direction of effect, may remain obscured. Additionally, researchers or practitioners, whether quantitatively-oriented or qualitatively-oriented, seem unsure of what they believe they are objectively or subjectively measuring. The result is that the potential impact of such measurements remains unclear. Merton (1936) extended his earlier theory of
unintended consequences to include the manifest and latent functions of purposive actions. Merton (1936) distinguishes between ‘manifest’ functions (objective and intended consequences for a specific unit such as a person, which contribute to their adjustment or adaptation), and ‘latent’ functions (referring to unintended or unrecognised consequences). By applying the concept of latent functions, researchers or practitioners can, “extend enquiry in those directions which promise most theoretic development ...” (Merton, 2016, p. 71). One direction is qualitative research, from which may emerge new ways to understand the unique and subjective experiences of clients or practitioners, within active therapy sessions. This could help further develop our understanding of iatrogenesis and how it may arise.

**Research Approach 2: A Qualitative Perspective**

Within the hierarchy of science, qualitative research is positioned below quantitative research. What is noticeable across the research into iatrogenesis is that the quantitative research does not appear to justify its position. In short, the position seems taken as an accepted given. In this review of the literature, that assumption is challenged through three qualitative studies which state their aim as the exploration of the client’s subjective experience of iatrogenesis. Each study sets out to challenge the assumption from a different perspective by investigating the phenomenon of iatrogenesis within the therapeutic field.

**Therapists Report Causing Harm and Living With This**

Flor’s (2016) qualitative study applied systematic text condensation (STC: Malterud, 2012), a pragmatic research approach inspired by Giorgi’s (2012) descriptive phenomenological perspective. STC’s procedure applies four analytical stages: total impression of the texts (chaos to themes); identifying and sorting meaning units (themes to codes); data condensation (codes to meanings); and synthesising (condensation) of
descriptions and concepts. Malterud (2012) considers that the intersubjectivity becomes visible through the transparent presentation, analysis, reflexivity and subsequent conclusions drawn from the data in relation to the existing literature.

Flor (2016) conducted semi-structured interviews with 10 Scandinavian psychodynamic psychologists to access their thoughts about their patients’ “deterioration” in individual psychotherapy. Multiple findings relevant to this literature review are explored. In contrast to the papers reported above, Flor (2016) explicitly noted that the participants appeared to have little knowledge regarding the concept of patient deterioration, or understanding of the reasons for deterioration. This supports the extant literature that therapists typically have trouble in defining or even recognising patient deterioration. Although this central area of noticing and so managing drawbacks is central to the topic of iatrogenesis within the consultation room, only brief examples are provided here because this research has its own body of literature, to which the reader is referred.

Hatfield, McCullough, Frantz, and Krieger (2010), tested two assumptions that are central to good clinical practice: that therapists can reliably detect deterioration, and the reliability of therapists’ judgments of deterioration. Hatfield et al. (2010), reported that therapists had considerable difficulty recognising client deterioration, which means that the therapists’ judgments of deterioration were inaccurate in many cases. Hannan et al. (2005) reported that nearly all their practising psychotherapist-participants were completely unable to predict treatment failure, and overestimated positive outcomes in relation to measured outcomes on a standardised assessment. Walfish, McAlister, O’Donnell, and Lambert (2012) reported that “25% of mental health professionals viewed their skill to be at the 90th percentile when compared to their peers” (pp. 644-645). As this is statistically impossible, a significant degree of self-deception seems evident; Merton’s (1936) theory posits that self-deception is a significant cause of drawbacks. None self-assessed as below average. As some therapists seem unable to register iatrogenesis within the consultation
room it seems reasonable to suggest that this difficulty extends to the impact of harm beyond the consultation room. This supports this thesis’ definition of harm as lasting and negative experiences “directly attributable to therapy” (Strupp et al., 1977, p. 53), are difficult yet essential to define and investigate, for therapy to become more effective and accountable.

Flor’s (2016) study concluded that quantitative studies of the topic are methodologically challenged because they offer no validity with respect to the meaning of an experience. For instance, quantitative researchers cannot say how a negative outcome is interpreted by the client. Additionally, they cannot give an objective statistical weighting to the subjective perception of a harmful experience (Ladwig et al., 2014; Parker et al., 2013; Rozental et al., 2016). While each of the studies reviewed thus far recommend further training, Flor (2016) is explicit. The participants reported that the lack of training regarding deterioration means the participants lacked a psychologically safe environment to ‘thematise’ or explore the impact (to the client and the practitioner-self), of making errors. The participants reported this means they try to make sense of the issues at the level of educated guesswork. In another qualitative study presented in this thesis (Study 2), a participant called this ‘being guided by your own compass’ (Cox, 2016a), which he considered to be unethical and clinically dangerous (Tribe & Morrissey, 2015). The point here is to question where the qualitative compass points.

In contrast to the previous papers presented thus far in this review, Flor (2016) drew a key conclusion of great import to the topic of unintended harm. In their therapeutic role, these participants were asking their clients to stay with their discomfort and work through their difficult experiences. However, the therapists stated they were unable to do this themselves, such as with peers or feel safe enough in supervision to explore errors. They were uncomfortable with their position. This is seen through the participants’ comments that, when errors occurred, they felt ‘guilty’ until proven innocent. Merton’s
(1936) theory proposes that error is one of the underlying mechanisms which generate unintended consequences. Flor’s (2016) participants also reported feeling shame at their perceived inaction, and experienced helplessness due to their lack of skills.

At the heart of Flor’s (2016) study the participants were unaware if harm had occurred to the patients. We only know that the participants felt they may have harmed their patients. The surprise seems to be that having critiqued the quantitative papers for assuming knowledge of the others’ experiences, the same can also be said of this qualitative paper. In both paradigms, the participants lacked an epistemological frame or research-based knowledge through which to orient themselves to the topic of iatrogenesis.

**Limitations and strengths.** Flor (2016) concluded that the participants’ judgments were influenced by cognitive fallacies which complicated their efforts to identify, explain and so address deterioration. Surprising perhaps for a qualitative paper, Flor (2016) applied the term ‘deterioration’, which is arguably linked to the measurement of symptoms. Additionally, although unstated, to manage their dissonance the therapists may have employed the Fundamental Attribution Error (FAE: Ross, 1977), whereby the perceived characteristics of the other person are used to explain a situation. Transposed to the therapeutic context, the client may be blamed when they deteriorate, which protects the therapist from acknowledging their potential part in the intersubjective process; until phenomenologically-oriented research, such as the STC’s analytic process, encourages a transparent and reflective examination of one’s own behaviour. This may be one reason the participants were left feeling uncomfortable.

What stands out in this paper is its strength. Firstly, only Flor’s (2016) participants spoke directly of shame at feeling they engendered harm. When reporting their feelings, most of the participants said they had no place to speak of their guilt and shame. It seems they used anonymous research to explore these issues. This was perhaps their only safe option, which would say much about the field of psychotherapy, and supports my claim
that unintended harm is a taboo topic within the field of psychotherapy. Secondly, Flor (2016) was one of the few researchers in this review, or across the wider literature, to consider whether the participants could identify any group at risk of iatrogenic practices. None could identify any such group.

Towards understanding iatrogenesis. Boisvert and Faust’s (2002) paper, Iatrogenic symptoms in psychotherapy, offers a theoretical exploration of the function of terms and language applied in research and psychotherapy. The term ‘deterioration’ applied in Flor’s (2016) research implies a decline in symptoms to a worse state from a better state. The same interpretation could apply to ‘unintended harm’, which implies there is an alternative state that is beneficial. The difference between the interpretations is that within the literature pertaining to iatrogenesis, ‘deterioration’ is arguably a construct with social and cultural implications, which is purposively applied by the researcher to describe the participants’ subjective experiences. The unintended consequence (Merton, 1936), is that this potential mechanism of change risks missing or devaluing the client’s unique lived experience of iatrogenic practices within psychotherapy.

Therapists Find it Difficult to Identify Harmful Practices

Bystedt, Rozental, Andersson, Boettcher, and Carlbring’s (2014) study recruited members of the Swedish Psychological Association. The participants completed an anonymous online survey of 14 open-ended questions. Responses were analysed using Thematic Analysis (TA: Braun & Clarke, 2006), which can be utilised by quantitative or qualitative research. Bystedt et al.’s (2014) study applied a quantitative TA. Three survey questions were adapted from Strupp et al.’s (1977) seminal study on iatrogenesis. The analysis resulted in three core themes: the characteristics of negative effects; causal factors; and methods and criteria to evaluate negative effects.

Of the participants ($n = 74$), 45 (60.8%) were female and 28 (37.8%) male, while one (1.4%) individual chose not to disclose their gender. The mean age of the participants
was 45.52 years (SD 10.36), ranging from 26 to 67 years. The mean number of years working as a clinician was 11.98 years (SD 8.71), ranging from 1 to 39 years. In terms of therapeutic orientation, 63 (85%) of the participants described themselves as Cognitive Behaviour Therapists (CBT), and 19 (25.5%) identified as using CBT with varying degrees of Acceptance and Commitment Therapy (ACT; Hayes, 2012). This CBT focus accords with Ladwig et al.’s (2014) and Parker et al.’s (2013) research, where CBT was also the predominant modality. The study reported that 63 participants (94.5%) agreed that negative effects of psychological treatment pose a problem, and curiously four (5.5%) disagreed. 55 (75%) of the participants described clinical experiences of deterioration and/or negative effects in their clinical practice, while eight (11%) had received some training on the topic.

Several participants offered a different perspective to the previous studies regarding negative effects or deterioration. Uniquely across the studies in this literature review, some of Bystedt et al.’s (2014) practitioner-participants considered some of their patients may have been better off without any therapy. This means that attending therapy could itself be potentially harmful. Many participants acknowledged that incompetence or the inadequate application of clinical methods or techniques could cause negative effects. Further, several considered it is the clinician’s responsibility to ensure their skills are informed and current with the literature, yet seemed not to have done so. This raises ethical and moral questions of motivation and responsibility. This suggests a manifest function of limited reporting to supervisors or trainers who might sanction such conduct, in order to self-protect. The process may also serve a latent function that is hidden from the participants because none acknowledged causing harm. As Merton’s (2016) theory states, “[p]erceptions of latent functions can complicate the picture because they can introduce moral judgments” (p. 72). In a circular process, the ethical and moral questions of motivation and responsibility stay unchallenged, because they are unaddressed.
Additionally, I suggest this engenders a circular process whereby therapists need self-protection (a manifest function), against practising in ways that can lead the therapists to feel shame. Therefore, to avoid feeling shame the therapist’s perception of morals can become skewed (a manifest function), such as blaming the client through the function of the FAE (Ross, 1977), or working outside of a professional code of ethics. This in turn engenders a further need for self-justification (the manifest function of self-protection), which just as Merton (1968) originally described, perpetuates a self-reinforcing belief.

Qualitative research to explore therapists’ perceptions of manifest or latent patterns could serve the field well. Similar to Flor’s (2016) study, it is of concern to this review that none of these participants could identify a specific group or diagnosis that could alert them as clinicians to take additional care to avoid causing unintended harm.

Across the papers presented in this review, there seems a tendency for the participants to locate difficulties in the patients’ cognitive abilities (Flor, 2016; Parker et al., 2013). Bystedt et al.’s (2014) study of socially constructed diagnoses such as depression, anxiety and personality disorders may complicate their results. These diagnoses feature as the same discrete categories or attributions noted in the previously presented papers (Ladwig et al., 2014; Parker et al., 2013). The point here is that these clinicians did not take responsibility for any negative effects or negative outcomes. This seems unsurprising as few to no participants across the studies could foresee poor outcomes in their own clinical practices. I suggest this is likely to engender greater harm, and seems a particular risk factor when engaging with marginalised client groups. Briefly, even if foreseen by the 11% who had some training on the issue, 89% of the participants lacked any training in how to work with preventing deterioration or adverse effects.

Bystedt et al. (2014) state they used TA (Braun & Clarke, 2006) to examine the specific concept of adverse effects through the unique perspective of the practitioner-participants. Exploration of this claim affords a way to review a weakness present in each
of the quantitative papers, most of the qualitative papers in this review, and much of the wider literature. The weakness is to apply constructs whose origin and perspective are epistemologically-grounded in the medical model. This means the words of the clinicians are viewed through the constructs of diagnosis and symptoms. The point is, the meaning of a patient’s or participant’s unique ‘insider’ perspective has already been framed by the ‘outsider’ researcher (Merton, 1968). Therefore, I suggest it is questionable whose experience is being researched.

**Limitations and strengths.** Clinicians as well as researchers need to become more aware of how to monitor and manage situations that may have a negative impact on the therapeutic process, and therefore treatment outcomes. At 5%, Bystedt et al.’s (2014) response rate was very low, and could have been increased by a reminder to participants. In their study, Boisvert and Faust’s (2003) participant reminder served to raise the response rate to 28%. This higher rate increases confidence in the findings. Also, the very human interaction with the other seems to hint at how best to utilise quantitative and qualitative methodologies.

Bystedt et al. (2014) considered their use of a survey rather than the relational human contact used in qualitative interviews led to the low response rate. They also added that an interview could have supported and encouraged participants to, “think, speak and be heard” (Reid, Flowers, & Larkin, 2005, p. 22). Additionally, this could have also helped the interviewers to probe for interesting and important issues during the interview (Smith, 2004). Enriched data for both the quantitative and qualitative paradigms is considered a measure of good research (Morrow, 2005). In their own words, Bystedt et al. (2014) recommend that future research uses interviews, “to further explore perceptions and experiences of negative effects ... to identify patients at risk of deterioration or adverse effects” (p. 329).

**Towards understanding iatrogenesis.** Merton’s (1936) theory of unintended
consequences suggests that what is desirable to the person or ‘insider’ within the context, for example research or psychotherapy, “may seem axiologically negative to an outside observer” (p. 895). Merton (1936) also suggests that consideration of the ‘insider’ position underpins ethically-based social action. The studies presented thus far in this literature review, whether quantitative or qualitative, seem to be epistemologically influenced by the perspective of the ‘outsider’. This is to say that each of the studies thus far has applied Western-centric socio-cultural constructs such as personality disorders, and the deterioration of symptoms or internal states, to explain the other.

Merton’s (2016) concept of latent functions could extend research towards the analytic aspects of subjective experiences of iatrogenesis that promise the most therapeutic development for a given modality or discipline. Within mental health care generally and psychotherapy specifically, a shift of emphasis towards a qualitative discourse of the lived experience (Smith, 2017) of unintended harm, could extend the literature on this important topic. Qualitative research could also inform clinical practice, and so link back to theoretical developments. This, in turn, could shape research and feedback virtuously into clinical practice and so forth.

**Therapists in the Role of Client Talking About Harmful Therapy**

Bowie, McLeod, and McLeod’s (2016) title captures the essence of their research, “It was almost like the opposite of what I needed.” The authors’ review of the literature reported that little research exists regarding what clients consider to be unhelpful therapy. To address the qualitative gap in the literature regarding iatrogenesis, Bowie et al. (2016) conducted semi-structured interviews with 10 therapists (nine females, one male), who reported on their perspectives of what was unhelpful in their own personal therapy. The therapy occurred 1-12 years previously. Transcripts were analysed using Interpretative Phenomenological Analysis (IPA: Smith, 2015; Smith et al., 2009). The findings reported three superordinate themes: difficult encounters characterised by an absence of negotiation,
collaboration and care; the pivotal moment the client knew s/he would not be returning to therapy; and ongoing negative effects. Ongoing negative effects are “a lasting and negative experience directly attributable to therapy” (Strupp et al., 1977, p. 53), which is the definition of iatrogenesis applied in this review of the literature, and throughout this thesis.

Additionally, Bowie et al. (2016) reported that some therapists have reported negative outcomes in more than half of their clients (Kraus, Castonguay, Bowswell, Nordberg, & Hayes, 2011; Okiishi, Lambert, Nielsen, & Ogles, 2003). Otherwise stated, IAPT reports a successful outcome in less than half of its patients (Clarke, 2016). Whichever way this is stated, addressing this apparent deficit of care is the aim of EBP outcome measurement studies, and particularly those that seek to understand the therapist’s contribution to the process of iatrogenesis (Bystedt et al., 2014; Flor, 2016; O’Hara et al., 2011; Parker et al., 2013). Bowie et al. (2016) also noted that sometimes clients can find it difficult to express dissatisfaction to their therapists (Symons, Reeves, & Wheeler, 2011). The conclusion of this study is for training and strategies to support therapists and clients who feel harmed by therapy. This is consistent with the findings of other studies (Cox, 2014; Flor, 2016).

Most of Bowie et al.’s (2016) participants stayed in therapy for some time after feeling harmed. This suggests interestingly, that the therapists may have failed to identify difficulties before the client ended, or that the client stayed hoping the therapist might work with an interpersonal problem. The EBP trend towards outcome measures seeks to allow clients to record their concerns through outcome measurement forms, so that the therapist can adjust the therapy. Yet there seem to be several fundamental issues with this general use of EBP. It is assumed that the therapist is capable of weekly inter-session change, which may be difficult if there is an inflexible worldview. Also, rigid adherence to a theoretical model has been reported as one issue (Cox, 2014), while rigidly reported gender roles and rigid ethnocentric views offer other examples (Semlyen et al., 2016). This
suggests that some EBP practices may be flawed.

**Limitations and strengths.** While we know, ‘It was almost like the opposite of what I needed’, we do not know what was needed (Cox & Brown, 2014). Bowie et al. (2016) reported participants felt hindered when thinking of complaining. This suggests two things: the level of dissatisfaction and so potential unintended harm may be higher than the generally accepted 10% level; and the increasing level of formal complaints is unlikely to represent the full picture (Health & Care Professions Council, 2016; O’Dowd, 2017). I hope that linking Bowie et al.’s (2016) innovative research to the wider literature will serve their work, and enhance this literature review of this complex topic.

**Towards understanding iatrogenesis.** While expanding upon what, from the therapists’ experiences in their own personal therapy was not needed, the development of understanding iatrogenesis merits an exploration of what is needed. Merton’s (2016) theoretical grounding for this thesis considers, “[i]t is precisely the latent functions or beliefs which are not common knowledge which promise most theoretic development” of a topic (emphasis original; p. 81). Bowie et al. (2016) chose to select participants with professional knowledge yet who were also clients. This means the research focused on one aspect or potential source of data. It was also limited by the 90/10% female-male cisgender sample, which could hide aspects of harm experienced by either, and or other gender identities. This seems important as stigmatisation and marginalisation have been sub-themes weaving through many of the presented studies. Curiously, other participant sample choices were available, such as the therapists reporting on their experiences of receiving psychotherapy, or perceptions of delivering psychotherapy experienced as iatrogenic.

From their theoretical perspective and to understand the causal mechanisms of iatrogenesis, Boisvert and Faust (2002) suggest a way forward: “therapists may be able to reduce the level or impact of negative effects through re-examining some of the more fundamental aspects of the therapeutic relationship, and reconsidering some of the tacit
assumptions within the professional belief system” (p. 256). This could be operationalised through a sample of professionals in the role of client, who have dual experiences and therefore knowledge, of what happens in the therapeutic space. Since participants cannot ethically be placed into a context where they would experience harm (BPS, 2014), this approach could ethically access their ‘insider’ and ‘outsider’ experiences around the topic (Merton, 1972). Further, this could also support the development of knowledge which could inform both future research and clinical praxis, by uncovering potential themes obscured within a qualitative data set (Braun & Clarke, 2006). The manifest and especially the latent functions of purposive actions could then be extracted from the data for analysis, and any findings applied to help open Pandora’s box and extend our understanding of unintended harm within the consultation room.

**Research Approach 3: A Mixed-model Perspective**

**The Adverse Effects of Psychological Therapies**

How EBP and Iatrogenesis Research Drives Publicly Funded Healthcare

The Adverse Effects of Psychological Therapies (AdEPT: O’Hara et al., 2011), is a mixed-methods prospective study which expects to report in 2017. Publicly funded by the government’s Research for Patient Benefit, AdEPT (O’Hara et al., 2011) the study considers iatrogenesis is an under-researched area with “lots of conjecture but few good empirical studies” (para. 1). AdEPT is the first study known to the writer that distinguishes between the terms ‘deterioration’, ‘harm’, ‘adverse events’ and ‘adverse effects’. AdEPT has two key aims: firstly, to understand the risk of harm caused by therapy, and to determine what causes negative outcomes. AdEPT intends also to utilise its data to meet the second aim, which is to develop quantitative outcome measurement and monitoring tools for clients and therapists, to complete to prevent harm.

The AdEPT project, which is arguably the UK’s most comprehensive to date
regarding the topic of iatrogenesis, is employing a range of research methods to synthesise the data of linked studies. The study’s design has four stages: a literature review of the existing evidence to assess prevalence; an analysis of routine data and a meta-analysis of previous trials to understand what types of people, and with what types of therapists, are most likely to experience adverse effects; qualitative interviews with clients and therapists to understand the experience of adverse effects to inform what might have prevented the problems; and the application of the developed tools to monitor therapy outcomes and so reduce adverse effects. The qualitative experiences of therapists and clients of failed therapy will be analysed to create a hierarchical linear modelling to understand the relationships in the hierarchical data structure (a hierarchy of science for the data, and innovatively an equal exploration of the client’s experience and therapist’s experience within the therapeutic context). AdEPT also intends to apply the research to implement programmes to address the issues of adverse effects and negative outcomes.

Unusually for the research of iatrogenesis and highly relevant, dropout rates will be collected and analysed. Additionally, data from RCT’s with a no-treatment control group will be analysed to investigate risk levels of harm (Duggan et al., 2014). Of the multiple research strands, a quantitative analysis of existing data sets is expected to determine what kind of therapists and therapies are most likely to experience or engender negative effects. In contrast to Bystedt et al.’s (2014) TA of survey data, AdEPT will utilise TA (Braun & Clarke, 2006) to conduct qualitative in-depth interviews with clients and therapists. Braun and Clarke’s (2006) method is applied to studies that seek to identify, analyse and report wider patterns within the data set.

Parry (2015) presented headline results ahead of AdEPT’s full study report. Eighteen themes have been identified from the survey of therapists, which include client factors, service parameters, therapist competence and difficulties within the therapeutic relationship. These themes are similar to the categorical data reported in the previously
reviewed papers. The significance of the AdEPT study is that deterioration ranged from .24% to 15.8%. The dropout rate ranged from 0% to 71.2%. One may sense the Holy Grail of psychotherapy, which is to identify the therapists who produce deterioration rates of .24% with 0% dropouts, and to understand how they practice.

However, while this approach speaks to the potential for alleviating lasting and negative experiences “directly attributable to therapy” (Strupp et al., 1977, p. 53), it does not seem to consider the mechanisms of change, or the impact of drawbacks beyond the consultation room. This seems relevant because Parry (2015) further reported the meta-analysis found no evidence of a systemic deterioration between the treatment groups and the control groups. This seems surprising given that Strupp et al.’s (1977) study and Clarke’s (2016) IAPT data noted significant treatment and control group differences. When the full AdEPT study is published these competing views, both positioned at the cutting edge of public healthcare provision, will be interesting to compare to the studies presented in this review.

Limitations and strengths. Overall, this review is concerned at the continued and widespread use of the term ‘deterioration’ by AdEPT, and across the debate. AdEPT states the term deterioration is applied to assess, ‘one or more specific statistically reliable and clinically significant items of feedback from the client’ (Supporting Safe Therapy, 2016). Yet the statistical data in Ladwig et al. (2014) and Parker et al. (2013) seems unreliable. This was particularly evident as the clients’ qualitative lived-experiences were omitted from the research, which could have acted to counter any gaps in the quantitative data.

Further, AdEPT states that reports of deterioration may not mean deterioration due to the therapy, because the client may have been on a deterioration trajectory without therapy. This raises the same question I posed regarding Parker et al.’s (2013) paper; using that line of argument, therapy itself is arguably at risk of becoming an adverse event for a significant minority of clients. There seem also to be ethical and moral questions (Merton,
do therapists exclude from therapy clients who may objectively deteriorate, such as in short-term CBT that is guided by the common dataset measures of outcome?

Additionally, we can question, by whose criteria are therapists to decide what is deemed good or poor health?

**Towards understanding iatrogenesis.** Allen-Scott et al.’s (2014) scoping review of unintended harm associated with public health interventions, aimed to develop typologies of unintended harm and outcomes. The aims were to describe the potential underlying factors of well-meaning yet harmful actions, and to inform a future systematic synthesis of research, theory development, evaluation and study framework refinement. However, “the measures that show change and no change within a study are not necessarily the same measures that show these effects between or among the studies of the same treatment” (emphasis original; Lilienfeld et al., 2014, p, 148). In addition, this review has considered whether the results of EBTs can be generalised from controlled research to clinical practice (Lilienfeld et al., 2014).

The synthesis of research, theory and practice seems superficially achievable through AdEPT’s methodology. However, AdEPT aims to produce outcome measures to limit or reduce iatrogenic practices, which risks shifting the focus away from the client and towards service delivery. Yet Clarke (2016), an architect of IAPT, which is one of the world’s largest psychotherapy public health care programmes, reports IAPT’s own data that shows the programme is not working for most clients (Clarke, 2016). IAPT’s data introduces some interesting ethical and moral dilemmas; if 52% of clients do not benefit from therapy, is it ethical to continue treating the other 48% with the same mechanistic intervention? Could this type of service provision be engendering harm to the remaining majority, and which groups comprise this majority whose treatment seems unsatisfactory?

As a society, what ideological or political choices drive how we spend national funds? Is the delivery of therapy shaped by clinicians or politicians with an ideological
agenda? Finally, is IAPT one mechanism that inadvertently introduces stigmatisation or even extends the stigmatisation of an identifiable marginalised social group? It seems therapy risks becoming a method of social control through the mechanism of blaming the individual for socially constructed issues. These are questions that I suggest the field of therapy needs to consider, and will be discussed elsewhere.

Counselling psychology’s training develops scientist-practitioners who can dialogue across paradigms and modalities. Counselling psychology training also develops reflexive practitioners who are sensitive to ethical, moral and social dilemmas. This means a core skill within the field of counselling psychology is the ability to bridge perceived differences or socially constructed boundaries. The public service delivery of psychotherapy described in this review’s introduction as mostly composed of shorter-term CBT, is set to expand (NHS, 2016b). CBT was the principle category of therapy delivered in the quantitative papers above, which appear to have omitted consideration of how researchers or psychotherapists may encourage clients to accept a, “new system of viewing their behaviour and so change their relationship to the experience” (Lilienfeld et al., 2014, p. 247). This is the adaptation process that Merton (1936) cited as a latent function of unintended consequences. For the field of therapy to develop, these latent mechanisms of change, whether perceived as positive, negative or otherwise, seem to merit investigation.

One way forward parallels the structure of this literature review. To deepen our understanding of iatrogenesis, quantitative research can explore which clients, psychotherapists, treatment modalities and situational factors correlate with negative outcomes. From this data, qualitative research could then hone in on the specific areas of research that promise potential ways to explore iatrogenesis, and bridge the research-practice gap in a focused and meaningful way. This is where qualitative research, such as exploring the client’s experiences of receiving therapy with unintended consequences, or
the psychotherapists experience of delivering therapy that leads to unintended consequences, could move the topic forward.

**Valuing all the Discourses**

Wendt, Gone, and Nagata (2015) approach the topic of iatrogenesis from a unique angle. These authors consider the scope or epistemological positions of the quantitative and qualitative discourses, from a normative conception of proper functioning to a personal sense of harm. Wendt et al. (2015) suggest that lowering the evidence bar is one way forward to explore iatrogenesis. However, this would seem to apply to quantitative research only, because if applied to qualitative research it would risk discounting personal experience. I suggest that each discourse adds value to the other. The benefit of ideographic research is its ability to access experiences that are quantitatively difficult to measure. Qualitative discourses offer a way for quantitative studies to fine tune their research designs and analyses. In turn, quantitative studies can also guide qualitative studies towards salient areas of interest that merit in depth analysis. This accords with Wendt et al.’s (2015) aim to bring these seemingly disparate discourses into a larger conversation for each to dialogue with, and benefit from, the other. This suggestion represents the essence of counselling psychology’s philosophy, which is to value the voice of the other and create the dialogue for health professionals to work together in the interests of those we seek to serve (Tribe & Morrissey, 2015).

**Is Unintended Harm the Last Taboo of Counselling Psychology?**

Counselling psychology’s reflexive humanistic training offers a way to balance the tensions between psychotherapy’s shift towards objective assessments with the client’s unique subjective experiences. I suggest that research and therapy need to be viewed within the context of economic, political and social factors (Larsson, Brooks, & Loewenthal, 2012). This wider perspective is something that all the papers omitted to consider, and what counselling psychologists are trained to consider. Further, counselling
psychology was founded upon principles which are enshrined in social justice, to protect the historically disempowered (van Scoyoc, 2004). With a keen regard for exploring a niche topic, counselling psychology has the openness and skills to explore research areas that other psychologists may find less interesting, or too problematic.

Therefore, it seems surprising that counselling psychology has yet to engage with the topic. For instance, any reference to the term iatrogenesis or its synonyms is either absent from key counselling psychology training handbooks, or only indirectly mentioned (Brown & Lent, 2016; Douglas, Woolfe, Strawbridge, Kasket, & Galbraith, 2016; Vossler & Möller, 2014). As counselling psychology trains professionals to work with philosophical and epistemological dilemmas, and to integrate field theory with practice and research, I suggest that counselling psychology is well-positioned to apply its multiple strengths to explore this complex topic. The essence of counselling psychology’s competence to ‘strive to do no harm’ (BPS, 2015, p. 24), offers the flexibility and a way forward to open the debate, and to dialogue in the service of all.

Recommendations

From their medical-model perspective, Nutt and Shape (2008) are highly critical of psychotherapy research for its failure to explore the phenomenon and characteristics of negative effects. The APA (2006) states that, “[c]linical experience can be placed on the same level as research data” (p. 272), and so can serve to identify marginalised sub-groups more prone to experience harm by attending psychotherapy. One way to reduce potential marginalisation is the use of moderators in meta-analyses. The identification of relevant moderators enables researchers to partial out heterogeneous groups into narrower subsets of individuals (Lilienfeld et al., 2014). This could then be applied to confirm which subsets would be most likely to respond to a given intervention.

However, Merton’s theory (1936, 1968, 1972, 2016) consistently advises us to be aware of the drawbacks or unintended consequences of purposive actions, which includes
research choice points. Data from moderators within psychotherapy research that do not also explore the client’s perspective of the impact of the moderators, risk an unintended research outcome. For instance, a “variable may moderate treatment, but that does not necessarily mean that some individuals (those on the ‘unfortunate’ side of the moderator) ... will respond poorly to treatment” (Lilienfeld et al., 2014, p. 153). The reverse position may be equally accurate. To link theory, research and practice we need to know how a variable or experience can significantly influence an outcome. This is particularly relevant to any hidden or marginalised groups within a data set or wider society, and justifies the use of qualitative research (Meyer, 2003).

The identification of psychotherapy treatment moderators for specific client characteristics could also be applied to identify subsets of individuals who did not respond well to their therapy, and then apply a qualitative research approach to uncover any obscured patterns in the data. Also, categorical moderators could be applied to compare the mean effect sizes of studies concerning iatrogenesis in journals for psychiatrists, clinical psychologists, counselling psychologists, counsellors and psychotherapists. The current UK trend is towards the publication of papers researching iatrogenesis in The British Journal of Psychiatry (Bhui, 2017; Crawford et al., 2016; Parry et al., 2016). An analysis might reveal any patterns regarding this trend. This could potentially identify very specific gaps in the literature and so enable mental health professionals to combine their skills. However, I suggest caution regarding moderators to guide research or intervention. Merton (1936) alerts us that data from moderators could also be purposively misapplied, which I here translate to mean targeting the treatment of the majority at the expense of a minority or vice versa. This concern seems well-founded given the IAPT outcome data.

Practice needs to be informed by evidence, not be directed by perceived evidence (Bohart & Tallman, 1999). The topic of iatrogenesis can be advanced by arguing that the objective data is unreliable without the complimentary data regarding subjective
experience. This seems a sensible proposition because leaders in the field of research into the complex topic of iatrogenesis have commented that while outcome studies do reveal statistically negative effects, which are obscured in the outcome variance, typically they are not reported (Dishion, McCord, & Poulin, 1999; Mohr, 1995). This points this review towards Lilienfeld et al.’s (2014) view that while “EBP essentially relies upon nomothetic findings, the task of the therapist is necessarily ideographic” (p. 891).

While the topic of iatrogenesis has been debated for several decades there remains no consensus over what may engender negative effects, the mechanisms of perceived harm, or even if negative effects exist other than in the eye of the beholder (Strupp & Hadley, 1977). This review recommends an increase in qualitative studies to explore negative experiences from the insider’s (client’s) perspective (Lilienfeld, 2017; Merton, 2016; Smith, 2017). This review also recommends research to synthesise the research paradigms. Boisvert and Faust (2006) showed the power of this by simply reaching out to participants to significantly increase their sample size, and so the transferability of their results. A further recommendation is to explore latent functions through qualitative research of the ‘outsiders view’ within the clinical context (Merton, 2016), which is to say the therapist. Professionally trained therapists who may also in another context be a client, could offer a dual focus upon the topic of iatrogenic practices within psychotherapy. This is a relatively unexplored potential pathway towards expanding our understanding of iatrogenesis.

**Conclusion**

The concept of unintended consequences (Merton, 1936, 2016) or adverse effects related to psychological interventions seems to be an unfamiliar and vague concept to many practitioners. While practitioners are committed to high moral and ethical standards, there is a risk that adverse effects in therapy often go unnoticed. Merton’s (1936) theory of unintended consequences explains this phenomenon through the concepts of drawbacks
and paradoxical outcomes. Developing and implementing concepts that cover different aspects of these phenomena could facilitate a much-needed inter-disciplinary dialogue. Research suggests that around 10% of all patients fare worse post-therapy, which indicates that unintended harm is not particularly uncommon. However, there is strong evidence to suggest the figure is higher. There is also strong evidence to suggest that some groups are at greater risk of poor healthcare. As psychotherapists’ intentionality is towards well-being, there seem to be manifest functions and latent functions underpinning the practice of healthcare professionals (Merton, 2016). The most underutilised sources of data are also the sources that could provide the richest data; the client receiving therapy, the psychotherapist delivering therapy, or a combination of both roles to render a dual perspective on what happens when two people meet in the consultation room and unintended consequences occur. The feedback to researchers in the reviewed papers suggests that clients are expressing their concerns and experiences. Therefore, it seems it is not only the clients who need to engage with the taboo topic of unintended harm, but also the professionals.

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RESEARCH REPORT 1

“I was Left Feeling she Hadn’t Included me in the Analysis”:
An Interpretative Phenomenological Analysis

Abstract

The benefits of psychotherapy are well-known but evidence suggests that up to 40% of therapists experience their therapy as harmful (iatrogenesis). Theoretically underpinned by Merton’s Unanticipated consequences of purposive social action, this paper applied a qualitative, phenomenological approach to explore the underexplored and underreported topic of unintended harm within therapy. The approach helped explicate mechanisms of change that can produce change in any direction of effect. Semi-structured interviews were conducted with four participants, all qualified psychotherapists, who reported their experiences in their personal psychotherapy sessions. The data was analysed using Interpretative Phenomenological Analysis (IPA). The findings yielded three master themes: Competing world views: clashing epistemologies; How and by whom is therapy constructed?; and Making sense of an experience. Important aspects to emerge questioned how clients manage, or not, to move on from therapeutic ruptures, and the dilemma of whether negative experiences are harmful. Findings are examined in relation to past literature, and limitations of the theoretical assumptions and potential philosophical inconsistencies underpinning IPA. The philosophical implication of is harm harmful? and the implications for clinical practice are drawn. Recommendations for training and education are discussed.

Keywords: Iatrogenesis, interpretative phenomenological analysis, “do no harm,” unintended consequences, “insider” & “outsider,” Merton

The potential benefits to mental health through the impact of psychotherapy are generally well-known and have been well-evidenced (Roth & Fonagy, 2013; Galbraith,
Psychotherapy creates a safe space where people can gain a better understanding of themselves in relation to others and the world, achieve personal growth and explore how past experiences may shape actions and feelings in the present. A core benefit of psychotherapy is the opportunity for a non-judgemental, warm and empathic therapeutic relationship where clients can feel heard, respected and validated (Cooper, 2008; Douglas, Woolfe, Strawbridge, Kasket, & Galbraith, 2016). Additionally, the supportive conditions of psychotherapy can engender a sense of becoming a fuller self (O’Hara, 2014), and developing a life purpose as well as meaning-making (Heidegger, 1985). However, within the therapeutic context, dilemmas can arise. When dilemmas remain unrecognised or unexplored, psychotherapy sometimes produces the opposite of its intended aims (Lilienfeld, Ritschel, Lynn, Cautin, & Latzman, 2014; Vossler & Möller, 2015). The topic of unintended harm, also known as iatrogenesis, is the topic of this research.

**Etymology of Iatrogenesis**

In antiquity, Iatros the Healer (460-399 BC) was the cutting-edge practitioner of his era. He would bleed patients, sometimes to death, which in itself created a double-bind; if the patient became well, Iatros was credited with professional knowledge, and if the patient died they were too ill to recover. From within that scientist-practitioner frame, there was no room for the consideration of unintended harm caused by the well-meaning practitioner. 2,500 years later it seems the field of psychotherapy has yet to engage with and explore, the impact of unintended harm, and that the same double-bind may still be evident in some cases or approaches today. After all, the mind is a powerful tool and there is an inherent power dynamic within any relationship, but particularly with regard to a patient or client in relation to a person with an acknowledged greater degree of training, insight and skill.

The term iatrogenesis or practitioner-caused harm came from other disciplines, namely medicine and education, and I considered it an appropriate term to develop and transfer into the field of psychotherapy. I became aware that the concept of harm is very...
broad and did not elucidate what I was aiming for, which was to talk about unintended harm within psychotherapy. For the purposes of my research, I sought to develop a clearer definition to help explore how psychotherapists can sometimes engender unintended harm even when they mean well. Also, when I began to research this topic I had a somewhat unformulated idea that iatrogenesis might be connected to the marginalisation of specific groups of people who seek help from psychotherapists. This led me to investigate how best to apply a term that is not confined to any one helping profession. I had also in mind that the research of unintended harm can be applied within the many schools of psychotherapy, and across disciplines.

**My Personal Relationship to the Topic**

My personal relationship to the topic of iatrogenesis began with an overlap of professional and personal experiences of therapy. My interest in the topic began decades ago, first as a marginalised ‘expert by experience’, followed by my entry into professional training. 20 years ago, when working in Primary Care, I heard physicians speak of white coat iatrogenesis, where the act of taking a patient’s blood pressure inadvertently raised their blood pressure level. Three points struck me: firstly, the physicians could simply retake the pressure level and move on with the consultation, while for therapists once an action was taken or perspective voiced, it was ‘in the room’; secondly, once in the room it became part of the relational dynamic, which influenced the shape of the therapeutic relationship.

How the dynamic was worked with, or not, could impact or even define the therapy. Thirdly, over my 25 years of training and practice, I have rarely heard psychotherapists openly talk of this issue. I also began to consider how it could be possible for health professionals to hold a certain philosophical or professional position, then act in ways contrary to that position. I noticed how medics were encouraged to address the issue of practices that cause unintentional harm while trainees and professionals within the field
of psychotherapy, a profession based on openness and exploration, seemed to avoid the topic. This made me wonder about iatrogenesis as a taboo topic within psychotherapy (Pope, Sonne, & Greene, 2006). It also made me wonder what psychotherapy could bring to the topic.

**Previous Research of the Topic**

**Previous research from the client perspective.** The studies presented in this thesis are intended to extend research conducted in my previous university. I explored previously the issue of unintended harm from the perspective of the client. My thinking at that time related to my past professional experiences as a counsellor in primary care and my experiences as a client. From these roles, I conducted research titled, *The experiences of day-centre attendees: An interpretive phenomenological analysis* (Cox, 2010). In the small (*n* = 3) interpretive phenomenological analysis (IPA: Smith, Flowers, & Larkin, 2009), the client-participants were young men (age range 19-24) years. The participants were court-ordered to attend therapy. From the IPA research three master themes emerged: The impact of previous experiences of poor healthcare upon the initial therapy sessions (in their mandated current healthcare programme); The paradox of whether mandated healthcare can engender improved health care; and Can the therapist ‘take’ the clients’ anger.

The findings reported that all the clients began therapy with feelings of suspicion and that to their surprise, ‘forced attendance’ of therapy as a bail condition could be a beneficial experience. The findings also reported one key factor; the practitioner had to pass the ‘test’ of an angry client who felt forced to attend therapy, in order for both to meet as equals in the therapeutic space. The convergence of helpful therapy and the divergence where therapy had been experienced as unhelpful emerged as the higher order convergence of helpful therapy. This seemed to pivot on one key element; could the practitioner and client work together so that the client could let the practitioner make mistakes without
either retaliating by terminating the sessions. This suggests the quality of the therapeutic relationship was paramount for these day-centre attendees to experience therapy as beneficial. This suggested also the direction of future research.

This thesis’ literature review and the previous research described above (Cox, 2010), provided the rationale for the design of the two empirical studies that complete this thesis. Each of the three studies which form this research explore a different aspect of iatrogenesis. This is intended to support an exploration of unintended harm from various epistemological and methodological positions, and different analytical perspectives.

Having explored the topic of iatrogenesis form the clients perspective, I considered the other person in the consultation room with the client; the practitioner. The practitioner holds multiple perspectives such as being a client in their own psychotherapy, or a professional delivering psychotherapy. These perspectives, in addition to the previous clients-oriented perspectives, were considered suitable to give a multi-perspective overview of the phenomenon of iatrogenesis, and also insights into the phenomenon of iatrogenesis.

Study 1 applied IPA’s methodology to narrow the scope of the data collection to one specific group of practitioners with a distinct professional identity. The counselling psychologists (n = 4), reported on their experiences within their personal therapy. Study 2 applied Thematic Analysis’ method to broaden the scope of the data collection to several groups of practitioners. The rationale for the thesis was to capture the diversity within the experience of the phenomenon of iatrogenesis by exploring the topic from multiple perspectives. The intention was that one identity group might contribute a new understanding to the debate around iatrogenesis and the wider literature, thereby improving the fidelity of the thesis. However, several identity groups might contribute new understandings at a broader level of analysis and potentially healthcare policy. Combined, the designs of Study 1 and Study 2 were intended to develop findings that would address
different types and levels of diversity within the experience of the phenomenon of iatrogenesis. Each part would thereby add to the whole in relation to the topic.

**My Understanding of the Topic**

When I first began to explore the topic of iatrogenesis, I sought to explore the experiences of clients without professional experience of therapy, who reported feeling harmed by attending therapy. However, as my understanding of the topic developed, my rationale changed regarding further research of clients who were not simultaneously psychotherapy practitioners. My rationale was to extend my previous study (Cox, 2010) with clients who had no experience of being psychotherapy practitioners. I decided to explore the topic from a wider angle than clients without professorial experience of therapy. The meant considering the other person in the room; the practitioner. This decision meant recruiting practitioners who were either receiving therapy or providing therapy.

My development was to link the literature review in this thesis with ethical practice, and to appreciate that an essential aspect of ethics is to safeguard clients (Bond, 2015). The almost year-on-year upward trend in complaints across all the professional registration bodies led me to consider the role of the practitioner in the therapy room. I was curious to understand what was happening in the growing gap between reported perceived harm by people in the role of client, with the ethical responsibility of the practitioner. I decided therefore to interview psychotherapy practitioners in their personal therapy (Study 1). This was based upon the assumption that practitioners would have knowledge and a skill set (Merton, 1972) unavailable to non-professional clients. The limitations of the decision to recruit practitioners, and particularly counselling psychologists as participants, is set out in the limitations section.

Also, on further reflection I made a reflexively informed decision that further exploring the experiences of clients without professional experience of therapy, was likely
due to my over-identification with the client role. When I reflected still further, I came to the conclusion that my choice felt too close to the issue. Being true to myself from my humanistic perspective, it feels important to recognise that I and “[w]e are the bad therapists too. If there is someone who says he has never done bad therapy (whatever that is), then this is someone who is likely to be doing bad therapy (whatever that is)” (Shohet, 2017, p. 70). This reflexive understanding can be further refined to say the issue is not one of a binary good or bad, yet rather the subtle relational ripples or intersubjective effects that occur within all human interactions.

Through personal practice and reflection, I have come to appreciate the nuances of epistemological reflexivity. I concluded there might be serious ethical challenges if speaking with non-professionals as clients about their experiences of therapy perceived as engendering harm. Being a therapist myself, after careful consideration I decided to explore the experiential world of practitioners, and so I selected a research methodology that considers the person (participant, practitioner and client), as a whole rather than split off parts or in a mechanistic individualised way. In terms of being relational, I reached the conclusion that it was most appropriate to use a methodology which facilitated exploring my research question in its social context. I concluded also the value of designing the research question to relate personally with the topic, and from the perspective of participants with experience of research, clinical practice and being a client. I considered they might proactively engage in the research process of this topic. Interpretative Phenomenology Analysis’ epistemology (IPA: Smith, Flowers, & Larkin, 2009), which gives voice to multiple forms of knowledge, resonated with me. I am drawn to IPA for its ideographic approach because it can be applied to explore a social context and any findings applied at policy level, which speaks to my political interests.

To clarify my position further, personal reflection of my over-identification has translated to working for social change from within a socio-political system, rather than
throwing critical stones from outside it. In short, while I identify strongly with Bond (2015) that an essential aspect of ethics is to safeguard clients from harm due to attending therapy, I came to realise that I could now be of more use to all the stakeholders in therapy by exploring iatrogenesis through the eyes and broad experiences of a professional rather than a potentially narrower client perspective. To achieve this, I needed professionals who were willing and able to explore questions that members of the public may have but, at the same time, may not have the means or the ability to openly address. In essence, I believe that to support therapists is to support clients is to support therapists.

Also, I wonder if the thesis’ topic could be interpreted to imply that I blame therapists for causing or being directly implicated in all forms of unintended harm. For transparency, I suggest that to focus on therapists, their experiences of receiving therapy, plus their professional experiences of delivering therapy, seems a reasonable approach to explore a complex and under-explored aspect of clinical work. The most salient aspects of therapy, which therapists will be aware of and clients may not be, include creating a safe environment for the therapy, holding the safe space, transparency, the ability to work relationally which means we bring ourselves to the work, and a commitment to practice therapy within a professional code of ethics.

Finding a definitive and all-encompassing understanding of iatrogenesis is problematic. Firstly, the word iatrogenesis, that which is brought forth by the practitioner, starts from a relatively narrow and clinically defined medical base. This limits alternative perspectives such as ‘transference field’, and the influence it may have upon communication among therapists (Ehrlich, Zilbach, & Solomon, 1996). While including unintended harm engendered by the well-meaning practitioner, my definition excludes ‘complex intersubjectivity’, which is often applied in psychoanalysis. The term describes “the complex field that is created when ... unique subjectivities come together” (Buirski & Haglund, 2001, p. 4). I excluded it because this would require an exploration or
understanding of what is in the other’s mind (‘theorytheory’ or ‘mindblindness’: Baron-Cohen, 1997). Also, I suggest that ‘transference field’ and ‘complex intersubjectivity’ are terms often applied to pathologise people. This runs counter to my personal philosophy, which values transparency, freedom and due regard for those on the margins of society whose voices are seldom heard.

It was not my intention to produce research limited to psychoanalytic or psychodynamic concepts, or any therapeutic modality which could potentially limit the application of any findings. However, that does not preclude incorporating such concepts into the study where they serve a specific purpose, such as offering one of many alternative viewpoints. Also, the participants in their professional roles were situated in different theoretical modalities, and I aimed to give equal consideration to their positions. In this study, my aim was to explore the process of unintended consequences from the perspective that therapists mean well, yet sometimes therapy unravels in perplexing ways. To explore this, I sought a theory that would provide a good fit with the purposive actions of therapists, who are assumed to formulate interventions, and the unintended consequences of those well-meaning interventions.

The fact that I have added unintended harm to the traditional meaning of the term iatrogenesis creates a further problem, and this merits consideration regarding the research question. I have included this aspect into my analysis because I consider it to be vitally important. The intendedness is important to me, and so is the additional consideration that I have included with the traditional definition. Intended harm in the form of malpractice has its own literature (Wendt, Gone, & Nagata, 2015). Unconscious harm, such as the emergence of the therapist’s shadow side (Jung, 1938), the therapist’s reactive countertransference (Clarkson, 2003) and the therapist’s projective identification (Klein, 1946), are encompassed within literature that speaks specifically to such unconscious actions or interventions. Therapists working through the client to resolve their own issues
also has its own body of literature (Clarkson, 2003). In this study, I sought to explore a novel area that I believe is of interest to the field of psychotherapy, and related disciplines. This relates to the fact that iatrogenesis is an underexplored topic that I suggest is highly relevant to clinical practice.

My use of the term unintended harm could be problematic in that my term introduces a limitation whereby I speak of harm generated by, or beginning from, the therapist in a linear way. If viewed in narrow terms, this could be seen as a limit within the field of psychotherapy, which typically considers relationships to be richly layered. However, there are important actions which can occur within the therapy room that are the responsibility of the therapist. Part of the therapist’s role is to set a safe environment, free of interruptions or intrusions from outside the room, as far as reasonably possible. Examples include people walking in, telephones ringing, computers being turned off, keeping agreed times and managing context parameters. Also, in the private sector there are obligations specific to that setting. In this thesis, I am assuming that therapists are well-intended towards the well-being of their clients.

This means I am open to questions regarding whether I introduced a predisposition that all therapists always mean well. This position may have inadvertently shaped my research question. In response, personally, I would be uncomfortable looking for practitioners who do not mean well towards their clients, whose intention is not well-being. I perceive therapy as a context where even in dynamic or fraught relationships, practitioners mean well towards others; and things can go wrong because we are all human. Difficult relationships and the experiences they can engender, can be transformative in terms of personal development, just as they can also signify that there is something inherently damaging and unhelpful in a relationship.

Within a therapeutic relationship, the ethos is typically to explore or manage such difficulties, and often for both client and therapist to gain insight from such difficulties.
This depends on whether client and therapist can work though the difficulties, however therapists conceptualise them. I feel it would be a big statement to make about therapy, that a significant group of practitioners set out to harm their clients. I do not deny the possibility, yet I do say that is not the research I wished to conduct. Yet as I stated earlier, I have experienced and witnessed therapy that sits at the border of intended-unintended harm, such as someone with narcissistic characteristics facilitating group therapy, or a therapist applying their religious beliefs or sexual mores to others for their own sense of well-being and righteousness.

Therefore, it is important to say that the idea of unintended harm has come also from the participants themselves, and that my experiences made me sensitive to notice this important distinction. It is my aim to facilitate openness and discussion. The participants in this study came to therapy expecting to be helped. I selected counselling psychologists in the role of clients to help explore the distinction because they are trained to “always consider values and ethics in the work” they undertake (Galbraith, 2017, p. 153). As therapists, I considered they could appreciate ethical dilemmas and subtle relational nuances, such as what may be considered harmful and unethical. To my surprise, what emerged from the data was not what I expected.

My reflexive learning has enabled me to be aware that I sought a sample of professionals to help me explore the research topic, and to be aware of including my own sensitivity to what forms a harmless-to-harmful continuum. We paralleled each other, all expecting therapy to be helpful yet having experienced therapy that at times felt less than helpful; or did it? My research turned into a journey of discovery. Therefore, my personal reflexivity and epistemological reflexivity are clearly stated throughout this study. This is to help readers reflect upon the research process and my findings. How I position myself within the study is stated throughout. This transparency is evident in my decision-making, or at times lack of it, and this is a recurring reference point throughout the study.
Theoretical Grounding

Located within the social sciences, Merton’s (1936) theory of the Unanticipated consequences of purposive social action, explains the problem of the unintended consequences of actions intended to engender social change. While I considered alternative theories such as the development of professional skills (Knapp, 2014), the evolving self in human development (Kegan, 1982) or psychoanalytic theories (Freud, 1899/2017; Klein, 1946), they did not meet the aims of this study. As there seems no clear theory within Counselling Psychology which encompasses the phenomenon of iatrogenesis, I chose Merton’s (1936) sociological theory of unintended consequences. Merton’s (1936, 1968, 1972, 2016) theory underpins this thesis’ exploration of what happens when two people enter the social context of the consultation room. Merton’s (1936) theory and its effects in practice aligns well with psychological research because, “Psychological considerations ... are undoubtedly important for a more complete understanding of the mechanisms involved in the development of unexpected consequences” (p. 896).

Merton’s (1936) theory groups unintended consequences into three types: an unexpected benefit such as a positive therapeutic outcome; an unexpected ‘drawback’ defined as an unintended consequence from the desired effect of an action; and a perverse result, which is here termed paradoxical, to what was intended. This study draws particularly upon Merton’s (1936) notion of drawbacks and paradoxical outcomes. Merton (2016) also considered that unless the meanings of unintended consequences are explored, their impact may remain unrecognised and so unconsciously function to mask their underlying meaning. The concept of drawbacks and the concept of paradoxical outcomes both help to explicate the topic of unintended harm within the context of psychotherapy.

Merton’s (1936) sociological theory was the only conceptual frame I found that distinguished between the drawbacks of actions that could be good, negative or simply a surprise, from paradoxical outcomes, which are opposite to the expected outcome. Also, I
sought a theory that could distinguish between intended and unintended harm. Further, the developments in Merton’s theory (1968, 1972) afforded exploration of a space in-between intended and unintended harm, where a therapist might be applying an intervention whereby the client feels harmed, yet that is so subtle that it would be difficult to detect as a prohibited behaviour. I would be surprised if any practitioner could claim to have not occupied the space in-between at some point in their personal experiences or professional career. I own I am not sure if I have currently the ability to be neutral, which reflexively speaks to my heart felt interest in doing this research, and my genuine concern for the well-being of clients, as well as my need to self-care in exploring intended or unintended harm that emerges in therapy sessions.

Of relevance to the research and practice of psychotherapy is Merton’s (1936) view that what is desirable to the actor inside the context, “may seem axiologically negative to an outside observer” (p. 895). Merton’s (1972) theory developed to incorporate insider-outsider theory, which in this thesis translates as ‘insider’ (client) and ‘outsider’ (therapist) doctrines, or positions. When the client and therapist examine the same problem, they may “not deal with the same questions [and concerns] and so will simply talk past one another” (Merton, 1972, p. 16). The implication of this for psychotherapy research and practice is that competing insider or outsider “epistemological doctrines are apparently not nearly so obvious” as therapists might believe (Merton, 1972, p. 22). A mutual understanding between the therapist and client of each other’s roles, and what the therapy is for, seems integral to a healthy therapeutic relationship. Therefore, accessing ‘insider’ and ‘outsider’ perspectives of the therapeutic experience offers a novel pathway to explore the phenomenon of iatrogenesis.

**Conceptual Definition of Iatrogenesis**

Definitions of the phenomenon of iatrogenesis and how the topic is approached vary greatly, and this impacted upon research choices and findings. For example, some
quantitative research has reported client experiences of unintended harm within sessions (Bystedt, Rozental, Andersson, Boettcher, & Carlbring, 2014; Parker, Fletcher, Berk, & Paterson, 2013). Yet, within sessions it is likely that clients may experience increased distress precisely because problems are discussed (Boisvert & Faust, 2002). What happens within psychotherapy sessions, or once therapy is completed, may also impact upon others in the client’s social world. For instance, a client may gain the confidence to become more assertive with a partner, and so change the dynamics of the relationship, leading the partner to feel harmed (Lilienfeld, 2007).

Therefore, in this study a suitable definition of harm is, “a negative effect [that] must be relatively lasting, which excludes from consideration transient effects ... [such as in session anxiety or between session sadness, and] must be directly attributable to, or a function of, the character or quality of the therapeutic experience or intervention” (Strupp, Hadley, & Gomes-Schwartz, 1977, pp. 91-92). While I recognise that this definition gives primacy to the client’s subjective evaluation of their therapy over a perceived objective measurement, or the views of others, this is the essence of exploring Husserl’s (2001) ‘back to things themselves’ within the consultation room (p. 168).

The Phenomenon of Iatrogenesis

Any therapy with the capacity to help also holds the potential to harm; we “cannot acknowledge one without the other” (Foulkes, 2010, p. 189). The phenomenon of iatrogenesis is widely recognised within the medical profession (Illich, 1995; Makary & Daniel, 2016). However, it is less recognised in the field of psychotherapy, counselling psychology and clinical psychology. There seems little evidence in the literature that the topic is explored either directly or indirectly in most psychology or counselling psychology training programs. A comprehensive search yielded only one American graduate training (Boisvert, 2013) and one e-training (Lambert, 2013) programme specifically exploring the phenomenon of iatrogenesis. Internationally, and including within the UK, the
phenomenon seems hardly included in any teaching module. This extends to core
counselling psychology training materials (Brown & Lent, 2016; Douglas et al., 2016).

International and UK studies evidence that, on average, individuals receiving
psychotherapy are 80% better off post-treatment than untreated individuals (APA;
However, this statistic implies that 20% of clients remain unchanged, or even functionally
deteriorate. Within this 20% group, the literature suggests there is an unseen sub-group.
Irrespective of underlying theoretical approach or the presenting issue, practice setting,
industrialised country or research method, around 10% of clients reportedly experience
psychotherapy as harmful (Barlow, 2010; Boisvert & Faust, 2002; Cox, 2012a, 2012b;
Lilienfeld et al., 2014; Scott & Young, 2016; Strupp et al., 1977).

As psychotherapy tends to explore troubling issues such as anxiety, depression,
interpersonal difficulties and life crises, therapy can increase the experience of difficulties
in the short-term. Such difficulties encompass symptoms worsening, the reporting of new
symptoms and the exacerbation of existing symptoms (Boisvert & Faust, 2003; Lilienfeld,
2007). Here, these are not considered to be intrinsically iatrogenic. It is clear, for example,
that insight-therapies exploring painful issues in the short-term, regard this as an integral
part of the therapeutic process. To avoid confounding within-therapy experiences with
post-therapy experiences, this paper reports on the client’s perceptions of harm reported
post-therapy. Therefore, this study will focus on experiences with participants who have
completed their therapy.

This research is relevant because of the reluctance of psychotherapy to recognise
the phenomenon of unintended harm, which is reflected in the increasing number of
complaints to professional regulatory bodies. For instance, in 2012-13 the Health and Care
Professions Council (HCPC), established to protect the public and regulate professionals,
received 1,653 complaints against its members (.52 of the total membership). Between
2011-12 and 2012-13 complaints against practitioner psychologists increased 30% (HCPC, 2013), which at .75 (of the total membership) is currently higher than other HCPC regulated health professionals (.64 of the total membership). The upward trend is similar for the British Association of Counselling and Psychotherapy (BACP: O’Dowd, 2017), where a finer grained analysis reports that 71% of complaints were made by practising therapists (including trainees) against other therapists (Khele, Symons, & Wheeler, 2008). The number of complaints against United Kingdom Council for Psychotherapy (UKCP) members for 2014-15, rose by 48% (UKCP, 2015). However, UKCP recently changed its data collection methods, which may account for the significant increase.

The relevance of the statistical data seems broadened when categorical data is considered. Pope and Tabachnick’s (1994) quantitative study utilised a large sample size of American health professionals in their personal therapy. These professionals reported the ten most serious categories of harm (excluding malpractice such as sexual or criminal acts) as: incompetence, emotional abusiveness, failure to understand the client, boundary violations, uncaring or self-centred therapists, dogmatic reliance on theory or preconceived notions, a tendency to blame clients and overlooking abuse issues. Macaskill and Macaskill’s (1992) UK study reported that up to 40% of participants experienced some negative effects from their personal therapy. Williams, Coyle, and Lyons’ (1999) large quantitative study of UK chartered counselling psychologists found 27% of participants experienced some negative effects of their personal therapy. A further 17% said some unstated elements of therapy negatively impacted upon their own therapeutic practice. Overall, the lack of empathy, ethical concerns and relationship issues scored highly for harmful effects. Across these two studies, the complaint categories were broadly consistent (Rogers, 2013).

Recognition of the topic of iatrogenesis may sometimes be exacerbated by the different approaches of quantitative and qualitative investigations of research. To address
This issue, this first empirical study in the thesis is contextualised within the current debates between theory, research and clinical practice. Each perspective of the topic may sometimes advocate different epistemological and methodological approaches (Smith, 1996). From the perspective of Merton’s (1972) theory, this extends to the ‘outsider’s view’ (broadly objective quantitative research), or the ‘insider’s view’ (broadly subjective qualitative research), of the phenomenon. The above statistical and categorical data reflects an ‘outsider’s’ realist approach to the investigation of iatrogenesis.

As the above studies are epistemologically positioned within a post-positivist paradigm it seems possible that methodological issues could be responsible for producing such results. Such statistical or categorical results are of value to broaden our understanding of iatrogenesis, and help us see one aspect of the phenomenon at hand. This would suggest that research positioned within a different paradigm might offer an alternative view or aspect, and so potentially deepen our understanding of the topic. One example is that the potentially outsider quantitative research methodology’s use of pre-therapy and post-therapy measures to evaluate the impact of an intervention, tell us relatively little of the insider’s subjective experience of an intervention.

Where psychometric measures are assumed to objectively represent subjective experiences, participants or clients can feel “distal from the daily dilemmas and decision making challenges [of lived experiences, and measures can feel] .... even undermining of the clinical encounter” (Wolpert, 2014, p. 142). Experience, which represents an ‘insider’s view’ is more proximal to an encounter than external measurements, and so can build on the quantitative data to more closely evaluate personalised negative experiences. Consequently, and equally relevant to both paradigms, what is considered to constitute a harmful effect is value-laden and may rest upon unarticulated a priori assumptions (Lilienfeld, 2007). However, judgements of therapy outcome, whether quantitative or qualitative and positive or negative, will depend largely on the perspective of the evaluator,
for instance the client or the therapist (Smith, 1996).

The present qualitative study assumes that building on the existing quantitative research can shift the focus towards subjective accounts regarding experiences of iatrogenesis, and that these accounts can be accessed through a qualitative methodology. This study adopts a qualitative perspective to reflect a growing interest in the topic. Examples of the developing interest include the National Audit of Psychological Therapies (NAPT; Chambers, 2011) and the Adverse Effects of Psychological Therapies project (AdEPT; O’Hara et al., 2011). Both studies utilised the method of Thematic Analysis (TA: Braun & Clarke, 2006), which can be applied to analyse quantitative or qualitative data. However, both NAPT and AdEPT report from a quantitative overview of the data, with the aim of improving the delivery of therapy services. It is here assumed that there remain aspects of adverse effects or unintended consequences (Merton, 1936) that these projects have apparently not considered. One such alternative focus is the lived experience of unintended harm, viewed through the experiences of psychotherapists in the role of clients. From this angle, qualitative studies are appropriate because they afford a finer-grained analysis of a phenomenon.

The mapping of the psychological research literature regarding iatrogenesis is in its infancy (O’Hara et al., 2012). Additionally, iatrogenesis is an under-researched area with “lots of conjecture but few good empirical studies” (O’Hara et al., 2011, para. 1). To formulate a research question and to develop the design study, my intention was for a broad and open research question without any attempt “to test a predetermined hypothesis; rather, the aim was to explore, flexibly and in detail, an area of concern” (Smith & Osborn, 2015, p. 28). Therefore, the research question was not intended to be overtly directive so that the participants could respond to the semi-structured interview questions as they wished.

Within the frame of IPA, an appropriately constructed research question can
capture the specific context and allow the broad-based knowledge from this thesis’
literature review to be contextualised within the social and cultural setting of therapists in
the role of client, and the interactions that take place within the consultation room
(Charlick, Pincombe, McKellar, & Fielder (2016). This has the potential to produce
relevant findings for this study and the wider field of psychotherapy. The aim of this
research question is to set the scene for an explorative and flexible study (Smith, 1999).
Therefore, to add to the emerging body of research this study asks: *What are
psychotherapists’ experiences of therapy when clients?*

**Justification for the Research**

The number of clients reporting experiences of unintended harm from attending
psychotherapy was “once thought to be a relatively small minority” (Strupp et al., 1977, p.
4). However, the literature review presented within this thesis evidences that this small
minority is likely to be a serious underestimate of the prevalence of subtle iatrogenic
influences. The research to date has generally been quantitative, which affords a broad
nomothetic analysis rather than an in-depth ideographic analysis, of the experiences of
people undergoing therapy. The justification for this thesis is to explore the ways in which
therapy perceived as harmful is conceptualised from multiple perspectives, so that the
delivery of therapy may be improved.

The justification for designing this study as I have done, and which is the first of
two empirical studies exploring the topic from different angles, is provided by Kazdin
(2008), who specifically advocates “more extensive use of qualitative research in practice
settings” (p. 764). Within practice settings, the study of mechanisms of change has
received the least attention even though understanding mechanisms of change may well be
the best long-term personal and economic investment for improving clinical practice, and
therefore service delivery and client care (Strupp et al., 1977). While IPA may not
typically explore mechanisms of change, the approach does look into personal experiences
that can shed light upon mechanisms or lived processes, and IPA does seek to influence public health care such as the provision of therapy.

By mechanisms of change, I refer to the processes that explain how therapy works (or does not), which practitioner actions (or the omission of actions) are considered to engender harm, and how therapy can produce change in any direction of effect. Merton (1936) defined the consequences of purposive action as, “those elements in the resulting situation which are exclusively the outcome of the action, i.e. those elements which would not have occurred had the action not taken place” (p. 895). Therefore, this first empirical study justifies the employment of a qualitative approach to enable an in-depth analysis, which focuses on practitioners whilst they occupy two positions in the therapy room. This dual focus of participant-practitioners, firstly as clients undergoing their personal therapy, and secondly as practitioners with specialised knowledge of what professionals consider acceptable processes and actions within therapy, is an under-explored and under-reported area regarding the phenomenon of unintended harm.

**Choice of Method**

To answer the research question, the choice of method needed to be consonant with Merton’s (1936; 1972) theory of unintended consequences, and suitable to access the practitioner in the role of client, which affords an ‘insider’ experience of iatrogenesis. A qualitative methodology is a suitable approach for this purpose. Amongst the family of qualitative methodologies, Interpretative Phenomenological Analysis (IPA: Smith, 1996; Smith et al., 2009) was selected for its theoretical commitment to trying to understand lived experience, and its concern with how people make sense of their perceptions and experiences. IPA is important to qualitative research generally and this study specifically, “because it is explicitly concerned with developing a psychological experiential methodology ... [and can be applied without] being overly influenced by prior psychological theorizing”, and perhaps the researcher’s personal preferences (Smith, 2017,
IPA has a theoretical commitment to ‘the person as a cognitive, linguistic, affective, and physical being. This commitment assumes a chain of connection between a person, their thinking and their emotional state’ (Charlick et al., 2016, p. 210). *Being* (Heidegger, 1962) a therapist myself, selecting a methodology that considers the person (participant, practitioner and client) as a whole rather than as split off parts or conceptualised in an individualised way, resonated with me. IPA is committed to three key areas. Firstly, the phenomenological approach to explore an individual’s personal account of an event or state. Secondly, hermeneutics (the theory of interpretation or textual meaning: Ricoeur, 1970); the hermeneutics of empathy (attempts to describe and reconstruct experience in its own terms), and the hermeneutics of suspicion (a balance between explanation and understanding to validate expressions of a representation). IPA takes the centre-ground with a hermeneutics of questioning, which explores the insider’s perspective, and stands alongside the person to look at an experience from different angles (Smith, 2015).

In this study, I questioned the increase in complaints and the fact that each registration body’s new codes of ethics revealed a phenomenon ready to “shine forth, but detective work is required by the researcher to facilitate the coming forth, and then to make sense of it once it has happened” (Smith et al., 2009, p. 35). I feel it is important to note that IPA applies an ideographic approach. Ideography is concerned with the particular, and operates at two levels: “a thorough and systematic depth of analysis to the detailed analysis of the lived experience; and an understanding of how a particular experiential phenomenon (an event, process or relationship) has been understood from the perspective of particular people, in a particular context” (Smith et al., 2009, p. 29). In this research study, the therapy session affords the context, and within the context is the process of therapy between two people.
Heidegger’s (1962) philosophy underpins IPA’s methodology, which is to say that humans, participants, or clients are *thrown* into a narrow cultural and social world; their *Being* in the world is always perspectival, always temporal and always in-relation-to something. IPA’s methodology encompasses the *phenomenological attitude* (a reflexive gaze directed inwards, towards perceptions of objects), applies *intentionality* (the relationship between the process occurring in consciousness and the object of attention), *reduction* (each lens offers a different way of thinking about the object at hand to decide what is salient), and explores the *life-world* (what is taken for granted in everyday life) (Smith et al., 2009). Major themes emerge through the systematic application of IPA’s methodology, which applies the concepts of *being-in-the-world* (Dasein), *horizontalisation* (rather than a hierarchy of experiences), and awareness of *epoché* (bracketing personal meanings; Cox & Brown, 2014). IPA’s methodology is thereby able to elicit key experiential themes within a participant’s narrative, and between participants’ narratives. The methodology is *iterative*, which means constantly returning to the participant’s narrative to check meanings, which in turn shape the analysis and so forth. IPA is especially useful for research “concerned with complexity, process or novelty” (Smith & Osborn, 2015, p. 28).

Heidegger considers that a person’s interpretations, which similarly applies to the researcher’s interpretations, are founded upon fore-conceptions; interpretations are always of something presented, which means we cannot help but look at an encounter in the light of prior experiences. This means we each bring our own prejudices and worldview to the analysis. As practising counselling psychologists in the role of clients, each participant elicits the first viewpoint in the hermeneutic circle of their own experience. This means the participants in this study have insider knowledge as a client and outsider knowledge as a professional. As the researcher, I am an outsider to their experiences, yet have insider knowledge of the world of psychotherapy (through the mandated aspect of my counselling
psychology training to provide and receive therapy). This means I have a second viewpoint in the hermeneutic circle, trying to make sense of the participants’ trying to make sense of their own experiences (the double hermeneutic; Smith & Osborn, 2015).

We can also imagine a third viewpoint in the hermeneutic circle, whereby the reader is an outsider, yet may also have insider knowledge of research and mental health practice (as a client, patient, practitioner, researcher, trainer or developer of professional practices). Merton (1972) considers the implications for competing insider-outsider “epistemological doctrines are apparently not nearly so obvious” as professionals might believe” (p. 22). A research question that aims to analyse the subtleties within these potentially competing epistemological viewpoints suggests a phenomenological approach. Few approaches can cast light on whether insider and outsider ‘truths’ and personal accounts can counter each other, and also complement each other (Merton, 1972). In the study, the configuration of our inter- and intra-personal positions constantly shifts. This could be a drawback in the study’s design as to its ability to reveal a hidden and sophisticated story to illuminate both perspectives.

IPA has a proven record in accessing pressing clinical concerns, and influencing practice and policy. For instance, Flowers, Smith, Sheeran, and Beail’s (1997) research of sexuality illustrates how topics that, “require a nuanced understanding of people’s subjective meanings of their experience ... and an identification of possible ways to intervene”, can be investigated and the findings applied (Frost, McClelland, Clark, & Boylan, 2014, p. 121). IPA’s nuanced methodology is especially useful to researchers interested in understanding the meanings and experiences of phenomena such as iatrogenesis, that are not well understood or are insufficiently theorised. To achieve this, IPA’s sampling tends to be purposive and broadly homogenous, so that a small sample size can afford a sufficient perspective, given adequate contextualisation (Smith & Osborn, 2015). This differentiates IPA from other methodologies, such as thematic analysis (Braun
& Clarke, 2006) or grounded theory (Charmaz, 2006), because IPA specifically selects participants to illuminate lived experience in relation to a particular research question. Even critics of IPA acknowledge that its methodology can help develop a full and interesting interpretation of the data (Brocki & Wearden, 2006). Yet to achieve this, a suitable group of participants is required.

**Choice of Participants**

Strupp et al. (1977) consider the views of clinicians, researchers and theoreticians are highly relevant to the link between theory, research and practice. The design of this study initially considered clients with personal experience of therapy, yet without professional experience of therapy. However, I realised that my initial design idea presented serious difficulties. Swift and Greenberg’s (2012) meta-analysis reported 40% of clients discontinue psychotherapy prematurely, with dropouts estimated at 17% in efficacy studies and 26% in effectiveness studies. Erekson, Lambert, and Eggett (2015), reported a relationship between session frequency and psychotherapy outcome for therapy conducted in naturalistic settings, and with clients who were not considered therapy practitioners.

The attrition rate in psychotherapy posed a problem for this study’s design because the modal number of psychotherapy sessions is one (Roseborough, McLeod, & Wright, 2016; Stevan, Bailey, Nielsen, & Pedersen, 2016). Therefore, a significant number of clients who have received unsuccessful therapy may be inclined against therapy. To answer the research question, I also had to develop beyond my preconceptions and inclinations towards interviewing clients who were not simultaneously psychotherapy practitioners. The implications of this choice are explored in the limitations section.

Further, clients potential unaware of the accepted ethical frameworks of therapy may be unaware of what constitutes ethically-informed practice, and so unknowingly experience subtle iatrogenic practices. Additionally, numerous interventions once considered by many researchers and policymakers as therapeutic, are now known to be
ineffective, or even harmful (Lilienfeld, 2017: Parry, Crawford, & Duggan, 2016). Clients
drawn from the public would seem less likely than counsellors and psychologists to know
that therapy holds the potential to help, or harm. Different clients have different reasons for
entering therapy, and this can compromise their ability to reflect on unexpected and
potentially harmful outcomes, particularly if there is a rupture in the therapy itself as a
result. Further, the insider doctrine, as proposed by Merton (1972), states some groups or,
by extension, individuals have access to knowledge not available to outsiders such as non-
professional clients.

This means in order to report on the topic of iatrogenesis, careful consideration had
to be given to such methodological sampling issues. To address these points and avoid
methodological flaws at the sampling stage, this study sought people who believe in
therapy and can reflect upon ethical issues or dilemmas. Amongst professionals registered
to deliver mental health care, which includes all HCPC registered applied psychologists,
only counselling psychologists are mandated to experience, and complete, 40 hours of
personal therapy as part of their training (BPS, 2015). Therefore, and uniquely among
applied psychologists, counselling psychologists were assumed to be able to speak from
insider and outsider perspectives. Counselling psychology is a “distinct profession with a
specialist focus on the application of psychological and psychotherapeutic theory and
research to clinical practice” (BPS, 2015, p. 15). Hence, counselling psychologists were
assumed to be informed of and able to speak from, the three positions of theory, research
and practice. This pluralistic ability and interdisciplinary attitude is core to the counselling
psychology identity of the reflective scientist-practitioner, who is skilled “to investigate the
human predicament as it unfolds within and outside the consulting room” (BPS, 2015, p.
16).

Several skills were considered paramount to considerations of participant selection:
the ability to explore “a broader definition of ‘evidence’ that synthesises research and practice and encompasses the paradoxes and divergences encountered in a variety of research paradigms (e.g., qualitative and quantitative)” (BPS, 2015, p. 17). This was intended to manage any strong paradigmatic or theoretical disposition in modality preference by the participants or myself. Also, to answer the research question, suitable participants needed to be able to maintain a dual-focus or multi-focus of being a client, yet with the knowledge of being a therapist (an ‘insider’; Smith, 2015). The nature of their competency-based training means counselling psychologists have demonstrated the “ability for critical self-reflection on the use of self in the therapeutic process” (Galbraith, 2017, p. 156). In addition, counselling psychologists are trained to practice with intersubjectivity, the shared, overlapping and relational nature of our engagement with the others. This is particularly important because the phenomenon of iatrogenesis is not a property of the individual or a context, but needs to be understood in-relation to the phenomenon.

In contrast to clients without professional experience of therapy or other practitioner identities, counselling psychologists seemed better placed to report on the intersubjective relationship between the therapist and client. As a group, they also seemed better placed to report any experiential connections between the therapeutic interaction and negative outcomes. As the aim of qualitative research is to produce a more in-depth account, counselling psychologists were considered able to speak from the dual focus of being an informed client, as well as being an informed practitioner. This is particularly relevant because Lilienfeld (2007) considers the harmful effects of psychotherapy are most certainly multidimensional. Therefore, with their philosophical training rooted in the phenomenological method and humanistic values, counselling psychologists were considered the most suitable group from whom to recruit, and who could help answer the research question.
However, through conducting the research I have developed a broader and deeper understanding of myself and others. I acknowledge that while the above points all seem plausible, every choice precluded other choices. This means that by including words such as unintended in my thesis title and in my definition, and selecting participants for whom I imagined all the above points would apply, I may have already shaped the kind of conversations that would be had, or not had. This became evident when I began to reflect on the methodology I employed to help explore whether therapists in the role of clients – my interviewees – were able to engage with the processes that I had assumed. I began also to reflect on how that developed my research as well as my intention to add to the knowledge-base of iatrogenesis. This brought forth issues of intersubjectivity, and questions of parallel processes. In summary, I over-estimated in my thinking what we, as professionals, bring to other roles and contexts, and which impacted the study in unexpected ways. I would add that this served as a reminder during the process of writing up this research, that the complexity and subtleties of the task that I had given myself was daunting.

Method

Design. The method of data analysis used in this study is Interpretative Phenomenological Analysis (Smith, 1996, 2015; henceforth IPA), as IPA is concerned with how people make sense of their lived experiences. IPA’s epistemological underpinning is phenomenological as IPA focuses on the lived experience of a phenomenon, which is to say from the insider’s perspective (Smith et al., 2009). IPA is particularly suited to research of ‘unexplored territory’ (Reid, Flowers, & Larkin, 2005); its inductive approach can capture the meanings that participants assign to their own experiences. Moreover, IPA (Smith, 2015) offers a way to access the nuanced accounts of similarities and differences within a case or between cases, and so is highly relevant to the reflexive researcher (Etherington, 2004). Additionally, participants can feel that they are
Participants. In accordance with IPA’s suggested guidelines, the study followed a purposive sampling strategy (Smith, 2015). That is, the study sought a homogenous group of individuals who had the experience of the phenomenon under investigation (Smith et al., 2009). The term in a qualitative setting means that the individuals participating in the research found the research question to be significant (Rodriguez & Smith, 2014). Participants were initially sought through a request via the Division of Counselling Psychology’s bi-monthly email, which was sent to the 2,062 newsletter registered members (Appendix A). A simplified request was subsequently sent to Linked-in’s Counselling Psychology members group (Appendix B). Additional attention was paid to the request because it was placed through this public site. Linked-in is the world’s largest business-oriented social networking site (Gross, 2012; Shah, Ilyas, & Mouftah, 2011).

The first five respondents were invited to take part in the research: three females and two males. Their age range was 34-50 years, with an average 3.5 years since graduation (range 2.5-10 years). One withdrew (female) due to time commitments. Each participant originates from a different ethnic origin. With one exception, none speaks English as their native language. While ethnically diverse the sample was considered homogenous because all shared a key requirement, the perspective of being a counselling psychologist, which conveys contextualisation. Counselling psychologists were specifically recruited because they were considered to have psychological mindedness (Coltart, 1988), are trained to practice from an ethical stance, to be reflexive and are philosophically aware. It was assumed that counselling psychologists could apply these skills to report from a personal level and professional level on their experiences of personal therapy.

Apparatus. Two Olympus audio recorders and two encrypted USB’s; one to store the anonymised audio files, and one to store anonymised minimal participant data. I used
coloured highlighter pens to code the data.

**Procedures.** A participation information sheet, inclusion criteria, consent form and guiding questions were provided by email pre-interview (Appendices C-F). Interviews took place at convenient locations for participants including university meeting rooms and residences. Interviews lasted forty-five minutes each, were audio-recorded and transcribed verbatim. The semi-structured interview schedule used for data collection was developed following the readings of the researcher. The schedule focused on participants describing what it is to be a therapist in the role of client (Appendix F). Following IPA guidelines, the questions in the schedule were few but broad (Smith, Jarman, & Osborne, 1999). These were developed from past literature and the researcher’s own interests. The semi-structured format encouraged participants to follow areas of interest to them within the topic. Brocki and Wearden (2006) consider researchers who utilise IPA are obliged to transparently show their own reflections in the dynamic process of analysis. Given my two perspectives of insider knowledge, that of counselling psychology (first order), and my previous knowledge of therapy with the consequence of shaping my preconceptions, in order to transparently own the fore-structure of my knowledge (second order) a research diary was kept. The diary, which I constantly returned to, informed the data analysis and write-up (see personal reflexive section).

**Semi-structured interviews.** The suggestion here is that psychotherapists, placed in the role of client, can gain and provide an insight into clinical practice. It is further suggested that such insights may help form an opinion derived from their experiences. As such, and to help answer the research question, this study adopted a semi-structured format of data collection. This format is ideal in qualitative research because it allows participants “to think, speak and be heard” (Reid et al., 2005, p. 22). It also means the researcher can lead the interview and simultaneously not lose control of the interview situation. This approach has been called “a conversation with a purpose” (Smith et al., 2009, p. 57). My
intention was for participants to feel at ease when potentially discussing unintended harm. IPA also confers the advantage of real-time adjustment to unpredictable, “interesting and important issues that come up during the interview” (Smith, 2004, p. 50). This is particularly relevant with professionals in the role of client, as it is important to create a flexible frame to facilitate exploration of the research question.

The level of flexibility in qualitative research methods can be a weakness or a strength, depending upon its application. A strength is the flexibility to work with unexpected turns in the narrative, unanticipated territory and areas of interest. A weakness is that my interest in the topic and my own experiences could unintentionally divert the interview towards my own fore-structure of knowledge, and so unintentionally shape the analysis (Denscombe, 2002). The research diary helped me remain grounded in the data. It also helped me remain aware of the difficulties in exploring relatively unexplored territory about the sensitive aspect of professional therapeutic practice. I remain unequivocal in thinking that therapists, as a general rule, do not set out to do harm. Where that is an issue it is dealt with in the literature under the category of malpractice.

It takes a certain degree of courage to own up to making harmful mistakes, and to share such occurrences and uncomfortable truths with others. This is likely due to an overriding socialised tendency that one automatically feels shame as a human being who cares for others because when errors occur, as they will, there is an inherent risk that hurt has been engendered. Guilt, which in the literature review Flor’s (2016) participants spoke of, serves as a reminder that we are social beings and our relationships with others are an important source of well-being.

Ethics. Ethical approval was granted by the University of Surrey’s Counselling Psychology Department. Care was taken to maintain a research rather than a therapeutic focus. As qualitative research and therapy may overlap no clear distinction was assumed. Participants were debriefed post-interview and provided with support contacts. Participants
were sent a pre-submission manuscript; all commented. This contact afforded an opportunity for participants to provide feedback. When asked for, we negotiated control over part or whole data deletion and withdrawal. I followed BPS (2014) research ethics throughout.

**Credibility of the work.** The study followed Yardley’s (2015) suggested steps to establish the study’s credibility throughout each stage

**Sensitivity to context.** The research is contextualised within the different epistemological positions recognised in the researcher’s literature review of the topic (Cox, 2012b), and the personal philosophies and epistemological positions of the participants.

**Commitment and rigour.** This study aims to excel in a rigorous in-depth microanalysis of the dialogue, with a commitment to explore the philosophical underpinnings of the participants’ therapeutic experiences. The writer is a long-term service user or ‘expert by experience’ whose commitment can be seen in developing the skills to explore the topic, and conducting an in-depth analysis to contemplate and empathically explore the data (Yardley, 2015).

**Transparency and coherence and impact.** These can be assessed by understanding how the rhetoric drives the research and how the analysis functions to construct meaning-making. An audit trail establishes transparency, such as the recruitment procedure, application of the methodology and analytic process (Appendices A-H).

Credibility is established through a good fit between the fully transcribed transcripts as related to the extracts. When the philosophical perspectives of IPA, counselling psychology and the writer elicit a consistent, plausible and complete voice, then credibility is enhanced. There is a potential impact factor within academia, the therapeutic community including clients, and for incorporation into university training programmes.

**Reflexivity.** Although any account of the researcher’s background is subjective, it
may help readers to understand where ‘I’m coming from’. This supports making sense of my making sense of the participants’ sense-making, which is Britten et al.’s (2002) third-order interpretations or third hermeneutic position. Additionally, and as a therapist, a student and fledgling academic, each identity shapes my perceptions and so impacts the research. By being transparent and remaining grounded in the data I seek to limit the impact of my ‘epistemological premises’ unintentionally shaping the research (Bateson, 2000). I recognise the need to balance having a healthy interest in this topic without my commitment and passion becoming a blind spot that engenders omissions. Hence, IPA’s structured yet flexible methodology can pre-empt my personal interests paralleling the iatrogenic practices reported in this study. In consideration of this, at each stage the analysis and themes were checked with a supervisor.

**Analytic Strategy**

Smith et al. (2009) outline a six-step analytical process which was used in this research. These six steps included:

**Multiple readings.** The participants had been referred to a psychology service for therapy in London, UK. All were suffering from a first onset of depression. We did not include presence or absence of recent negative life events in our selection criteria. However, it turned out that all reported having suffered negative life events at the time of onset. None had any form of therapy before and they were interviewed before therapy started. There were four males and three females. Mean age was 44 years. Five were unemployed and two were doing occasional work, but all had worked before the onset of depression for most of their adult lives. All seven were born and educated in the United Kingdom. The assessment suggested that they had suffered depression less than 2 years. All names have been changed to protect confidentiality.

**Procedure.** The interview schedule focused on the experience of depression and on
what had been happening to the person as they became depressed. Here are two sample questions from the schedule: (1) Can you describe what it is like being depressed? Prompt: words, images, metaphors, associations; (2) Can you describe the actual experiences you have on a daily basis? For example, your activities, thoughts, feelings. Questions were open-ended and the schedule used very flexibly in the interview. We encourage participants to recount their experience in their own terms so questions are intended to facilitate this process rather than elicit certain types of responses. All interviews were audio-recorded with permission of participants and transcribed verbatim. Each transcript was analysed first in its own terms.

**Multiple readings of the transcript.** This stage involved repeated listening to the audio recording and repeated close reading of the transcript. Each transcript was analysed first in its own right (Smith & Rhodes, 2015). This helped the researcher to note anything of interest, immerse himself in the data, recall the atmosphere of the interview and the setting in which it was conducted. This step helped also, as far as possible, to step into the participant’s shoes and so connect with how they experience and make meaning of their lived world. Prior to making notes, Smith (2015) recommends keeping in mind the purpose of the research, which is encapsulated by the research question.

**Initial noting.** The entire transcript (data item) is treated as data and fully coded. In this study, a wide range of single coloured highlighters and colour combinations were applied to code individual parts of the transcript. IPA’s ideographic mode of enquiry can delve deeply into the data to extrapolate from the subjective accounts with relevance to the general. Through the application of horizontalisation (equalising of accounts) and bracketing (epoché or suspending of critical judgement), IPA investigates topics of ‘hot cognition’ which “are emotionally charged and are a potential cause of dilemma[s]” (Aresti, Eatough, & Brooks-Gordon, 2010, p. 174).

Wide margins on the left and right sides of the transcript allow for comprehensive
notations. Initial notes were made in the left margin regarding use of language, similarities and differences, assumptions and amplifications or contradictions in what the participant says. Smith (2015) recommends noting the participant’s sense of self, the researchers sense of the participant and noting any significant features of their interpersonal interaction during the interview process. These broad left margin notations allow the researcher to stay close to the descriptive level of the participant’s meanings and link them to the extant literature. Key words or short phrases were recorded in the left margin to capture the essential quality of what the researcher found in the text. This stage of notation supports a focus on content notes (what was being discussed), and process notes (linguistic features such as metaphors, symbols, repetitions, pauses), the context of the initial interpretative comments.

Mindful of Merton’s (1968) theory of unintended consequences and theoretical differentiation of ‘insider’ positions and ‘outsider’ positions, which framed the research in this thesis, the researcher recorded also in the left margin and sometimes in a reflexive research diary, how his status as a counselling psychology trainee to the insider practising counselling psychology participants perhaps impacted this constructed research context. For this, the researcher noted how his personal characteristics, such as gender and age perhaps affected the rapport with the participant. This helped to highlight distinctive phrases and the participant’s and the researcher’s emotional responses.

Transforming notes into emergent themes. Returning to the beginning of the transcript, micro themes or emergent themes were recorded in the wide margin on the right side of the transcript. Working more from the initial notes and less from the transcript, the notes were “transformed into concise phrases which aim[ed] to capture the essential quality of what was found in the text” (Smith, 2015, p. 41). From the detailed and comprehensive notes in the previous stage, this shifted the analysis to a higher level of abstraction. At this point, references were made to psychological conceptualisations. However, through IPA’s
iterative method of returning to the text to check the participant’s and researcher’s meaning-making (the double hermeneutic; Smith & Osborne, 2015), the analysis remained grounded in the detail of each participant’s account.

Searching for connections across emergent themes. Emergent themes were listed on paper in the order that they presented in the transcript. As the clustering of themes emerged they were checked against the primary source of material, each participant’s words, to ensure the themes were grounded in the data and not driven by the researcher’s presuppositions. This interpretative process involved a close interaction with the text. The function of a theme within a transcript formed one cluster. The process of abstraction (putting like with like), polarisation (whereby oppositional relationships emerged) and numeration (which themes repeatedly emerged) helped develop superordinate themes. Some themes acted as a magnet to pull in others themes, which helped to make sense of them. This analytic process of subsumption was particularly useful to show how an emergent theme itself acquired a superordinate status (Smith et al, 2009). A table of superordinate themes was constructed. (Limitations regarding this process are discussed on pp. 61-79).

Moving onto the next case. The steps applied to the initial transcript were then repeated for each subsequent case.

Looking for patterns across cases. The final step looks for patterns across the transcripts and identifies the most important things to say about participants (Pietkiewicz, & Smith, 2012). A table of master themes for the all the transcripts, with their subthemes, was constructed.

Findings

All the accounts exhibit a strong narrative structure apparent through three master themes: Competing world views: clashing epistemologies; How and by whom is therapy constructed?; and Making sense of an experience.
Table 1

*Table of Master Themes*

<table>
<thead>
<tr>
<th>Theme</th>
<th>Exemplars</th>
</tr>
</thead>
<tbody>
<tr>
<td>Master Theme 1</td>
<td>It’s closer to religion than maybe a science, or another theory</td>
</tr>
<tr>
<td>Competing world views: clashing epistemologies</td>
<td>Psychoanalysis, it captures you at an unconscious level when you’re not fully aware of your choices</td>
</tr>
<tr>
<td></td>
<td>She just went into the therapy role, and was behind this kind of veneer or reflective outlook</td>
</tr>
<tr>
<td>Master Theme 2</td>
<td>I feel as though she’s constructing my world without recognising that</td>
</tr>
<tr>
<td>How and by whom is therapy constructed?</td>
<td>She was just smiling and dancing in and out of changing people’s lives without them actually signing up to that</td>
</tr>
<tr>
<td></td>
<td>What I didn’t realise was that whether you want to or not it changes you</td>
</tr>
<tr>
<td>Master Theme 3</td>
<td>Well if this is not my philosophy this was the one therapy that kind of got to places others never did</td>
</tr>
<tr>
<td>Making sense of an experience</td>
<td>I like to challenge myself by asking someone from a totally different paradigm to help me</td>
</tr>
<tr>
<td></td>
<td>What distinguishes counselling psychology is the importance of the personal development</td>
</tr>
</tbody>
</table>

While there is some convergence between the participants’ experiences of being professional psychologists, when in their own personal therapy their experiences were more divergent. The following composites capture the convergent and divergent patterns. These master themes and the dilemmas faced by the participants are explored in more detail now. The master themes are illustrated by firmly anchoring the findings in direct quotes taken from the participants’ accounts (Smith et al., 2009).
Theme 1: Competing world views: Clashing epistemologies

The first master theme is concerned with what the participants consider a core feature of psychotherapy. The theme illustrates the competing world views or epistemologies in the therapy room by contrasting the client’s own view of their therapy, with what they perceive to be their therapist’s view of the therapy. For Lee, therapy is “a place where you can meet each other.” For Jade, therapy “means having multiple frameworks based on the relationship.” For Jon, therapy is about “collaboration”. Alex speaks of painful “dilemmas”. These participants explain how these qualities can engender trust and support a working relationship (Madison, 2014). Research shows that therapists who are perceived as uncaring, who convey preconceived notions, and who dogmatically rely on theory or overlook abuse issues, lose the trust of their clients (Pope & Tabachnick, 1994). Preconceived notions regarding religion emerge as an area of contention for Jade and Alex, who were seeing psychoanalytically trained therapists. Both grew up in a socio-cultural milieu where religion played a highly-valued role in family life. The participants share their perspectives of how what they perceive as helpful or harmful, can diverge from their therapist’s views. Jade describes the environment she grew up in and interprets her therapist’s non-verbal response to Jade’s early and formative environment as critical. This metacommunication is interpreted by Jade, who as a counselling psychologist is trained to be reflexive, as dogmatic. We will subsequently see two ways that Jade works to assert herself:

…there has been several some difficulties for me to trust her … What comes to my mind here is around religion … in terms of mismatch … I think they’re inevitable … ’cause I come from a very Christ, from an Evangelical Christian background … it was a big part of my childhood. And my first therapist was very critical of that, I could tell she didn’t like it and thought it was dogmatic and it was err getting in the way of the real self.
The importation of a psychoanalytic concept into the extract above moves from Jade’s description of her early environment to an interpretation of the text (Smith, 2004). The concept helps explore the subjective account and so here fits with Heidegger’s (1962) *Dasein*, or Jade’s way of *being-in-the-world*. Within psychoanalysis, the real self, describes a sense of self that is based on spontaneous authentic experience (Winnicott, 1960). Its counterpoint is the false self or inauthentic self. Religion, or the God-object as a transitional object is believed to assist growth “through training and practices that facilitate imaginative thinking” (Pruyser, 1985, cited in Nelson-Jones, 2009, p. 170). The therapist’s and client’s competing views bring forth fundamental issues such as personal identity, social identity, agency, the meaning of life and one’s personal philosophy. While Jade is critical of her psychoanalytic-oriented therapy, we witness how her allegiances and identities evolve. Jade adapts to incorporate what she believes to be the generally held views of other counsellors and psychologists:

> in therapy religion is a big thing and philosophical style that is very very different, and many therapists are not religious … and I think psychology has in history historically been partly minimalising and err err ridiculing religion to a large extent … err I feel my MY philosophical stance is more accepted, accepting to therapy, its more in-line with therapy.

From both of Jade’s extracts above, and both of the following interpretations, we can see Jade does not seek to control the situation; in what feels like a potential conflict with her therapist and also with herself, the crucial element is that Jade seeks to assert her identity. In contrast to Alex’s later extract, Jade’s “[p]artly grounded mutual suspicion gives way to partly grounded mutual trust” (Merton, 1972, p. 11). To achieve this, Jade states her views as a way to manage strong feelings within her current environment; her therapy. Firstly, Jade describes the early formative and developmental experience of her “Evangelical Christian background”, and angrily and emphatically asserts her current
identity through her felt experience of “MY philosophical stance”.

Secondly, reflexively sensing Jade’s sudden and angry shift of body language I sought to delve into this unexpected turn in the narrative. To take Jade’s ‘insider’ perspective and also to stand alongside her to look at an experience from a different angle, I attempt a hermeneutics of questioning (Smith, 2015). I asked Jade if it was possible the therapist was presenting a false self through the mechanism of stating openness, yet paradoxically (Merton, 1936) presenting a dogmatic response? Jade snapped at me, ‘No’ and changed conversational tack. Having asserted her identity with her therapist, in a parallel process it seems she also did so with me in this exchange.

Intersubjectively, I suggest that outside of my awareness we shared some anger towards the therapist who was not in the room. What seems interesting is that my original interest from years ago, and which seeded this research, was my silent questioning of how health professionals may hold a philosophical or professional position then act in ways contrary to that position. My interest in how this apparent contradiction between beliefs and actions can become part of the relational dynamic and thus shape the therapeutic relationship, was happening here between us; and I had not fully recognised it. This notion of a parallel process seems so important that I have devoted a section below to pull together the threads where the process appears, as it did throughout this study. To illustrate it clearly, I will here link the interaction to the frame for this research (Merton, 1936, 1968), so that the distinction between beliefs and actions is clear.

Merton’s (1936) theory of purposive actions that engender unintended consequences, explains how Jade had seemingly distanced her from her therapist (and subsequently became one reason for changing the therapy). Jade’s reaction to her therapist and myself is open to several psychotherapeutic interpretations, such as the use of a defence, or a reaction to the transference from a dogmatic therapist to a dogmatic interviewer (because I stayed with a point that Jade had dismissed). Yet, underlying both
interpretations is a process that is fundamental to therapy; change-work. I say change-work because I am assuming that clients attend therapy for something other than the status quo in their lives, even if it is an acknowledgment of something in their life, such as gaining acceptance or peace. While IPA is critiqued for its assumed low level ability to generalise findings, here it becomes evident that it may be possible to identify a mechanism of change for the client, or others in relationship with the client; the manifestation of an interpersonal conflict.

When the interaction with myself is viewed from an alternative theoretical perspective, Jade’s reaction shows Merton’s (1936) notion of a paradoxical outcome because her response is the opposite to my expected outcome of agreement. As this is research and not therapy, it was not ethically appropriate to continue with this aspect of the narrative, or my interpretative thread. Jade chose to conversationally move on, which I respected. Reflectively, Jade may have sensed that I appreciated her candid and open reaction. Reflexively, I felt this interaction seemed to deepen our relationship in this research context. Jade was clear from the outset that she had a story to tell; she was telling it from many aspects, being heard, and being included. What is interesting is that it seems I also have a story to tell, which is unpacked in the parallel process section.

The next extract illuminates how the participants find different ways to manage any drawbacks (Merton, 1936) when asserting their own views with their therapist’s conflicting views. We can see how two participants seemingly employ different processes or ways-of-being. The difference seems initially to be superficial; however, the underlying principle is whether they can work with a perceived epistemological and relational clash. Jade incorporates the difference by moving towards bridging the interpersonal gap, and she seems more at peace with her developing identity. This is contrasted by Alex’s relational tension and leads to a greater divergence, which is seen through her move away from her therapist. Alex’s “[p]artly grounded mutual suspicion [does not] give way to partly
grounded mutual trust” (Merton, 1972, p. 11), and her angst is evident here in this quote:

I’m scared that I’m going to be erm … seduced by the model, yeah. And it’s exactly what happened. And I think that’s part of what psycho-analysis is, it captures you at an unconscious level … when you’re not fully aware of your choices ... That’s why it’s closer to a religion again than maybe a err than a science, maybe yeah, or another theory.

The above extracts illuminate an epistemological and consequent relational clash. At various points, each participant uses the term ‘clash’ or ‘mismatch’ to describe repelling their therapist’s theoretical views. The clash here is seen on two levels of analysis: firstly, between the competing therapist and client life-worlds (van Manen, 2014); and secondly, between the clients’ visible selves. These are accessed through the flexible interview discussion, and the hidden inner selves are accessed through IPA’s reflective methodology. Additionally, although beyond the scope of this research, there is a future potential to explore any clash between the therapists’ seen and unseen selves (O’Hara, 2014).

What Jade calls a mismatch between her religious belief and her therapist’s non-religious psychoanalytic stance can be contrasted with other therapeutic issues. Jon also reports a mismatch between his experience of sexual harm and his therapist’s stance on sexual harm. Both Jade and Jon link the mismatch with a lack of trust in their therapists. The shift in context from religious to sexual issues highlights the underlying principle between the two seemingly disparate areas. Jon describes what he perceives as a form of sexual abuse, and how this conflicts with his therapist’s view. Jon’s account adds to Jade’s meaning-making because both feel their therapist is minimalising their subjective experiences of something painful. The therapists’ interventions leave both participants feeling like outsiders in their own therapy, which they react to:

actually it started off very very well. I felt warm to her and she’s very reflective … Just the nature of that unfolding, so when I was sixteen years old
... I was on holiday and it was a friend of mine put his hand down my pants and put it on my groin … And and I I remember her response and it was very much it was very dismissive. And the language she used was ‘well you were sixteen’ so it’s not sexual abuse … I was so taken aback by the almost rejection of that experience … I lost trust, I lost trust in someone I respected.

This could be viewed as the therapist’s attempt to impose their theoretical stance upon the client. However, the nature of the unfolding epistemological clash seems to be located in a fundamental aspect of clinical practice; to actively listen, and hear. Not hearing the client’s meaning risks missing the intersubjective relationship. However, by looking at the nature of the phenomenon rather than exploring the phenomenological meaning as presented by Jon, his meaning-making is undermined (van Manen, 2014). This risks the therapeutic encounter being governed by arbitrary social and categorical norms which miss Jon’s lived experience.

Towards the end of Jon’s next extract, we can see a convergence of missed experiences. This pushes the analysis to a higher level of abstraction through what Biggerstaff and Thompson (2008) term a ‘paradoxical complexity’. The paradox is that the complex divergent experiences meet at a nexus, or point of convergence. The point of convergence is the principle that underpins each of the extracts. Therefore, the therapist seems available only in terms of theory rather than in terms of a common humanity. This illustrates that although the contexts and personalities described in the above extracts are different, the pathways of competing world views begin to look interpretatively similar.

Interpretatively, a pivotal moment is occurring in Jon’s therapy; Jon first experiences a sense of disillusionment with his therapy and his therapist. This manifested in various ways, such as anger in the following two extracts, at the discounting of his experience and so his internal world by the other. This I was personally sensitive to, which explains why I was drawn to this powerful extract. Part of my motivation for this study is
to understand how sometimes as therapists we mean well yet the intended intervention is either misunderstood or produces a paradoxical outcome. My motivation is also to raise awareness of our responsibility to explore the topic of iatrogenesis. In this situation, the other is Merton’s (1972) ‘outsider’:

and she said ‘Oh I’ve noticed that you seem less present … and she empathically listened to me. And that’s all she did, she said ‘oh yes I understand’, and that was almost worse, because it’s almost like I understand I’m taking a part in that but I’m not gonna take any responsibility. She didn’t say sorry, and it really really hurt … she just went into therapy role, and was behind this kind of veneer of reflective outlook and that was it.

Through IPA’s hermeneutic and interpretative lens is seen a parallel convergence and divergence between each of the therapists working with their clients, Jade, Alex and Jon. The extracts show the therapists converge where each seems unable to understand or explore their clients lived-experience, yet diverge by theoretical models. Unlike Jade, and Alex’s analytically-oriented therapist, Jon’s therapist is Humanistic. While the latter model proposes a developing tendency towards self-actualisation (‘to be all that one can be’; Rogers, 1961), the former orientation conceptualises therapy as ‘a conflict-ridden process to resolve intra-psychic conflicts’ (Klein, 1946).

One interpretation from an imported concept, which Smith (2004) states can push IPA to a higher level of analysis, is from the psychoanalytic model of therapy. The model theoretically constructs the therapist as a projected representation of the friend who tried to seduce Jon. In the psychotherapeutic setting the offered interpretation can theoretically translate into purposive action (Merton, 2016). Phenomenologically, “an interpretation is never a pre-suppositionless apprehending of something presented to us” (Heidegger, 1962, pp. 191-192). Therefore, and to present my fore-conception, I am here inclined towards a psychodynamic interpretation, which potentially draws me away from Jon’s original
meaning and so shapes the analysis. The therapist has perhaps placed her hand on the private parts of Jon’s psyche, which is experienced as playing with him. The point considered here is that some form or principle underpins the way the analytically-oriented therapists and the Humanistic therapist conceive the client’s being (ontology) and their own knowledge (epistemology), as applied in practice, yet still unintendedly harm their clients.

Jon offers us his way of making-sense of the experience, which may have been influenced by his training as a counselling psychologist because he is working with a professional who does not share the counselling psychology identity or training, and so influenced the interpretations:

the mistake if I reflect back on it that she made, she had a template of reality in her head that certain experiences count, and certain experiences don’t count, and therefore an experience of being touched at 16 years old doesn’t really count.

Alex deepens the analysis by bringing forth her dilemma with her therapist:

she was probably wonderful in so many ways or I wouldn’t have been there for five years … there were times when I wanted her to go outside her model, to step back and reflect on how the psychoanalytic theory sees the other … in fact she would probably interpret it as a defence … so that that brought dilemmas with it for me

Here the opportunity presents to interpret multiple aspects of a dilemma. Alex seeks to expand her worldview and perceives a potential clash with her therapist’s psychoanalytic theory, yet stayed for five years. Her reason remains unclear, although there is research evidence that in some therapeutic approaches clients implicitly accept the view that clashes in therapy are a sign of progress (Howes, 2012; Lilienfeld, 2007). This remains so even when psychologically aware clients, such as reflexive counselling
psychologists in the role of client, consider practices ethically questionable (Williams et al., 1999). Alex also suggests there is a model existing outside of the therapist’s view, indicating that Alex’s view is different.

We could say that as a counselling psychologist, Alex’s broad Alex’s epistemological perspective is broader than her apparently theory-bound therapist’s perspective, and so influenced my findings. We can see in these extracts how the therapeutic contexts, the therapist’s views and client’s views compete as explanatory versions of the phenomenon in the therapy room. We can interpret this to mean that rather than Alex engaging with her therapist’s interpretations, the dilemmas evoke a conflict or clash of views. Consequently, she feels relegated to an observer, an outsider (Merton, 1936) in her personal therapy; this leads her to focus on the negative aspects of her therapeutic relationship. The issue at hand is when competing world views or epistemologies clash whose view is prioritised?

**Theme 2: How and by whom is therapy constructed?**

The second master theme is concerned with the way three of the four participants question how and by whom therapy is constructed, or their experiences deconstructed. The fourth participant, Lee, applied the concept although not the actual term of construction. All the participants described dilemmas regarding whether goals were shared, subtly imposed, or remained obscured. Additionally, potentially fundamental philosophical questions regarding therapy emerge. Here we see Alex questioning the ethics of her therapeutic encounter. This ability to move beyond the position of being a naïve client and report from the position of a professional with expert knowledge of psychotherapeutic practice, is the reason counselling psychologists were selected to help answer the research question. This multiangle perspective provides a ‘good fit’ with Smith’s (2004) multiple levels of data analysis, such as the importation of concepts, the examination of the use of metaphor and shifts in time sequencing (temporal referents), which enhance IPA’s
interpretative process:

it’s it’s almost unethical because people go into that without realising what it’s doing, and then she said with a smile, and I’m still feeling really angry about that, yeah, it should come with a warning label … she was just sort of smiling and dancing in and out of changing people’s lives radically without them actually signing up to that … and that’s not informed consent … and my dilemma … there is a price, there is a benefit … but actually who makes that choice, why is it not my choice to say actually you know that’s not where I want to go.

Questions about who constructs the therapy are encapsulated within Alex’s complex dancing through ‘changing lives’ metaphor, which graphically captures her dilemma; her goal is personal exploration, not change. Kazdin (2008) interprets the use of this type of metaphor as a way to deliver an unspoken message: in clinical practice, much of psychotherapy “is not about reaching a destination (eliminating symptoms) as it is about the ride (the process of coping with life)” (p. 147). Taking this interpretation one step further, Alex’s extract below shows her implicit agreement with Kazdin (2008), and her explicit disagreement with the therapeutic model being applied. This affords two perspectival aspects or levels of theoretical analysis within Merton’s (1936) theory of drawbacks.

From the therapist’s perspective, the intention is to help, yet the intervention has the unintended consequence of being experienced as harmful. From Alex’s humanistic perspective, the intervention is expected to facilitate a helpful journey of self-exploration, yet has also the unintended consequence of being experienced as harmful. Alex’s metaphor therefore illustrates a sign of inter- and intra-personal movement. This process supports an interpretation that when Alex now turns to speak of informed consent, she is feeling insecure or unsafe. The inter-personal movement is that informed consent would support
Alex to occupy the space between harmful-helpful, and decide what to engage with, if at all. Above, with me, when I mentioned the other’s real-self or false-self, Jade internally shifted to the middle space and just changed the conversation. Here we do not pathologise this as avoidance or denial, as it was effective for her to remain in our relationship. Here, Alex remains engaged with one aspect of the harmful-helpful continuum:

I don’t know how she did it … she started to undermine me to such an extent, and I remember every time I felt her images were always deconstructed, and every time I kind of recovered a bit and started to build myself up again, she would go right back in there and kind of blow it up … it feels there’s so much ethically wrong with it … but I consciously know it was very effective but also against my will because actually I didn’t want those places to be changed.

One interpretation of Alex’s extract would seem to question the whole venture of therapy, which some studies implicitly questioned in this thesis’ literature review (Bystedt et al., 2014; Parker et al., 2013). There is a question regarding whether Alex’s therapy is her own construction, being co-constructed, or if she is merely accepting her therapist’s epistemological stance and staying in therapy to be de-constructed against her own ethical values. Alex speaks to the decimation of her constructions yet without understanding what is happening. This seemingly cuts any relational connectedness. Yet Alex’s extract is revelatory as it raises the question, what happens if we allow ourselves to relate, even in the face of imposed alternative epistemologies? Who then constructs the therapy?

Drawing from the social psychology literature to inform the interpretative process, Alex’s extract also sheds light upon a mechanism of change. Rotter’s (1996) “locus of control construct is a measure of an individual's perceived level of control” (emphasis original: cited in Smith, 1996, p. 269). It was the assumed ability to reflect upon personal experiences and intersubjectivity that shaped the design study choice of recruiting counselling psychologists as participants. In the above extract, Alex yielded control of her
internal world to the outsider (Merton, 1936), who imposed change “against my will”. Yet in the extract below, Jade moves forward to develop from, “I feel as though she’s constructing my world” to subsequently stating the big topic is, “creating who you want to be, creating your world, and your theory”. The point is that Alex shows a disconnecting movement of change in the negative direction while Jade shows a connecting movement of change in the positive direction. The pivotal moment in the process is how each interprets the meaning of the interaction, and the level of control the therapist or Self has.

The interpretative analysis of the phenomenon at hand, personal change (Smith et al., 2009), supports us to see the change by continuing the connection of one narrative to other narratives. We have seen and interpreted what happened in the first master theme: Competing world views lead to clashing epistemologies, and how each participant managed, or not, to hold in mind competing perspectives. This second master theme: How and by whom is therapy constructed?, continues to shed light upon convergences and divergences. These occur when philosophically and ethically trained reflective practitioners are thrown into the role of client in their own personal therapy. To see and then interpret the process, Jade’s extract begins with a similar experience to Alex’s; yet Jade subsequently offers an alternative view of the role that constructions play:

it is so so different and so I prefer to remain in that sense I think our worlds are constructed, and so I think when she talks about that I feel as though she’s constructing my world without recognising that, do you know what I mean?

Jade takes the analysis one-step further than Alex. She highlights a pathway towards the role the therapist plays in the client’s constructions. From this extract, we can see Jade co-creating the therapeutic process because the intersubjective process appears even in the face of an attempt by the other to construct her internal world for her. Also, there appears to be an associative-dissociative element or process between the previous two extracts. While Alex appears dissociated from the co-construction and bewildered by
her dilemma, Jade also seems bewildered yet appears more associated to her experience of
the co-construction. Jade shows agency through using the therapist as an external agent for
change. Jade also remains connected to the experience even when uncomfortable. This
connectivity suggests the engagement of higher functions, such as interactions that are not
categorically good or bad, just good enough (Winnicott, 1953).

Therefore, in her extract above, Alex speaks to being detached from the
construction of her therapy, when she wants to feel attached. This lack of connection to her
therapist is also a lack of connection with herself, and the narrative suggests her therapist
has not supported her to bridge what Kazdin (2008) terms a practice-theory gap. In the
practice, Alex does not relate to the theory underpinning the therapy. Jade however, sees
herself as being both a part of the construction process, and despite or because of the
interpersonal difficulties, which we do not yet know, she feels attached to her ‘dogmatic’
therapist. Jade feels connected with herself:

the concept of good enough though, it’s important because the way I see it
therapy is a mixture of finding oneself and creating oneself … the big topic is
creating who you want to be, creating your world, and your theory … and the
therapist has a huge role co-creating that.

Lee, our fourth participant-client interweaves multiple pathways that have emerged
through the narratives so far. The co-construction of our personal epistemologies means to
be “human is to participate in interrelationships” (Adams, 2007, p. 53). This seemingly
suggests that being human means sometimes experiencing painfully, the world alone. Lee
illustrates this as he reflects upon how therapists can provide transitional support towards
exploring a client’s ideas, or anxieties. Lee’s perspective seems to be that each human
being faces the existential paradox of simultaneously being alone, yet also with another.

Lee exemplifies the paradox in the next extract. The extract is supported by
emotion theory and the theory of cognitive distortions, because anxiety is a future-oriented
state (Barlow, 2000). Lee had spoken about his anxiety when a therapist does not reveal anything of her/his/their Self, and here describes how he is able to utilise a mechanism to transition between Self and other in a natural human interrelationship. The deep connection is through working with a competing epistemology, from which he experiences a sense of safety to therapeutically work together. Their differences are synthesised into the similarity between them.

Smith et al. (2009) state that IPA is concerned with trying to understand lived experience and with how participants themselves make sense of their experiences. This sense-making process is what Lee describes. Lee’s extract illustrates how IPA provides a good fit with this study’s research question: *What are psychotherapists’ experiences of therapy when clients?* This is because IPA’s phenomenological grounding explores the personal perceptions of an event or state, which means the methodology is ideally suited to access the link between cognitions and emotions, and to interpret the meanings which those experiences hold for the participants:

I really believe that we create our own epistemologies, our own ideas about what’s good or what’s bad and on the basis of that we work … it’s a kind of reciprocal process where we develop together the therapy.

Lee’s therapist-client interaction stands in stark contrast to earlier accounts of degrees of separation or dissociation from the therapist. Through living “in the currents of universal reciprocity” (Buber, 1970, p. 67), therapy supports the way client and therapist, as objects, move towards each other through the primacy of interrelating (Adams, 2007). This intersubjectivity is core to counselling psychology’s philosophy and training. In contrast to Jon and Alex, Lee and his therapist are counselling psychologists. Also, I am a counselling psychologist in training. For the participants and myself, looking through the lens of counselling psychology’s philosophy and training likely shaped how each viewer sees and interests the data, and so shapes the findings presented in this study:
so I was really happy when … he started to show something of himself … how it was for him to give therapists this therapy.

The participants speak to the convergence or divergence between ontological positions, and epistemological positions. These positions underpin the beliefs and so practices of the therapists, the participants and the researchers alike. This study’s phenomenological ontology means the phenomena is the Being, which is the ontology. When epistemology is perceived as a correlate of ontology, “the real world is the perceived world is the phenomenal world” (Merleau-Ponty, 1962, p. 156). This means the being and knowing of the phenomena is found only in the encounter (Heidegger, 1985), and cannot be therapeutically imposed. In other spaces, applying psychology to construct the world of the other is termed brainwashing (Temerlin & Temerlin, 1982; Walsh, 2010).

Although unspoken, the issues of informed consent and who decides how the therapeutic encounter is constructed (or deconstructed), are intrinsic ethical issues. In a field that is ethically based, the recognition of such issues engenders strong emotions and disruptive cognitions. As Merton (1968) suggested, the same process that operates at the micro (individual level of therapy) is reflected at the meso level (professional registration bodies), and the macro level (socio-political). This can explain how decades after Strupp et al. (1977) stated, “[t]he systematic study of how one client improves and another gets worse is an absolute necessity if the field is to advance” (p. 12), remains obscured. I suggest the field of psychotherapy needs to say more about these issues.

This study offers one of three perspectives to explore the theory-research-practice gap in therapy, which as reported here, seems intent on attempting to separate out the phenomenal and perspectival worlds. This means some therapists are unable to attend to more than a part of their client’s experiences. Therefore, I suggest that clinical approaches based on an ontological position of oneness and that the world of the other can be fully
known, provide fertile ground for clashes or mismatches to take root. The same seems equally true of realist research positions that posit a modernist unidirectional causal process. These assumptions, which emerge from the findings of this study, merit further exploration.

This study’s epistemological perspective enables an analysis of potentially incompatible patterns within and between the therapist’s positions, as perceived by the clients. Jon tells us his therapist has a template of reality regarding which experiences count as sexual abuse. His view of the breach of trust by his friend, then therapist, seems overlooked because it does not fit the therapist’s epistemological premise (Bateson, 2000) of what constitutes sexual abuse. Yet, Jon does not perceive a dilemma, more an ethical issue. Alex does consider aspects of her therapy were questionable ethically, such as what constitutes informed consent and who decides what to change. However, Alex speaks of a fundamental dilemma perhaps hidden to Jon. Although against her will and perceived as harmful, Alex also perceived her therapy as effective. This leaves her feeling confused and struggling to make sense of her experience: “what I didn’t realise was that whether you want to or not it changes you.”

**Theme 3: Making sense of an experience**

With the antithesis of a ‘good experience’ being a ‘bad experience’, the participants reveal another master theme, or aspect of their experiences; the integration or synthesis of their client-therapist encounter (Žižek, 2003). Through this process, they make sense of their experiences. As each therapist was thrown into the role of client, each sojourned across the landscape of their personal therapy, and then returned to being a therapist. Their personal experiences shaped their professional **Being** (Heidegger, 2005). This means they have engaged with their past and present selves, which shapes their future self, or not. Yet one participant, Jon, seems particularly stuck in his past harmful experience. In contrast, Jade looks back to how she
makes meaning of the clashing epistemologies and questions who constructs therapy.

Making sense of her experience of being a professional in personal therapy, Jade offers us her hierarchy of how she turned a bad experience into a good experience. We again see the psychological and spatial shift of moving closer or moving away from the therapist, previously described by Alex and Jon. Jade encompasses and integrates multiple perspectives of herself, the therapy and her therapist to develop a holistic overview. This seems the essence of her strong identity with counselling psychology and so how she perceives her lived world, which influences on how we perceive her perceptions (the double-hermeneutic; Smith & Osbourne, 2015). Regarding Jade’s sense-making, Smith (2004) considers the analysis of temporal referents enriches research employing IPA’s methodology. The next extract shows the temporal shift of register from the past to the present.

Jade signals her inclusivity of the other from “I feel” to “we made a personal journey”. This suggests Jade is reflecting upon her experience, and further signals her engagement with her own interpretative process because she says, “I feel” about her Self. Reflexivity sits at the heart of counselling psychology training, and in the next extract we see Jade’s professional Self emerge in the role of a client. This potential reflexive personal-professional link supports the rationale for the selection of counselling psychologists as participants in this study. Jade’s growing agency is seen through her speaking her truth, and through her reflexivity. Jade begins to perhaps leave us wondering if anger, upset or disappointments are categorically negative (Cox, 2012a), or whether their opposite, such as feeling good is always good:

so, that’s kind of one thing I feel that distinguishes counselling psychology …
the idea of the importance of the personal development aspect and how we made a personal journey … so so vocalising, this was important for me and erm important for the relationship. Erm, the second thing is to take a reflexive
stance and … its interesting anyway where I feel sensitive or angry or upset or disappointed, erm those feelings do not lose sight of them because those are the meaningful bits.

We can see how in her present, a new world opens for Jade, by contrasting the narratives. Yet it seems the same cannot be said for Alex. Jade’s adaptation supports her to explore greater self-freedom, and new levels of experience through the connectivity with her therapist. Above, Lee says he valued his therapist showing his real self. Alex’s and Jon’s connections with their therapist seem decimated, so it seems reasonable to suggest the potential cost to clients when their personal philosophy is overlooked holds the potential to undermine or even destroy, the therapeutic alliance. How to manage divergent epistemologies or personal philosophies brings forth deep-rooted dilemmas. Alex suggests in the next extract the need to explore what Smith and Rhodes (2014) term the “structural nexus” (p. 10), which describes the point where each unique experience converges with another’s unique experience. Alex seems to suggest that the exploration of the point where personal philosophies meet is an important aspect of therapy because it could provide a way to make sense of clashes:

Dilemmas, oh! I would think dilemmas are part of it … when I think about personal therapy … you know, well if this is not my philosophy because I would experience a clash, well with who or what can I be, or is this therapy shaping me against my will.

Lee extends Alex’s extract towards the conscious application of the structural nexus, where competing fundamental perspectives meet and can clash, or meet and create something new. Unlike Alex, Lee seems to perceive that by asking fundamental questions he has greater control of his worldview. This hermeneutic of suspicion is a crucial element in asserting his sense of identity. Lee thereby offers one purposive way forward:

I like to challenge myself by asking someone from a totally different
paradigm to help me … someone from my own paradigm it’s likely he or she will just confirm what I’m seeing, what I’m doing. I’m afraid of that … it’s really important as well to explicate it more about what our philosophies are … there are days where we often forget about those small fundamentals questions.

Different paradigms compete to interpret what it means to be a person, whether a client, professional or both, and how knowledge seems to be acquired and applied. For instance, deeply held beliefs and interpretations inform the theories practitioners draw upon to explain how and why people do things; even in or because of adversity. Adversity here is interpreted as a perceived harmful experience and the participants employ several strategies to maintain a positive sense of Self: Lee confronts his ‘clash’ head-on through challenges; Jade manages the ‘mismatch’ of beliefs by working relationally; and Alex remains ‘angry’ at her therapist. Here, each participant moves forward individually to explore their experiential dilemmas. However, in contrast, Jon rejects his therapist and perhaps an aspect of himself; he seems stuck in the past, still battling to find meaning in the present. Yet, counter-intuitively and despite an intense account of a clash between selves and personal philosophies, Jon appears the most connected to his therapist. She remains a powerful and psychically consuming figure in his life. Jon comes to experience a sense of disillusionment with his therapy and his therapist. This manifests in various ways, such as swearing, shaking while speaking here, and expressing his anger:

…and she empathically listened to me. And that’s all she did, she said ‘oh yes I understand’. And that was almost worse, because it’s almost like I understand I’m taking a part in that but I’m not gonna take any responsibility. She didn’t say sorry, and it really really hurt, and it hurts now, just for fuck’s sake, I’m angry about it, you you you hurt me.
On one hermeneutic level, three participants exhibit global changes from a relatively passive to an active self. Jade, Alex and Lee seem galvanised through encountering their therapeutic dilemmas. Their selves seem stronger through varying degrees of greater perspectival flexibility. Jon in contrast acknowledges, “I remain tempered by the experience”. This seems a different form of galvanisation. He hurts deeply from his therapeutic experience of Being (Heidegger, 1962) thrown into a difficult relationship where he expected empathy and understanding. He finds himself stuck, “without being able to explain how and why this is ... [and] also stuck with a particular system of meanings” (Withy, 2016, p. 320).

‘Stuckness’ emerges as an unanticipated salient theme and merits further exploration. The potential to resolve the experience may no longer rest with Jon’s original therapist, and so involves a risk. The risk is to return to therapy where the epistemological clash may or may not be resolved, to do nothing, or to find another pathway towards holistic well-being. Linking Jon’s extract above with his extract below, his painful negative outcome seems exemplified by the loss of confidence in the therapist. However, it is notable that this seems not to have generalised to a disillusionment with other human relationships. He has continued to practice for 13 years and relates to me during the semi-structured interview. I interpret this as Jon now feeling he is being heard, and acknowledged. Perhaps this is the reason he wanted to participate in this study of iatrogenic practices in psychotherapy:

she still has denied me that, and she can never unless we go back into therapy again and I say ‘Look, 10 years ago, 13 years ago, and I’ve been talking in research recently and I need to have this final session whereby this is what’s what’s been bugging me for 13 fuckin’ years.

This third and final master theme, making sense of an experience, has helped illuminate the paradoxical complexity of how therapy can simultaneously be perceived as
harmful and therapeutic. Here, IPA can explore whether there is a process or mechanism of change for a drawback (Merton, 1936), which can serve also to develop into an asset. This moves the findings towards emergent philosophical dilemmas. While some ontologies and epistemologies appear potentially incompatible, across the range of psychological and counselling theories a principle is seen to emerge. This is how far the therapist and the client explore the nature of the experience, or place the primary focus on the experience as it presents itself (an open phenomenological attitude; van Manen, 2014).

I suggest exploring the nature of the experience is akin to looking at the client’s experience from the outside inwards (Merton, 1972). This means therapists may explore the experience from the perspective of their sometimes unknown, or unstated, personal philosophy. I also suggest this is what much of the literature pertaining to unintended harm has alluded to, yet remains unstated (Lilienfeld et al., 2014; Pope & Tabachnick, 1994). Working with such issues and dilemmas sits at the heart of being a counselling psychologist. It supports the assumption that counselling psychologists can link the professional reflexively with personal resources (Galbraith, 2017), and lies behind the rationale for asking counselling psychologists to participate.

At a deeper hermeneutic level, Alex powerfully describes the clashing nexus of personal philosophies. Therapists arguably take for granted that within the therapeutic space the other’s life-experiences will be respected and not transgressed. Yet, Alex’s quandary shows a beneficial philosophical transgression. This merits further exploration because thus far the findings have replicated the way the topic is generally explored. For instance, in the wider literature the philosophical dilemma is seen through the Cartesian categories of good always being good, or bad always being bad (Domasio, 2006). Therein sits Alex’s inherent dilemma, an unresolved ambiguity that seems to suggest a philosophical question; is harm harmful?

Otherwise put, a question is here posed; can seemingly harmful therapy also be
helpful? This question is the essence of Merton’s (1936, 2016) notion of a drawback. While Merton (2016) speaks of a synthesis of information leading to different outcomes, here, and just as in her earlier extract, Alex remains confused. She experiences the unwanted change, she knows there is a philosophical clash between her worldview and her therapist’s worldview, yet for all her training as a reflective counselling psychologist the synthesis is currently beyond her emotional or cognitive capacity to benefit from the experience. This is the drawback, for it seemed Alex expected the professional to support her insight, while I expected her professionalism to support the research. We both felt surprised and unsure where to go with this drawback:

well if this is not my philosophy … this was the one therapy that kind of got to places others never did, or wouldn’t ever.

Through the methodology of IPA, the participants have highlighted the dilemmas of thinking in terms of good or bad within the therapeutic context. Counselling psychology’s philosophical perspective values the other’s worldview (Jones Nielsen & Nicholas, 2016), and to honour the participants’ sharing of their experiences, use of the phenomenological attitude is briefly discussed. This is seen where participants synthesise, or not, their experiences of perceived harmful therapeutic practices. The final question in the interview schedule asks; ‘you are still practising; would you recommend therapy to others?’ The question invites each participant to step out of the client role and again become a therapist. The responses were mixed.

Curiosity is intrinsic with the role of researcher-practitioner. So, I was curious of the value the participants would now place on their personal therapy after discussing their individual dilemmas. The findings support that new and valued experiences emerged from their ‘bad’ experiences. Jade, Lee and Alex describe how they are now more acutely aware of consciously offering their clients informed choices. However, Jon’s learning seems similar yet simultaneously different: “having a bad experience teaches ways of not
replicating that for other people”. It seems each participant embodies some meaning-making of what seemed to be a negative experience. This example illustrates the transformation of the negative into a positive experience.

The excerpts from the superordinate themes illustrate how studies like this, which apply IPA (Smith, 2015), can contribute to the topic of unintended harm. Firstly, we now have a detailed experiential account where several clients felt harmed by their therapy. We can see the commonalities between each participant’s accounts and what each participant was able, or not able to do, to manage the unexpected consequences of attending psychotherapy – we can see the meaning of their therapy to them. Secondly, the participants introduce the topic of mismatches or clashes with their therapist’s view. Thirdly, we can see how each participant explains the mismatch or clash to themselves, and how they managed, or not, to use these clashes.

Where the participants take up a position or make a change, we can see that it is their perceptions that are important rather than their therapist’s views. Finally, the methodology employed has shed light on how these therapists in the role of client make sense of their experiences. We can further surmise that this experiential shift may not be so readily available to clients or members of the public without professional training; the public may not be able to make sense of unintended harm, and so may be at greater risk of harm. An alternative perspective is that members of the public may end therapy without fully understanding why, and therefore be left like Jon who is still hurting. Even though he is a professional therapist, Jon painful struggle to make sense of his therapeutic experience is evident.

Discussion

Grounded in Merton’s (1936) notion of drawbacks and the paradoxical outcomes of the unanticipated consequences of purposive actions, this study explored from their
narratives, the experiences of four therapists thrown into the role of clients. Three master themes emerged: *Competing world views: clashing epistemologies; How and by whom is therapy constructed?*; and *Making sense of an experience*. Individually and combined, the narratives afford access to each participant’s experiences and dilemmas regarding the phenomenon of unintended harm, or iatrogenesis (Cox, 2012b; Parry et al., 2016).

Smith and Rhodes’ (2014) IPA applied an existential-phenomenological lens through which we can view the participants’ experiences as they encountered the phenomenon of iatrogenesis. Looking through their lens can support the discussion to link the IPA findings reported here, to the literature regarding iatrogenesis. Smith and Rhodes’ (2014) term, the ‘structural nexus’ (p. 10) provides an entry point to explore what made our participants’ experiences meaningful for them. The findings reveal that divergent experiences can be as equally informative as convergent experiences. Exploration of this point involves the concept of a structural nexus, which supports the discussion of the patterning of superordinate themes as presented. Also, the concept of the structural nexus can be applied to avoid my “falling into the trap of objectification” of positivist enquiry (van Manen, 2014, p. 106).

Smith and Rhodes (2014) also consider that the dimension of relationality is usually pre-reflective, and so taken for granted. The findings of this study can be applied to explore this assumption because relationality is taken for granted as an expected quality of the therapeutic encounter. Therefore, relational clashes help illuminate the phenomenon of iatrogenesis where the therapist’s intentionality is towards well-being. Yet where the therapists’ intending is at odds with the reports of this study’s participants in the role of clients, a dilemma exists; what is the purpose of therapy?

This research fills a gap in the extant literature by reporting how philosophically-based dilemmas emerge when two therapists, one in the role of client and one in the role of a professional, with competing ways of meaning-making, intersubjectively clash. These
clashes hold the potential to make or break the therapeutic relationship. Therefore, how the client and the therapist manage, or not, to resolve such clashes shapes the therapists’ experiences of therapy as clients. The findings show how sometimes the client and the therapist work together towards resolving dilemmas, while at other times the client seems to work alone. Also, the findings show the effect when clients are left holding the dilemma of a perceived harmful therapeutic encounter, and what each participant does to make sense of it. Additionally, how the clashes are used challenges preconceived notions of what constitutes the categories of ‘good’ and ‘bad’. The resulting experientially based transformations present multiple levels of dilemmas.

**Consideration of Method**

Giorgi (2008) argues researchers and particularly students, tend to use ideas positioned within philosophies and methodologies, that present irreconcilable differences. Yet rather than a philosophical or methodological choice, it was the first words spoken by a participant that resonated with me, because the participant had in other research been dropped from contributing her own account. This resonated with the research question because being dropped seems antithetical to client-oriented research, or practice, and so gave this research direction. Jade said, “I was left feeling she hadn’t included me in the analysis.” Jade offered her simple meaning-making perspective; “I think participant care, it’s important.” The point is that in phenomenologically-oriented research we exercise care for the other’s subjective insider perspective to be paramount in their meaning-making process. To consider otherwise is to effectively deny their reality and so attempt to construct their lifeworld for them. Also, to reduce participant care to inconsistent philosophies and methodologies seems contentious and therefore, may miss the point of the therapy. It seemed that some of the therapeutic encounters reported in this study were lacking in basic human connection.

This study sought to explore individual experiences rather than broad thematic
structures (Braun & Clarke, 2006). Therefore, the study applied Heidegger’s (1962) “meaning of phenomenological description as a method [which] lies in interpretation” (p. 37). Many qualitative methodologies are available to explore experience so that we can relationally speak of our worlds to others through stories. In her story, Jade related the hurt of being dropped, yet showed her strength which parallels the strength of IPA. This strength is “creating one’s path, not in following a path” (van Manen, 2006, p. 720), such as accepting unquestioningly the others theoretical epistemology or philosophical values. Meaning-making and the creation of one’s world relate to the overarching themes. Therefore, IPA’s methodology supported the exploration of the topic at hand. If I were to uncritically accept IPA’s theoretical approach without consideration of its limitation, this would amount to following rather than creating a research path.

A possible limitation of this study is conversely the use of Heidegger’s (1962) phenomenological perspective because it values interpretation (Willig, 2013). The interpretations brought forth the issue of power because we each impact and touch upon the other. To work with this, each participant’s verification of the data was “worked into the final product” (Colaizzi, 1978, p. 62). Some researchers consider participant validation as untrustworthy because participants are considered to return to their natural attitude (Giorgi, 2008). However, for this study bypassing participant verification would parallel not fully including the participants in the study. This I considered would be unethical. The lack of discussion around ethics is also a limitation of this study (Tribe, 2015).

Acknowledging these weaknesses informs my pathway towards becoming a reflexive researcher (Etherington, 2004).

The feminist approach to the research enabled participants to be consulted about the interpretations (Fine, 1992). Alex, Jade and Jon were comfortable with the interpretations made. However, Lee disagreed with some of my interpretations regarding his narrative, and my references to DSM V (APA, 2013). Questions about whose view is prioritised
encapsulate the dilemmas that emerged in this study. We therefore negotiated the withdrawal of these extracts. This is consistent with my personal philosophy of including both participants and clients in the process of meaning-making. This is consistent also with the philosophy underpinning counselling psychology.

**Implications of the Research Findings**

The findings suggest multi-dimensional implications for clinical practice and training. When encountering our clients, the importance of listening with a phenomenological ear is suggested. This means an open attitude to hear the others experience as it presents itself. Additionally, to establish whether the goal of therapy is exploration, change or something else is recommended. This speaks to informed consent. Further, exploration of the other’s personal philosophy and awareness of one’s own personal philosophy, including spirituality, is also recommended. It is acknowledged that some of these implications for therapy are not new. However, this study has explored the implications from a new perspective, which is the lived experience of psychotherapists’ experiences of therapy when clients.

Further, a key implication is that iatrogenesis seems a taboo topic for it is rarely discussed directly (Pope et al., 2006). During training, this study indicates the value of explicating our personal philosophies, and how this often-unseen influence can impact upon the therapeutic process. I suggest that university trainings of future service gatekeepers incorporate workshops on iatrogenic practices into the curricula. Jon embodies this study’s key finding, which is also the study’s core philosophical dilemma; is harm always harmful?

The findings from the present study should be considered in light of the following limitations. The limitations are presented in the areas of the Topic of iatrogenesis, the Choice of method, Sampling issues: participation bias, Ethical issues emerging from the
research, Reflections on my developing identity: personal reflexivity and epistemological reflexivity, and Parallel process.

**The Topic of Iatrogenesis**

Wilson (1980) offers a response that I have heard when presenting the topic of iatrogenesis: the fact that clients report deterioration or adverse effects, “cannot be taken to signify that the psychotherapy has caused the deterioration – any more than one can rashly presume that positive changes observed during and after psychotherapy are necessarily the result of that treatment” (cited in Mays & Frank, 1985, p. 7). Otherwise stated, this argument could question the whole endeavour of psychotherapy because no one could know if the benefits (or not), are the result of therapy. Also, it seems disingenuous to discount personal reports and experiences of the phenomenon of iatrogenesis. To explore first-hand accounts of the lived experience of psychotherapy is a key reason that IPA’s qualitative ideographic methodology was selected.

**Limitations**

**The methodology of IPA.** As with any methodology, phenomenological methodologies come with limitations. For IPA, four limitations seem particularly relevant. Firstly, in this thesis’ Literature Review the quantitative and mixed-methods studies reported averaged participant differences. Yet IPA’s methodology has an ideographic focus, which in this study means there is “no average of patterned differences in perceptions and perspectives” (Merton, 1972, p. 118). I found IPA’s methodology to produce master themes rather than a focus on the rigorous exploration of a single, idiographic subjective experience (Biggerstaff & Thompson, 2008), to be particularly weak.

This is because the study’s gaze shifted away from the essence of the individual’s unique perceptions and experiences, towards a broader patterned or
themed small group perspective. This apparent weakness could be turned into a strength with a method to extend this study. I suggest a method that can identify and interpret patterns across a broader group through the application of an alternative thematic analytic approach (Braun & Clarke, 2006). Braun and Clarke’s (2006) Thematic Analysis offers a flexible method rather than a methodology, and is considered epistemologically neutral. This would help extend the findings of this study by viewing the topic from an alternative angle, and with a similar sample yet relating their narratives from different perspectival positions. This could then be used to advance the research within the philosophical approach that underpins this thesis.

As a scientist-practitioner, it seems important to state my concerns regarding the theoretical assumptions and potential philosophical inconsistencies that I consider underpin this application of IPA. The philosophy that underpins IPA (Heidegger, 1962), and which accords with counselling psychology’s ethos and philosophy, is non-hierarchical. This is to say that all human experiences have equal validity; this is the essence of horizontalisation. IPA, however, is presented vertically through the themes and subthemes of the analysis. It is worth noting, however, as reported elsewhere (Cox & Brown, 2014) that, “themes are not mutually exclusive but show the diversity of research” (Silverman, 2013, p. 15). Therefore, I argue it seems more appropriate to think of themes in terms of multiple strands, which are reminiscent of the strands that weave together to make a strong rope (Parfit, 2011).

Rather than a coded hierarchy, I prefer the term ‘strands’ as each theme or subtheme seems of equal value, just as it seems one cannot subsume any one part of an experience to any other part of an intersubjective experience. Therefore, the philosophy and the methodology of IPA sometimes seemed inconsistent. Linked to the extracts where the participant-clients often spoke of a clash or mismatch with their therapist’s views, this seems to be my reflexive clash with the philosophical underpinning of the research
method. To manage this perceived inconsistency, I applied Smith and Rhodes’ (2014) term ‘structural nexus’. This term allowed me to explore the interweaving superordinate themes, and where they meet to reveal the phenomenon being studied. For a more accurate fit between the philosophy, topic and research methodology I could apply an alternative thematic analysis, which does not have a methodology like IPA’s, and with a different participant sample. In an alternative study this could be therapists’ perceptions of delivering psychotherapy that they perceive as engendering unintended harm.

Secondly, IPA is often critiqued for the limited role of generalisability to larger populations. The narrow sample helped contextualise this study, which can now be applied to consider a broader range of therapists. Also, this study aimed for theoretical rather than empirical generalisability. This means that the reader is invited to make links between the findings of this study and their own personal and professional experiences (Smith & Osborne, 2015). Further, the reader is invited to consider the findings of this study with the extant literature presented previously in this thesis. Additionally, while smaller sample sizes which are difficult to generalise seem a limitation of IPA, the reduced participant numbers allowed for the richer and deeper analysis. Larger sample sizes frequently applied in quantitative research do not easily lend themselves to detailed analysis.

In a parallel process, what seems a limitation of this IPA research can also be a strength, as in the following example. In the third master theme: Making sense of an experience, Jade said it is important to “take a reflexive stance and … feelings do not lose sight of them because those are the meaningful bits.” The parallel is that I used my feelings to listen and learn during the research process; my learning is that just as the participants mostly synthesised what seemed like oppositional positions to make something new, so this has happened from my clash with IPA’s methodology. It seems this multi-dimensional process would not have been likely to have emerged from a large sample, yet may point towards a universal process that could be general in its nature. At the least, the findings of
this study can help reduce the gap between the broad knowledge principles of iatrogenesis presented in this thesis’ literature review, and the in-depth individualised findings reported in the localised context of therapists in the roles of clients within the consultation room (Charlick et al., 2016).

Thirdly, IPA is also often critiqued for its focus on participants’ language to access self-knowledge. From the primacy of language emerges the potential that experiences may have been lived but not yet languaged. Also, the participants related retrospective accounts of their experiences, which could have been affected by memory encoding, processing or recall issues (Baddeley & Hitch, 1974). Yet this could in some form be applied to most if not all research.

Therefore, this limitation is not unique to this study. What I consider most problematic, is that at points the participants offered a view of what they believed their therapists meant. This called for the participants to interpret and assign meaning to the perceived motivations and meanings of the therapists. This study then interpreted those meanings. Within this study, this was addressed through IPA’s methodology. IPA provided a particularly useful form of thematic data analysis, in that it allowed for both an understanding of which elements of an experience mattered to each participant (through a description of emergent themes), and the meaning of the experience (through the interpretive analysis; Smith & Osborn, 2015).

Fourthly, to cluster the themes, I transferred each emergent theme onto an individual Word document page. This meant I could use scissors to cut each emergent theme into a smaller piece of paper, which I placed across the floor. This allowed me to move themes around to form clusters and so create a spatial representation of how emergent themes related to each other, or not (Smith et al., 2009). This also gave me a sense of the hermeneutic circle, the part (pile of a theme) within the whole (all the theme piles). However, the technique raised a potential limitation because it was guided by my
overview, which in turn was shaped by my pre-suppositions. As Heidegger (1962) states, we never approach a context or relationship pre-suppositionless.

Finally, the above example demonstrates how the level of flexibility in qualitative research methods can be a weakness or a strength, depending upon its application. A strength is the flexibility to work with unexpected turns in the narrative, unanticipated territory and areas that are particularly interesting (Smith et al., 2009). This was important for a novel topic and was an aspect of IPA that particularly appealed to me. A weakness is that my interest in the topic and own experiences, could unintentionally hinder diverting the interview to my own fore-structure of knowledge, and so impact the analysis (Denscombe, 2002). To manage this I checked my meaning-making and interpretations with a supervisor. This was not for a right or wrong overview, yet to check for clarity. Also, I have aimed to be clear regarding my position throughout this study. A research diary helped me remain grounded in the data.

**Sampling issues: Participation bias.** The way the participants were recruited may have had an unknown influence upon the findings. The influence may have been on at least three levels; my own, the participants, or an interaction. The participant call was initially advertised via the Division of Counselling Psychology’s own fortnightly members only e-letter (Appendix A). I was surprised to find that for an unknown reason one-fifth of the counselling psychology membership was not registered to receive the email. There were no responses. When I engaged with critical self-reflection (Galbraith, 2017) and asked for peer feedback, I was told the participant call was written in a complex way and that this detracted from the call. My lack of interest in most social media sites was likely a drawback (Merton, 1936), because I am not familiar with their use, or potential problems. I had noticed a trend for researchers to use social media to recruit (BPS, 2012), and saw many advantages to this. While the medium of recruitment may change, the benefits or drawbacks (Merton, 1936) of these trends remains within the scope of the BPS (2014).
code of human research ethics.

A second revised and simplified participant call (Appendix B), received many responses. This call was placed on Linked-in, a social media site, which has a private closed group for counselling psychologists. I contacted Linked-in to clarify procedural and safety setting issues. Also, I consulted a supervisor who has much experience of the benefits and drawbacks of using social media, and consulted the BPS (2012) publication, e-Professionalism guidance on the use of social media. In a parallel process to my recruitment for ease, the participants potentially responded to meet their own personal needs. Also, the interaction at the point of recruiting when some people asked questions pre-participation, may have biased the recruitment process, and thus the participants recruited. It is possible that my enthusiasm had an unknown influence.

However, to encapsulate the issues, social media has its own etiquette, procedures and may have introduced a bias in terms of who uses a private social media group (Braun & Clarke, 2014). I suggest that such groups have a cultural membership, with shared values, interests and assumptions that make up being a member of the group. This may have had an unknown influence on the findings. I say this as I am not a user of social media sites, and without a qualitative sensitivity to such cultural or small community issues, may have missed the influences. That I overlooked reflexively noting that I dislike social media yet used it anyway, possibly led me to the meaning of other potential influences. That is a significant learning in and of itself. As Milton (2016) notes, “meaning is a much richer, more complex communication than simply words, (as any user of email or social media sites will probably confirm)” (emphasis original: p. 188).

This study is complicated by having practising therapists as participants, talking about their own therapy. It has been argued that these are not typical recipients of therapy (Mays & Franks, 1985). While I may disagree with Mays and Franks (1985) because many therapists do engage with personal therapy, nevertheless, they have a point. The question
of interviewing professionals about their experiences of attending personal therapy poses several problems for the present study, as the participants’ status of being a therapist may have in many ways influenced their narratives of being a client. First, as therapists they may feel that it is disloyal to their profession to discuss the problem of unintended harm, and therefore may be more likely to emphasise the positives of therapy. Second, they are vested in the benefits of their profession and therefore may minimise any problems they experienced. In contrast, as professionals they may be experiencing burnout or compassion fatigue, and therefore overstate the problem of harm due to their own mind-set at the time of being interviewed. However, my experience and which surprised me, was that in their personal therapy these therapists were like any other human. They seemed to struggle to engage their professional self in the personal context.

Third, while in the role of client these participants may have had an expectation that also being a professional means they should understand the processes applied to them, yet be unable to do so precisely because they are in the client role, and not the professional role. This seems to accord with Jon’s confusion around his difficult experience: “What hurts now isn’t necessarily harmful, it doesn’t cause harm but it hurts.” In addition, as reflective practitioners their level of analysis and insight about the content and impact of therapy may be greater than more ‘typical’ non-therapist clients. Therefore, their experiences may not illustrate the experiences of clients in general. What I found surprising was how little reflection three out of the four participants had given to the role of the therapist in challenging or questioning them in order to facilitate and also deepen their learning in potentially unexpected ways. My assumption that as therapists and particularly reflective counselling psychologists in a dual role, they would have a greater insight into unintended harm was generally unfounded.

This has implications for the research topic and my research: for the topic, I feel this supports the key finding of this study, is harm harmful? Regarding the thesis title, was
the practitioner engendering harm and even if so, was this due to an unintended action or a deliberate and formulated intervention that sought to push or challenge the client’s worldview? What I discovered was that these counselling psychologists were similar to all clients in therapy. In this constructed research process, what the participants spoke of equated to personal therapy rather than a professional practice, or even a synthesis. I reflected upon this, and consider my own history of being a client and practitioner. I became aware of different perspectives and my own past puzzling life events assumed a greater depth of analysis and discovery. I have been able to see how important it is to continue to ask questions throughout the therapeutic process and the research process, and not only that, to be unafraid to ask challenging questions and to risk unexpected consequences or findings as a result.

The third limitation above extends to a fourth limitation regarding sampling issues and participation bias. My assumption of the anticipated insights that counselling psychologists as participants would bring to this study, parallels my assumption that this specific sample would share the experience of their philosophically-based reflective training, which would engender more similarities than differences. In short, as a complex equivalence, I believed my developing identity of becoming a counselling psychologist would represent identification with this specific group; upon reflection, this flawed belief was my blind spot. I omitted taking into account differences such as socio-demographic factors and therefore the fore-conceptions of each participant. This is an important factor because each participant has a different native language, and experienced a dis-similar cultural background.

The hermeneutics of IPA considers that we each arrive with our own fore-conceptions (Heidegger, 1962). While I believe that from the spread of responses, it did not seem that ethnicity, age, UK geographical location or gender unduly influenced the research findings, I now feel uncomfortable with what feels like my design shortcoming in
relation to this aspect of the research design. My discomfort is encapsulated by Willig’s (2013) advice that, “Using preconceived ‘variables’ [or differences] would lead to the imposition of the researcher’s meanings and it would preclude the identification of respondents’ own ways of making sense of the phenomenon under investigation” (p. 9). My epistemological reflexivity is to acknowledge that by not considering the differences I unwittingly imposed the research design, and it is possible that some of my findings emerged as a result of my meanings and my needs. Acknowledging this opens many doors to alternatives choices.

Additionally, two therapists chose to work with professionals from different theoretical and practice areas of expertise, which may well have influenced their experiences. Both expressed anger about what had happened to them, and whilst this may just be a reflection of the content of the therapy, it may also illustrate a degree of conflict between different professional areas of specialism. Further, the two participants who chose therapists from different modalities other than their own, had stopped engaging with personal therapy. There is a possibility that this shaped their narratives because while being advocates of therapy to work with distress, curiously they were not using a professional service to work with their own distress.

Finally, there is one obvious question regarding participation bias that remains unstated. The participants could have had ‘an axe to grind’. In hindsight, I could have included an interview question to ask: What motivates you do take part in this research? I am sure this would have led to some interesting reasons and rich data, which could have ‘thickened’ the findings. This is particularly important as the earlier section sub-titled The phenomenon of iatrogenesis, reported that therapists lodge more formal complaints against other therapists than any other group. My personal reflexivity is to acknowledge that this issue of motivation has unknown implications for the findings. Perhaps more of myself was apparent in the study than I had realised because I advocate for the work we do, and
have personally reaped great rewards from attending psychotherapy. My blind spot may be apparent to the reader; it has been a revelation for me just how much the research process has opened-up my view of the world and my position on issues within it.

However, while therapists are typically the largest group of people who complain about therapy, as clients these professional insiders may have insights unavailable to those without professional training. Also, during training counselling psychologists engage with personal therapy and so are presumably believers in the value of therapy. Plus, counselling psychologists are “trained in the use of the self” (Galbraith, 2017, p. 153). This was a key reason for accessing the knowledge of this participant sample. Yet I acknowledge that the experiences of the selected participant sample are arguably complicated by their professional roles, yet they are also informed by their professional roles. This is the essence of Merton’s (1972) concept of insider knowledge and paradoxical consequences.

**Role conflict of the researcher.** An additional limitation relates to my role as a researcher whilst listening to therapists talking about their therapy. At times the participants talked with emotion and as a therapist myself, sometimes I found it difficult to steer a clear path between myself as a researcher with empathy for my participants, and as a practising therapist. This was made particularly complicated by the participants themselves also holding the triple role of client, therapist and research participant. Sometimes, in the back of my mind, I criticised the interventions the therapists had made, although my awareness came via the eyes and perceptual filters of the participants, alongside my own preconceptions. This has led me to consider social constructionist theories (Potter & Wetherell, 1987) as an alternative way to study purposive social actions (Merton, 1936), and the topic of iatrogenesis. A further limitation may relate to my identity of becoming a counselling psychologist. The participants are seasoned counselling psychologists with many years more experience than myself. Meaning-making takes place
through the use of certain resources including culture, and cultures are effectively frameworks for meaning-making (Smith et al., 2009). Counselling psychology has its own culture, the influence of which I may have underestimated.

While society has one form of culture, psychotherapy also has its own culture, language and narrative (Furedi, 2004). Therefore, within the culture of therapy generally, or counselling psychology specifically, there may have been an unknown influence regarding role conflicts between myself as a fledgling researcher-practitioner with these seasoned researcher-practitioners. In short, the seasoned professionals may have noted errors in my approach and had to decide whether or what purposive action to take, if any. The resultant consequences of acting or not acting for my best interests, which was to obtain data for my research, may have detracted from the interview process.

This is the essence of drawbacks in Merton’s (1936) theory of purposive social actions. For clarity, I noted in my diary how I experienced these professionals as people wanting the best for me as I conducted my first large empirical research project. We co-created a positive research experience for which I am grateful – these counselling psychologists guided me to be the best I can be, which reminded me of how I came to apply for training and the panel interview for training. My point is that counselling psychologists are adept at using the self to draw the best out of others.

Furedi (2004) argues we live in a risk society, “where the intensification of uncertainty and risk has led to the emergence of a reflexive project of the self” (p. 86). Perhaps in novel or stressful situations we can each lose the touchstone of our expected lived reality. After all our training, it may have been difficult for each of us to experience the triple and at times conflicting roles and positions of client, therapist and participant or researcher; at points in the narratives the participants and at times I struggled to make sense of unknown or perceived unintended harm. While the tension between our shifting positions can be viewed as a design limitation, through reflexivity I was able to position
the findings within the context of the study, and the limitations of the design. This was exemplified in my interpretation of Jade’s extract regarding the true-false self (Winnicott, 1960). However, the opposite process to confusion was also apparent, and like the participants, I also synthesised what I experienced initially as a negative experience with a good experience, to create a new experience.

In a widely-cited critique of IPA, Brocki and Wearden (2014) consider that IPA offers little guidance regarding, “the extent to which the interviewer should interpret what is being said as the interview proceeds, and the extent to which these interpretations should be shared with the interviewee” (p. 11). This means my role as researcher seemed sometimes unclear, and I experienced a role conflict during the research. I felt a double-bind between passive listening to avoid influencing the account, and active listening with the use of prompts and encouragement to elicit deeper disclosure at specific points, because I wanted my research to be ‘good’. At these times, I poured my heart out in my research diary. Sometimes the pen helped me cut through the Gordian knot of double-binds; at other times, I was left puzzled, and remain so to this day. My point is that the process of conducting an IPA was far subtler than I had expected, and deeper layers have kept presenting each time I have re-read the thesis.

One such point was Alex’s anger when perceiving her therapist as deciding the goal of therapy, yet without Alex herself stating what she wanted or did not want. I experienced the hermeneutic of empathy with Alex, the therapist and myself. This was coupled with a hermeneutic of suspicion, and my desire to push the analysis to a more abstract conceptual level by importing psychoanalytic theory into the interview process. Sensitised to my presupposition when trying to import the ‘true-false’ concept with Jade and shifting positions between clinical theory and research interviewer, my intuition helped me decide against this with Alex because I felt like I would have become a therapist rather than a researcher, and research, after all, is what Alex had given consent for. Instead, I was
sensitive to Alex’s narrative regarding informed consent, which I reflexively interpreted as unspoken guidance. I spoke to my supervisor about this and further poured my thoughts, feelings and dilemmas into my research diary (Brocki & Wearden, 2004). What I learnt was how much, “the results of psychological research reflect the researcher as much as the people researched” (Salmon, 2003, p. 26).

**Ethical Issues Emerging from the Research**

Little attention is paid in the literature to the topic of unintended harm in psychotherapy, and less so in this study, to the nocebo effect. As the opposite to the placebo effect, the nocebo effect describes a person’s anticipation of a side-effect causing the actual side-effect. For example, when physicians deliver a painless treatment yet say that it may hurt you, patients can “experience distress, which can tax the coping mechanisms of even well-functioning individuals” (Lang et al., 2000, p. 1486). In her extract, Alex suggests that therapy “should come with a warning”. This presents a dilemma; as researchers or clinicians, should we be warning our participants or clients that therapy could cause harm? Also, when we add the words, ‘to a significant number of people’, could that increase the risk of harm? My reflection is to wonder whether the title of my thesis, unintended harm, engendered an expectation that caused harm. This is something I am currently considering.

Further, if a client is from a marginalised group such as the BME or LGBTQR communities, and so is already at greater risk of an adverse outcome, how might therapists manage this situation? My point is that there seems to be an ethical double-bind, for to mention potential harm can increase its incidence, yet to omit mentioning the possibility of unintended harm seems unethical. This ethical quandary will be reported on elsewhere (Cox, 2017); here, I offer no resolution and suggest that as professionals we need to reflect on such processes or double-binds. Curiously, working with such paradoxes and “making the unknown known” (Strawbridge, 2016, p. 20), sits at the heart of being a counselling
psychologist.

What I can offer is my surprise that few if any members of the LGBTQR community or other marginalised groups took part in my research. Also, people from these groups were seldom included in the literature review, or chose not to self-identify. For multiple reasons, that troubles me; such groups could add to and benefit from the research. My intuition is that I need to further develop my presentation of the topic to broaden its appeal and relevance to those who are socially marginalised.

**Reflections on my Developing Identity: Personal Reflexivity and Epistemological Reflexivity**

In terms of personal reflexivity, this study is changing me as a professional and as a person. Although I was captivated by qualitative research, I also began to expand my horizons to use and look beyond the dilemmas I experienced with IPA. From a professional perspective, the dilemmas were about accessing internal experiences, and I was more heavily influenced by my concurrent psychoanalytic psychotherapy placement than I had realised. In brief, I began to wonder if we can ever separate out the strands of our Selves (Hood, 2012), in this type of research.

Also, it seems our deepest symbolic internal processes shape how we experience relationships and events. I was also beginning to question the philosophical ideas that underpin IPA. While IPA provided a useful methodology to appreciate and analyse parts within the whole, upon reflection I feel my filtered epistemologically blurred lens rendered bracketing or epoché ultimately implausible. It now seems to me that if bracketing personal meaning-making becomes potentially meaningless, perhaps greater clarity is instead afforded if writers state their own personal philosophy. Readers might then see the interpretative process at work. For this reason, I have placed my position statement at the beginning of this study. This allows for transparency. It also allows for readers to appreciate where I stand within the study and to see my strengths and weaknesses.
From the professional perspective of my insider knowledge of counselling psychology (first order), and personal perspective of my experiences of receiving psychotherapy with consequences for my preconceptions, to manage the fore-structure of my knowledge (second order), a research diary was kept. The diary informed the data analysis and write-up. In the diary, I also wrote of my personal experiences in therapy, whether good, bad or neutral, and how this impacted upon the research process and my interpretations of the participants’ narratives. I chose the topic of iatrogenesis as I have rarely heard it mentioned during my numerous trainings, or in any lectures. When I attempted to raise the issue that while therapy can help it can also harm, I began to experience iatrogenesis as a taboo topic.

What attracted me to the topic was the following type of comment. I have heard it said that some clients may be prone to disappointment and, “have a special talent for seeking it out (and finding it) even as they yearn deliverance from it” (Castlenuovo-Tedesco, 1977, cited in Strupp et al., 1977, p. 69). I suggest the unintended consequence of health professionals who purposively act from this belief are at high risk of delivering iatrogenic practices. I also suggest that this is one mechanism whereby clients are blamed or stigmatised for not conforming to the therapist’s world-view, such as when speaking out about poor services or unethical conduct, and particularly with reference to colleagues. The ethical duty to maximise benefit and minimise harm (BPS, 2015), is then reversed, thereby embedding marginalised people or groups into a system that blames the individual for socio-cultural issues. Such “negative effects cannot be ignored nor can they remain shrouded in secrecy” (Strupp et al., 1977, p. 4). Opening Pandora’s box to explore unintended harm in the consultation room, and beyond, is my professional and personal passion.

Merton (1972) considers there is a group of free floating intellectuals who are neither insiders or outsiders, who have diverse social origins and can transcend group
allegiances. Merton (1972) considers also this group “can observe the social universe with special insight and a synthesising eye” (p. 29). While I epistemologically shaped the research, this can be a drawback or an asset. Running the risk of being driven by my perspective and passion for this topic, the view I bring to this study is arguably a view necessarily focused on exploring this topic. I would argue that I study this topic because it has multi-dimensional meanings to me, and resonates deeply within me.

I view this as one pathway to greater social justice within our society. To achieve an impact, I have developed myself and expanded my knowledge base; I strive to present the research in ways that are more sensitive to the needs of others. My interest arises from a position of curiosity rather than any need to justify my own personal issues. Conducting this research has changed my identity. The process has helped me appreciate that the awareness and management of unintended harm signals good and ethically-grounded practice, rather than a continuation of poor clinical practice. This can be seen through my shift from personally focusing on the experiences of clients to applying this research to support practitioners (Psychotherapy and Counselling Union, 2016).

I hope that the following research project (Thematic Analysis; Study 2), will extend this study and shift attention towards identifying and reporting a broader group pattern analysis to extend this idiographic focus of this IPA. This will translate my willingness to facilitate social (therapy) and political (public policy) change (Fine, 2006). Both aspects speak to my position regarding social responsibility, and a core belief in our shared collective duty for the welfare of others (BPS, 2015). These reflections, through this study of iatrogenesis have impacted on my developing identity as a counselling psychologist. My increased focus on reflections has helped develop an increasing awareness of personal reflexivity, together with a broadening of my epistemological reflectivity. Jade’s single utterance captured the spirit of this study. Jade’s gem has great resonance within her particular experience and across the corpus of this work (Smith, 2017): “I was left feeling
she hadn’t included me in the analysis.” This gem encapsulates the value of applying IPA to explore unintended harm in the field of psychotherapy.

**Parallel Process: The “Me in You”**

While writing up this study I became increasingly aware that there are multiple points in the study where a parallel process emerged. Often the processes seemed to emerge in an unprocessed way, by which I mean that writing about the parallel processes helps to strengthen reflexivity. This can also strengthen and broaden insights into the interactions. Parallel process refers to where aspects of one relationship are expressed in another relationship (Carroll, 1996). While I have come across this in terms of the therapist-supervisor relationships, it provided a useful theoretical way to unpack the participant-researcher relationships within this study.

I find the ‘me in you’ and the ‘you in me’ an “intriguing, often enigmatic or uncanny phenomenon” (Morrissey & Tribe, 2001, p. 103). This phenomenon, within the topic of my acknowledged limiting literature review title, unintended harm, operates on multiple levels. Due to this complexity, Clarkson (2003) suggests that a parallel process should be conceptualised as a way of describing the pattern of the client–therapist relationship, or here participant-researcher intersubjectivity. I share Clarkson’s (2003) perspective, which conceptualises a circular dynamic relationship, rather than a linear process, which my literature review title may have unintendently suggested.

To explore where and how parallel processes emerged in this study, I collected multiple examples where my research question has been in evidence in my experiences, such as before my training, during the training and while conducting this study. These are interwoven with examples from the transcripts where the participants and I engaged in parallel processes. From the psychoanalytic literature, Searles (1986) described this as a ‘reflection process’ whereby those engaged in the relationship rest upon a “transitory unconscious identification occurring as a function of the relationship” (p. 161). This
definition has great appeal to me because it suggests a multi-dimensional process without attributing blame. My reflection process, which was triggered by my realisation that my assumptions regarding the participant sample were mostly unfounded, led me to re-consider a key aspect of this study; my assumptions regarding the counselling psychologists as participants. I assumed their reflexive use of self (Galbraith, 2017) would translate into rich findings. This left me curious to understand what was happening during the intersubjective moments where the parallel processes appeared, because although the findings seem rich, this seems unrelated to my assumption.

From my personal interest in the topic of iatrogenesis, I had considered a key aspect of this study to be the recruitment of counselling psychologists for what I perceived to be their ability to engage with the dual perspective or roles of a professional in the role of client. This underpinned the philosophical and pluralist nature of my sample’s training and to which I myself feel a great affinity. This philosophy underpins the Division of Counselling Psychology’s professional practice guidelines; to ‘negotiate between perceptions and world views but not to assume the automatic superiority of any one way of experiencing, feeling, valuing and knowing’ (BPS, 2014, pp. 1-2). My passion for the topic, which originated with once feeling marginalised and stigmatised, and then receiving excellent therapy, may have led to my imposing my views, and this may be in evidence in my literature search and my understanding of IPA’s methodology.

In this thesis’ literature review, I felt I had found a niche between the 80% figure for those who report benefit by attending therapy and the remaining 20% who either report feeling harmed by attending therapy, or consider there was no benefit or any drawback. I was surprised by how few people are looking at the 20% sub-group, and within the 20% found another sub-group of 10%, mainly comprised of clients in marginalised groups. I was motivated by the common factors argument (Lambert, 1992), that the quality of the therapeutic relationship accounts for 30% of therapy outcome variance. I am dubious of
that statistic, particularly as it applies to all clients, and not the 10% sub-group identified in the literature review. I suggest that if the therapeutic relationship is not going well, the reported 30% of outcome variance ascribed to the therapeutic relationship may seem implausible to a client who is experiencing their therapy as harmful. Also, the 40% of outcome variance attributed to extra-therapeutic factors (Lambert, 1992), may not matter to a client in the room experiencing difficulties with their therapist.

**Linking parallel process with the data.** My feelings around the parallel process emerged when Jade said: “it’s interesting where I feel sensitive or angry or upset or disappointed, those feelings do not lose sight of them because those are the meaningful bits.” While I was aware of my feelings, I am also aware that the reflexive aspect of my professional development is still at a relatively rough stage. That I am aware of this now suggests that my reflexive use of self in the service of my research question is developing sophistication. This feels important to me, and I find this resonates with Morrissey and Tribe (2001) in their consideration that a “student has cognitive understanding yet still needs to develop the affective skill of navigating and finding solutions to difficult encounters or ethical dilemmas” (p. 106). This, after all, is the art of doing therapy. My realisation is that both therapist and client journey towards separate and mutual discovery, that all relationships serve as learning curves, and further opportunities to explore how human beings cope with life when it raises dilemmas and challenging situations. It is apparent that there are no distinct or all-embracing answers. Parallel process operates largely in the realm of the emotions which are constantly shifting in order to find temporary footings, and so offer greater insight into oneself as a person who is constantly learning about and adjusting to the circumstances that life demands of each of us as we journey through it.

There seem to be parallel processes inherent within my research question: *What are psychotherapists’ experiences of therapy when clients?* The question limited choices to the
client role, to facilitate what I imagined to be a voice for those who might have experienced unintended harm. I had also assumed this may originate from the therapist. Here, I remember John saying, “the mistake if I reflect back on it that she made, she had a template of reality in her head that certain experiences count, and certain experiences don’t count.” As I reflect back, my research question was theoretically underpinned by Merton’s (1936) concepts of drawbacks and paradoxical outcomes. I intentionally excluded a psychotherapeutic theory to avoid imposing my worldview, yet inadvertently imposed my worldview.

Alex was clear that “there were times when I wanted her to go outside her model, to step back and reflect on how the psychoanalytic theory sees the other.” Like Alex’s therapist I did not do this. Perhaps Alex was speaking of her therapist and also to me about not listening to her. I say this because curiously, I now notice that the master theme emerged as: Competing world views: clashing epistemologies. The cognitive and affective skills were linking up; I just did not know what I knew. My learning in this regard has been to hold onto and to be aware of the in-between space - even as the therapeutic or research relationship unfolds - so that there are more opportunities to ask questions, reflect and explore within the room, whatever room it might be. In other words, to create room within the room, and this applies to training and supervision, particularly where ethics and professionalism ought to be able to be transparent, non-judgemental and exploratory.

My experiences of psychoanalysis were helpful, unhelpful yet rarely neutral. I had some concerns and could relate deeply to the parallel process with Alex: “I’m scared that I’m going to be … seduced by the model, yeah. And it’s exactly what happened. And I think that’s part of what psychoanalysis is, it captures you at an unconscious level.” The research question has given me a growing awareness of other ways that I could have undertaken this study. One alternative would be to focus on understanding the nature of the transference-countertransference interactions, and more importantly the impact of these
reactions on the client, therapist, researcher and reader. This does not mean we don’t look at the behaviour of the therapist, yet at the same time recognise that relationships are co-created. Curiously, theme 2 emerged as: *How and by whom is therapy constructed?*

On a deeper level of parallel process, I had assumed that these counselling psychologists in their own therapy would be able to report from the dual client-therapist perspective. What surprised me was that these participants seemed mostly unable to consider that their therapists might be trying to follow ethical guidelines or not, as the case might be. This meant that for the most part, they could not engage with this possibility. In their own personal therapy, the participants were people with their own needs and therefore, and I reflected not as different to members of the public as I had assumed. So, I over-estimated in my thinking what these professionals in personal therapy were able to bring to the research question. The parallel process was how much of my own client-therapist self I brought into the research question and the study, because I was similarly limited by how much I assumed about the mind of the other.

Curiously, ‘mindblindness’ (Baron-Cohen, 1997) and ‘the field of transference’ (Buirski & Haglund, 2001) were the very concepts I tried to close out of the study. Yet, they were subtly present throughout it. My reflexive development has enabled me to explore how the participants and I experienced a parallel process of anger towards some therapeutic interventions. It has become clear to me that this parallel process has important implications for future research into areas of misunderstandings, poor outcomes, self-protection and disclosure within the field. This is a powerful learning to take forward into further research of this topic.

My reflections have helped considerably to develop my growing sensitivity towards acknowledging alternative perspectives to my research question: *What are psychotherapists’ experiences of therapy when clients.* Perhaps the errors which were perceived and then reported as feeling harmed were instances where the therapist was
attempting to judge whether something would be useful or not, and the attempts having unravelled. The therapists in this study, as clients, seemed unaware that their therapists were potentially trying to match something or elicit a response in order to further explore a difficult experience. The implication necessitates considering whether a therapist’s decisions could be unconscious and also how aware might we, or the participants, be about that process of meeting difficulties as opportunities rather than harmful ruptures.

Conducting this research and developing this thesis has led me to an idea that there is a process that goes on within the process in the well-intended therapist. I hope that my readers will also appreciate what I have learned through this complex and intriguing process.

**Conclusion**

Underpinned by Merton’s (1936) theory of unintended consequences and framed by IPA (Smith 2015), this research explored the experiences of philosophically and psychologically aware professionals in their personal therapy. The literature reports that up to 40% of therapist’s report experiencing harmful effects from their personal psychotherapy. Therefore, it seems reasonable to conclude that the field of counselling and psychotherapy faces some philosophical and ethical dilemmas. Counselling psychology acknowledges that research, socio-cultural changes and client expectations, “have required us to re-examine what we offer the public [including therapists] and how we offer it” (Corrie, 2010, p. 46). While these therapists in the role of client were able to make some sense of their negative experiences, the public may find it more difficult to synthesise negative experiences into positive experiences. The key finding has philosophical implications for practice; is harm harmful?

I suggest that if the field of psychotherapy is unable to reflect upon the potential for iatrogenic practices, we leave ourselves open to criticisms regarding ethics and accountability. It is this call to accept and explore the phenomenon of unintended harm in
the consultation room that is my aim in conducting this study. To explore iatrogenesis is a
sign of good and responsible practice rather than poor practice. As therapists, we work
towards helping clients explore their experiences and alleviate distress. Here, this study
asks therapists to do what we ask of clients, to explore the more difficult aspects of what it
means to be a human being.

The conclusion I have reached is that it is as challenging to be a well-intended
therapist as it is to be a vulnerable client. In the end both people in the room are humans
and the difficult journey that doing therapy entails is a worthy albeit challenging one on
both sides of the therapeutic alliance. It has been a humbling experience to open Pandora’s
box and find that some of the greatest lessons are learned in the least expected ways, and
that it is the relational process itself that is the tool of enlightenment. I am grateful to be
where I am with this research as it continues to raise important questions about how best to
serve those who are in need of support, whilst at the same time creating a safe space in
which as little harm as possible is engendered, in what is by its very nature, a difficult and
emotionally charged process for all the stakeholders in psychotherapy.

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Appendix A

Research Participants Needed

I would like to invite you to participate in research provisionally titled: Unintended harm within psychotherapy: An IPA. The heart of this research explores: What are therapist’s experiences of therapy as clients? This research aims to explore the phenomenon of unintended practitioner-caused harm, also known as iatrogenesis. The objective is to legitimize the voices of those reporting their therapy as harmful.

Background: First, do no harm is the ethical and philosophical underpinning of the helping professions. Although 80% of clients benefit from psychotherapy this implies that 20% of clients remain unchanged, or even deteriorate. Within the 20% sits a sub-group who consistently report harm by attending therapy.

I am seeking six counselling psychologists with a minimum one-year post qualification practice experience in a non-NHS context. The minimum commitment is a 30-minute semi-structured interview, arranged at your convenience. The research has received ethical approval from Surrey University, and supervised by Dr. Dora Brown dora.brown@surrey.ac.uk Please feel free to contact me p.cox@surrey.ac.uk

Philip Cox
Appendix B

Participant Recruitment

Through the topic of unintended practitioner-caused harm, this study aims to explore how your personal philosophy shapes your practice, and add to the literature. This is an underexplored and so underreported area of psychology. As counselling psychologists, whose training is philosophically-informed, we could add to the knowledge base, and so serve clients well. Are you a qualified counselling psychologist with experience in a non-NHS context? The commitment is a 30-45-minute semi-structured interview, arranged at your convenience. This research has received ethical approval from the University of Surrey.

p.cox@surrey.ac.uk
Appendix C

Inclusion Criteria

Hello [name],

Thank you for considering participation in this study. By answering yes to all of the following questions you would meet the criteria for inclusion in this study. We could then arrange a time, date and place that suits you for the semi-structured interview.

I have also attached the Participants Information Sheet, and questions which may guide the semi-structured interview.

Kind regards

Philip

Email: p.cox@surrey.ac.uk
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<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
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<tbody>
<tr>
<td>Are you a qualified counselling psychologist?</td>
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<td>Have you experience of personal therapy?</td>
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<td>Have you experienced a difficulty in your personal therapy?</td>
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<td>Are you willing to partake in a 30 to 40 minute recorded,</td>
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<td>semi-structured interview (all data &amp; identifying</td>
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<td>information will be fully anonymised)?</td>
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Appendix D
Research Participant Information Sheet

Philip Cox, University of Surrey, Department of Psychology, Faculty of Arts and Human Sciences, Guildford, GU2 7XH. Telephone: 01483 300800 Email:
p.cox@surrey.ac.uk

<table>
<thead>
<tr>
<th>Working title</th>
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<tbody>
<tr>
<td>An IPA exploring how personal philosophy may influence practice</td>
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1. This is a research project, which I am undertaking as part of my Professional Doctorate in Counselling and Psychotherapeutic Practice.

2. The purpose of this research is to apply Interpretative Phenomenological Analysis to explore how personal philosophy may influence psychotherapy practice. The findings could inform training and practice for psychotherapists, academics, researchers, University training courses, and provide information to the public.

3. Practising qualified members of the Division of Counselling psychology have been asked to participate as co-researchers.

4. As a co-researcher, you will be interviewed for a period of 30 to 40 minutes at your office or a mutually agreed location. You will be offered the opportunity to discuss the findings prior to the final version being submitted to my faculty.

5. There is a possibility that during the interview you may recall painful and difficult memories. Advice on this will be provided.

6. Involvement in this research project is entirely voluntary.

7. You have the right to withdraw at any time from the project without influencing your current or future relationships, or practice setting.
8. Please be assured that all data will remain confidential and your identity will be protected when submitting to my faculty, or for potential publication.

9. The University will also remain anonymous.

10. There is a possibility that the work could be published.

11. If necessary, a refund of your travelling expenses from your workplace to the meeting is offered, upon production of a receipt. Any expense may be liable to tax.

12. Your presence for the semi-structured interview will be covered by the researcher’s Public Liability Insurance provision.

13. The tuition fees for my doctoral programme are independently funded.

14. Any comments or concerns regarding this study can be discussed with the research supervisor, Dr. Dora Brown, University of Surrey, Department of Psychology, Faculty of Arts and Human Sciences, Guildford, GU2 7XH. Phone: 01483 300800. Alternatively, concerns can be discussed with the British Psychological Society, St Andrews House, 48 Princess Rd E, Leicester, LE1 7DR. Phone: 0116 254 9568.
Appendix E

Consent Form

Working title:

An IPA exploring how personal philosophy may influence practice

The participant should complete the whole of this sheet him/herself

Please tick the appropriate box

Yes     No

Have you read the Research Participant Information Sheet?

You had an opportunity to ask questions and discuss

this study?

Have you received satisfactory answers to all your questions?

Have you spoken to?

…………………………………………

Do you understand that you will not be referred to by name

in the report concerning the study?

In the event of publication do you consent to your fully

anonymised data being used?

Do you understand that you are free to withdraw from the study:

at any time
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<th>Question</th>
<th>Yes</th>
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<td>without having to give a reason for withdrawing?</td>
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<td>without affecting your current/future practice?</td>
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<td><strong>Do you agree to take part in this study?</strong></td>
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<tr>
<td><strong>Do you agree to the publication of anonymised data?</strong></td>
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**Signature of Research Participant:**

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<td>Name in capitals:</td>
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**Witness statement**

I am satisfied that the above-named has given informed consent.

**Witnessed by:**

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<tr>
<td>Name in capitals:</td>
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Appendix F

Guiding Questions for the Interview

1. Would you mind describing to me what it is to be a therapist?

2. What is your experience of being a therapist in the role of a client?

3. Would you mind describing to me the experience that brought you to this interview?

4. What suggestions would you give, if any, to someone who has had the same or a similar experience as you?

5. You are still practising; would you recommend therapy to others?
Appendix G

Participant 1 (Anonymised)

“It’s MY therapy”

Clt: I never ever was contacted again. I was left feeling she hadn’t included me in the analysis

Int: Oh, she’d taken it out and not told you

Clt: Yes, yes, for some reason then my interview wasn’t then included in, so I thought umm, I wondered why, she never told me why or gave me an update on it, so it’s kind of been left with (brief pause), I did the interview and never heard again. I think all these things it’s important. I think participant care, its important

Int: Yeah

Clt: Because if you give something of value away it means something, and so to have the follow-up, and to make sure they have all the information and it’s clear, yep I think it’s very important

Int: That’s how you experience that

Clt: Umm

(Long pause)

Int: In a sense that goes right to the heart of, erm, that almost tension that you asked me about erm, about when we were talking, about um the philosophy side (pause) being very subtle and underpinning and how it influences practice

Clt: (Emphatic) Umm

Int: And I’ll bet that person didn’t intend that

Clt: (Cross cuts) Ummm,

Int: To happen at all

Clt: Not at all
Int:  (Cross cuts) And just missed something subtle

Clt:  Ah not subtle because she said she would give me a debrief and follow-up, but she never did. Which if it’s a student I think because as a student we just follow practical

Int:  Um

Clt:  Erm, and we have a lot of lot of practice on us and once you have the data you need to analyse it and I think I think we can’t forget about the ethics of, of the participant, even if they’re strong and we’re not worried about their health and safety or anything, I think it’s still, they’re there for a reason, and sometimes as a student I don’t think what we (brief pause) do we do the protocol out of a conviction we do it out of a duty, to follow the course and then we forget about it. So I don’t think it was minor or practical, I think she should have given me an update when she said she was going to

Int:  Yeah, yeah

Clt:  But erm I see what you mean about its erm sometimes even the researcher or the therapist are expected (brief pause) to know all the needs or (stumbles trying to say words) all we can’t, we all make mistakes as anybody does, and so it’s a part, yeah

Int:  For sure. It seems important to say err it’s an IPA research so there’s no right or wrong questions, I’m just interested in your experience, just as you’ve been telling me, vocal (participant smiles) thank you (both laugh) that’s lovely little link

Clt:  Yesss

Int:  Beautiful. So, that’s it really, not right-wrong just your experience that’s of interest. And if, perhaps it might be useful to ask kind of those demographic questions, just like age, background, when you err qualified approach

Clt:  Um hum
Appendix H

Counselling Psychology Quarterly

This journal

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**Instructions for authors**

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“First, do no Harm”: A Thematic Analysis of Therapists’ Perceptions of Unintended Harm

Abstract

Aim: Underpinned by Merton’s theory of unintended consequences, this study focuses on the ethical imperative ‘do no harm’ in therapy. The topic of unintended harm (iatrogenesis) is rarely discussed in counselling and psychology. Clients are increasingly complaining to the professions regulators that they experienced their therapy as harmful. One response has been the introduction of new codes of ethics. Method: Through semi-structured interviews, 10 counsellors/psychotherapists and 10 counselling psychologists (10 female, 10 male) from various modalities, were asked about their day-to-day experiences of ‘do no harm’ when delivering therapy. The data was analysed through Thematic Analysis. Results: Three themes; ‘Preparation for practice’, ‘Boundaries’ and ‘Issues of safety’, were transcended by the overarching theme of Professionalism. Therapists stated they work in a contradictory field that protects the public, yet may shame therapists who get the delicate balance of making errors vs. not making errors wrong. Concern was voiced regarding the manualisation of therapy, and whether therapists are professionals with therapeutic knowledge from which to draw intuitively, or technicians whose expertise follows adhered to rules and regulations. Transcending all comments was the key tension: ‘Is therapy an art or a science’? Discussion: The potential colonisation of therapy via top-down pressures giving rise to the notion that there is only one way to practise, or be psychologically healthy, was considered a particular risk to the health of therapy. Awareness of unintended harm is considered to signal good and ethically-grounded practice, rather than poor clinical practice. Implications are explored for training, practice and the future.

Keywords: “do no harm,” iatrogenesis, codes of ethics, Thematic Analysis, “latent” & “manifest,” professionals vs. technicians
Therapists and psychologists aim to offer treatments and interventions that reduce negative affect and improve their clients’ wellbeing. Yet sessions are not entirely free from harmful or iatrogenic effects. The study of and talk about unintended harm happens within medicine (Illich, 1995; Makary & Daniel, 2016), but it has received far less attention within psychology and psychotherapy (Lambert, 2013; Parry, 2015; Parry, Crawford, & Duggan, 2016). Increasing numbers of complaints and recent changes to codes of ethics within key professional bodies would indicate that iatrogenesis is indeed an issue. Yet to date the topic, which is complex and whose full implications require time and effort to clarify, has not become embedded as a standard part of psychology training.

For clarity, the terms applied herein are: ‘therapists’ to represent those who self-identify as psychotherapists or counsellors; ‘psychologists’ to represent counselling psychologists; and ‘practitioners’ to represent jointly counsellors, psychotherapists and counselling psychologists. This study is concerned with practices that may occur routinely when psychotherapy is being delivered, and not with what I term gross ethical breaches such as sexual, aggressive or financial boundary violations. The rationale is that the former can occur within ethical guidelines, while the latter are considered as malpractice by all mainstream ethical codes.

**My Personal Relationship to the Research**

My personal relationship to the topic of iatrogenesis began with an overlap of professional and personal experiences of therapy, and my interest in the topic continues to develop. My curiosity began decades ago, first as a marginalised ‘expert by experience’, followed by my entry into professional training. 20 years ago, when working as a counsellor in Primary Care, I heard physicians speak of white coat iatrogenesis, where the act of taking the patient’s blood pressure inadvertently raised the patient’s blood pressure level. Two points struck me: firstly, the physicians could simply retake the pressure level, while for therapists once an action was taken or perspective voiced, it was ‘in the room’
and; secondly, once in the room it became part of the relational dynamic, which influenced the course of the therapy.

Both my personal and professional pathways overlap, and have shaped my motivation for doing this research. When I first began this study, I initially sought to explore the experiences of clients who did not have professional experience of therapy, and who reported feeling harmed by attending therapy. On reflection, I decided this was likely due to my over-identification with the client role, and after further consideration, I came to the conclusion that my initial choice felt too close to the issue. At the present time, my interest has shifted towards working with and supporting practitioners who receive complaints. This application of the research has been an unexpected personal change because the more I have practised, the more I have come to experience therapy as a co-constructed and relational process.

**Previous research.** The studies presented in this thesis were intended to extend research conducted in my previous university (see pp. 9-11). I previously explored the issue of unintended harm from the perspective of the client in a study titled, *The experiences of day-centre attendees: An interpretive phenomenological analysis* (Cox, 2010). This thesis’ literature review and the previous research described above (Cox, 2010), formed the rationale for the design of the Study 1. I applied IPA’s methodology to narrow the scope of the data collection to one specific group, practitioners with a distinct professional identity who reported on experiences related to iatrogenesis within their own personal therapy. Study 2 applied Thematic Analysis’ (Braun & Clarke, 2006) method to broaden the scope of the data collection to several different groups of practitioners delivering psychotherapy. The rationale for the thesis was to capture the diversity within the experience of the phenomenon of iatrogenesis by exploring the topic from multiple perspectives. The rationale for applying an IPA and then this TA, is to “draw out aspects of the phenomenon that have not been considered previously” (Levitt et al., 2017, p. 16).
**My assumptions.** Also, the longer I am involved with psychotherapy, the more I have come to appreciate the subtlety of the therapeutic process. As a participant in this study stated, “a practitioner who causes harm in many ways is harming themselves” (Luis, counselling psychologist, Theme 2). To this I add, a practitioner who is well supported in many ways supports the client. It is interesting to note that I may have unconsciously developed a way to work with clients through the focus of this study. The participants are practitioners delivering therapy, who are reporting how they may have unintentionally harmed their clients. Therefore, the clients may at times be heard.

For transparency, it is important to state my personal position and own my personal assumptions about the topic, and where these assumptions come from. I consider that I myself, and “[w]e are the bad therapists too. If there is someone who says he [she or they] has never done bad therapy (whatever that is), then this is someone who is likely to be doing bad therapy (whatever that is)” (Shohet, 2017, p. 70). My assumption can be further refined to say the issue is not one of a Cartesian good or bad, yet rather the subtle relational ripples or intersubjective effects that occur within all human interactions. Just as my practitioner Self has developed over the years, so has my client Self (Heidegger, 1962). My point is to say this research is intended to support all the stakeholders involved with therapy; it is also intended to explore ways to potentially work towards extending the effectiveness of therapy. For clarity, I offer my rationale for my definition of unintended harm, and what this opens-up or closes-down, in the definition below (pp. 184-185). I feel that it is important to clarify what I have added to the more traditional use of the term iatrogenesis.

My assumptions come from my own history and the different angles at which I connect with the field of therapy. I have grown into therapy and so too has my willingness to consider ideas or challenges that would once have felt harmful, yet may now be seen otherwise. My personal assumptions have altered through the research process, particularly
the more I considered the Study 1 Interpretative Phenomenological Analysis’ (IPA: Smith, Flowers, & Larkin, 2009) key finding in terms of the philosophical question, ‘is harm harmful?’ A key that stands out and merits an explanation is that I have not applied a psychotherapeutic theory to underpin this research. Originally, I had intended to apply Attributional Style (Seligman, 1989) to underpin how the participants make sense of their reality. Yet, as I progressed through the training and learning about different therapeutic modalities, my focus changed. As a professional, my focus developed and sharpened towards viewing the world through a psychodynamic lens.

My personal assumptions about the topic now come from the position of transference and counter-transference. I suggest the position we assume in relation to the topic, praxis, codes of ethics and complaint procedures reflect an attempt to try to heal something in ourselves (Shohet, 2017); in myself. I feel this positioning also reflects our relationship to what therapy is for. In the IPA (Smith, 2015), a participant spoke to concerns that while her goal was the therapeutic journey, the therapist’s goal was different, a pre-conceived destination of what counts as well-being. By focusing my lens on subtle practices which clients and therapists deemed may engender unintended experiences within therapy, and excluding malpractice, it is my aim to highlight what I believe to be an important yet under-explored, poorly articulated and almost taboo topic. Through my psychodynamic lens, I acknowledge that this could be considered an avoidance technique within therapy.

My assumptions in regard to others and certainly towards myself, suggest that the way we position ourselves to the topic is also a reflection of our relationship with therapy. Whatever the assumptions, I think it is ethical to bring these personal motivations into the open for others to see ‘where I’m coming from’. I come back to the importance of looking at our personal counter-transference and that of our profession to the topic of iatrogenesis. I consider that doing this will be helpful in facilitating less polarised positions and will
perhaps help us to embrace an understanding and deeper curiosity, as well as furthering a
dynamic and fluid process model, rather than an inflexible and potentially harmful right or
wrong content model. I consider also that the greater awareness engendered as a result of
opening up this topic, can help us work towards all parties being able to voice the feelings,
unmet needs, values and expectations which might lie behind a rupture in the therapeutic
relationship, or a formal complaint.

My Personal Agenda as a Researcher

As we all come to a relationship, context or research with our personal histories and
worldviews, I suggest the world we each perceive is shaped by our presuppositions, or
worldviews. The way I seek to use this is to be transparent. I feel strongly this means
stating my agenda, owning my weaknesses which have developed or changed my agenda,
and where I may be heading. I have found that when I present this research, my motivation
of whether I am blindly acting out a personal agenda, which some would call my shadow
side (Jung, 1938), has been under scrutiny. I welcome questions that create a space in
which to dialogue, as this process itself sheds light upon the topic. From my own
perspective, I have experienced good, bad and neutral therapy. As Bond (2015) notes, an
essential aspect of ethics is to safeguard clients from harm that may be incurred by
attending therapy. To be perfectly clear, I suggest this study considers that awareness and
management of unintended harm signals good and ethically-grounded practice, as opposed
to poor clinical practice (Linden, 2013).

How my Worldview and Motivation Shape the Research Process and Findings

I have felt strongly motivated to conduct this particular study by what I have
noticed for decades as a client, then as a practitioner, and more recently as a researcher.
For decades, psychotherapy has conducted research to increase the 80% statistic of clients
who report benefits from attending psychotherapy (APA: American Psychological
Association, 2012; Strupp, Hadley, & Gomes-Schwartz, 1977). While much research has
been conducted around the common factors of therapy (Duncan, Miller, Wampold, & Hubble, 2010; Lambert, 1989), the statistic has remained broadly static. This thesis seeks to explore the remaining 20%, because if this can be reduced, the 80% would thereby be increased. It is the same aim, yet approached from an alternative perspective. It is my conviction that the design of this study is a new and creative approach to explore an old question.

It is with this particular pathway in mind that I set out to help clients and professionals, and there can be little doubt that my motivation and curiosity has affected the research process. Through transparency and reflexivity, together with the skills embedded through my counselling psychology training, I hope to show clearly how my perspectival beliefs impact the findings. Others will see where my presuppositions or worldview shape the research, and how this serves the purpose of the study, or not. I hope also that the reader too will feel motivated and inspired to explore other ways forward that may currently be outside of my worldview.

**Actively monitoring the impact of my own subjectivity on the research process.** I have gained much in terms of awareness with regard to monitoring the impact of my own subjectivity on the research process and findings. The process itself and the Study 1 IPA (Smith et al., 2009), which applied an interpretative ideographic methodology and philosophical foundation, has given me valuable guidance. This Thematic Analysis (Study 2), which also applied an interpretive method, has given me the freedom to reflect on and thus select the epistemological foundation of the study, as well as the techniques, needed to apply the method. In both studies, I ensured that I scheduled regular supervisory meetings in order to have another person overview the process.

This overview was important on at least two levels; with an interpretative approach, the research and I myself benefitted from another pair of eyes. This also helped me to develop my reflexivity when my supervisor questioned me about my rationale for certain
choices; I used my internal guide when I could, or more pointedly was unable to respond clearly. I applied member checking to ensure that I managed, or at least understood and thus could reflexively incorporate or own, my worldview. Each of these stages supported me to take another developmental step. People were generous with their time and have expressed a great deal of interest to support this research and myself. I have taken care to have a clear audit trail for readers to follow my line of thinking, and thus my interpretations and findings.

What I found particularly interesting and fostered deeper learning was my relationship with IPA and Thematic Analysis. IPA’s (Smith, 2015, 2017) epistemology, which gives voice to multiple forms of knowledge, resonated with me. I was drawn to IPA because it can be applied to help marginalised issues or taboo topics emerge, and can impact at policy level. This speaks to my political interests. The IPA gave me a way to structure the research, and in the early drafts my supervisor and I would explore my occasional heavy-handed interpretations. Yet curiously, in the Thematic Analysis, which had less structure and to which I was less drawn, I felt more comfortable with the flexibility of the method. My surprise is that in the Thematic Analysis rather than the IPA, I felt I stayed closer to the participants’ meanings, although in both studies I checked and discussed my interpretations with my supervisor and the participants. This surprise is an area that I continue to reflect upon.

**Personal reflexivity and personal epistemology.** While any account of the researcher’s background seems subjective, it may help readers to understand where ‘I’m coming from’. As a reflexive researcher, I acknowledge ‘centring’ myself in the research (Etherington, 2007). I seek to identify potential presuppositions or omissions in the research, and show how I use myself in the research process, or am impacted by the research process (Etherington, 2004). In addition, my positionality as a white British and seemingly middle-class male, seemingly hetero-normative therapist and fledgling
academic, shapes my perceptions; these identities and others, whether manifest or latent, also impact upon the interaction between the researcher and participant, and so impact upon the research. By being transparent and remaining grounded in the data I seek to limit the impact of my ‘epistemological premises’ upon the research (Bateson, 2000). To show awareness of the mutual impact, reflective comments are offered throughout the analysis.

In terms of axiology, I acknowledge that as human beings we each bring our own beliefs, morals, biases and experiences of therapy (as professionals, clients or both), to the research endeavour. For transparency, I hold the ontological assumption (Ponterotto, 2005) that Being-with-others is a natural state (Heidegger, 1962). This relational stance underpins my worldview. As my epistemological stance and personality have influenced each research choice point, or blind spots, I own my stance; “we create the world we perceive, not because there is no reality outside of our heads … [such as the superiority of one research method, therapeutic training, modality or gender], but because we select and edit the reality we see to conform to our beliefs” (Engel, 1987, p. vi). In the wider world I tend to see power relations and social constructions, much of which is influenced by my own life, and my psychodynamic orientation. In this study where ‘I’m coming from’ is a critical realist positioning. I also identify with the ethos and philosophy that underpins counselling psychology.

**Conceptual Definition of Iatrogenesis**

For consistency across the thesis, the definition of harm remains: “a negative effect [that] must be relatively lasting, which excludes from consideration transient effects ... [such as in-session anxiety or between session sadness, and] must be directly attributable to, or a function of, the character or quality of the therapeutic experience or intervention” (Strupp et al., 1977, pp. 91-92). This paper will apply the definition within the frame of Merton’s (1936) theory of the unintended consequences of purposive social actions, and specifically Merton’s (1972, 2016) concept of ‘manifest’ functions which are conscious,
and ‘latent’ functions which are unconscious. The definition of harm originated within the medical world to denote the unintended consequences of actions that bring forth harm. To this traditional meaning of iatrogenesis, I have added unintended harm. My rationale is to initially step away from the narrow-medicalised definition, which represents a unidirectional relationship (a purposively active physician towards a passive receiving patient), and step towards the context of a multidirectional and multidimensional relationship within psychotherapy.

Also, psychotherapy has its own body of literature pertaining to harm, and which is influenced by the ontological and epistemological foundations of competing therapeutic modalities. In this study, I aim to narrow down the focus to the actions or omissions of practitioners with clients, within the therapeutic setting. Here, I am assuming therapists are well-intentioned towards the well-being of clients. Malpractice or unconscious harm, such as practices influenced by the ‘shadow’ side of human nature (Jung, 1938), internal conflicts (Freud, 1899/2017) playing out through the client or projective identification (Klein, 1946), are not the phenomenon studied herein. I acknowledge that my definition of iatrogenesis can produce further insights in this research, or limit this research, with consequent problems. For instance, the definition applied here opens up the topic within the context of a therapy session, yet closes out other voices such as the client’s world, service providers and stakeholders in the wider world of therapy and society. It also closes out a study of the problem of iatrogenesis being a consequence of a dominant discourse of therapy, whose primary intention is to alleviate suffering, yet may inadvertently add to it. Such limitations are explored below.

**Epistemological Grounding**

This study is grounded in a contextualist epistemology. The contextualist position considers there is a reality which can be accessed through the data, yet that reality shifts between contexts, and within a context. Contextualism assumes that human actions
perform a function, are dynamic, and that human perceptions of reality are incomplete and can never be fully known. Contextualism emphasises that “the interrelationships between an event and its context ... do not arise out of a social vacuum and cannot remain abstract or irrelevant to the phenomena that gave rise to it” (Jaeger & Rosnow, 1988, p. 66 & p. 71). Therefore, what we call reality needs to be understood in terms of the context where a phenomenon occurs.

For instance, in this study the context of the consultation room cannot be partialled out or separated from the phenomenon being studied (iatrogenesis). Social contexts, the values placed on competing therapy modalities, types of training, and forms of regulation, shape what occurs within the therapeutic context. For the purpose of this analysis, reality is understood in terms of the context in which such a reality is made possible, and true to the perceiver. However, contextualism goes beyond the mere acknowledgement that context impinges on phenomena, and understands the “notion that culture and psychology are to be treated as mutually constitutive phenomena” (Adamopoulos & Lonner, 2001, p. 24).

Therefore, context is understood not as something separate from the phenomenon being studied, but is an intrinsic part of it. For several reasons, a contextualist epistemology was well-suited to my research aims, method and theoretical framework. First, contextualism supported this study to identify manifest (surface and conscious) features of relevance to the participants. This meant I could stay close to the participants’ accounts of their experiences as relayed via the body of research data. This meant also that I could faithfully describe how they were meaningful to each participant. Second, contextualism understands truth and meaning-making as being defined in relation to a context. Third, the description of extracts meant the analytic themes could be linked to the wider social context of therapy practice.

This epistemological stance underpinned the research question, which sought to explore the perceptions of therapists who delivered therapy they perceived to have
engendered unintended consequences (Merton, 1936). Fourth, contextualism encompasses the intersubjectivity between the client and therapist. Finally, and coming full circle, contextualism supported this study to interpret the data in order to identify the latent (hidden and unconscious) features of relevance obscured from the participants. As Boudon noted (1990), “[l]atent functions are not only invisible but sometimes half-consciously hidden. Social actors have good reasons not to recognize their existence” (cited in Elster, 1990, p. 136), because to do so may engender unwelcomed consequences. Therefore, contextualism can link the salient analytical points presented below to the wider social world of psychotherapy, in terms of clinical practice and professional regulation.

**Theoretical Grounding**

Following on from the theoretical grounding of the two previous studies in this thesis, Merton’s (1936) theory of the Unanticipated consequences of purposive social action, explains the problem when the unintended consequences of actions expected to engender positive social change, result in a negative outcome. While Counselling Psychology seems to have no clear theory of the phenomenon of iatrogenesis, Merton (1936) considers the difficultly involved with the development of his theory is due to, “the diversity of contexts in which social action occurs” (p. 894). Merton (1936) further considers the diversity of contexts has impeded a defined identity of the problem of unintended consequences, with the consequence that no systematic analysis of the phenomenon has been conducted. The difficulty of identifying a concept underpinning unintended harm is also paralleled by the diversity of contexts in which psychotherapy occurs. The contextualist epistemology narrows this difficulty to a point where the phenomenon of iatrogenesis can be studied.

Therefore, Merton’s (1936) theory provides a good fit with counselling and psychology (herein psychotherapy), because while Merton (1936) provides the theoretical grounding for this research, psychotherapy provides the specific context for the research.
This means that both can work together to improve practice and to extend the empirical research base. In this study, Merton’s (1936, 1968, 1972, 1975, 2016) theory of unintended consequences will be applied to explore what happens when two people enter the social context of the consultation room, and how important it is for therapist and client to remain alert and open to address unintended outcomes along the way.

Merton’s (1936) theory groups unintended consequences into three types: an unexpected benefit such as a positive therapeutic outcome; an unexpected ‘drawback’ defined as an unexpected detriment sometimes occurring in addition to the desired effect of an action; and what he termed a perverse result that is contrary to what was intended. This thesis draws particularly upon Merton’s (1936) notion of drawbacks (unintended consequences of purposive action), and perverse results (effects opposite to the expected outcome), which is here termed paradoxical. The concept of drawbacks and the concept of paradoxical outcomes both help explicate the topic of unintended harm within the context of psychotherapy.

The previous qualitative study in this thesis utilised Merton’s (1972) notion of ‘insider’ (client) and ‘outsider’ (therapist) positions within the frame of phenomenological research. Accessing insider and outsider perspectives of the therapeutic experience offered a novel pathway to explore the phenomenon of iatrogenesis. However, the methodology was not without its limitations. For instance, when the client and therapist examine the same problem, they may “not deal with the same questions [or concerns] and so will simply talk past one another” (Merton, 1972, p. 16). Also, the participants were counselling psychologists in the role of client, who may have merged their ‘insider’ (client) and ‘outsider’ (therapist) positions, or unintentionally been inclined towards one therapeutic modality or worldview. To move beyond the previous limitations, this study will utilise Merton’s (2016) notion of the ‘manifest’ (surface and conscious) and ‘latent’ (hidden and unconscious) functions of purposive social actions. While the previous study
explored the experiences of therapists in the role of client, this study will explore the perceptions of therapists delivering psychotherapy, who perceived their delivery of psychotherapy to have engendered unintended harm to the client.

From Merton’s (1936) theoretical perspective, what is desirable to the actor inside the context “may seem axiologically negative to an outside observer” (p. 895). The actors’ or practitioners’ perceptions of what happens within the consultation room can be extended to consider alternative and complimentary levels of analysis. Merton’s (2016) sociological theory adapted Freud’s foundational psychotherapeutic (1899/2017) concept of conscious and unconscious meanings into the terms manifest and latent social functions. Freud (2017) theorised that the manifest content of dreams is the superficial or surface level of the dream. The latent content of dreams is what the manifest content represents, which may be hidden. Therefore, actively following the manifest descriptions to discover latent meanings enables a deeper analysis of contextualised meaning making.

Merton (2016) considers his concept of latent functions extends enquiry “in those directions which promise most theoretic development of the discipline” (p. 71). Merton (2016) considers also that unless the meanings of unintended consequences are explored, their impact may remain unrecognised and so as Freud (2017) argued, unconsciously function to mask their underlying meaning. Merton’s (2016) theory states that the latent function of therapeutic beliefs is not common knowledge, and so may be inaccessible to clients who are not practitioners of therapy, and even the practitioners themselves. Thus, the process of unintended harm can arguably be perpetuated by the very people whose intentionality is towards well-being; the practitioners. This can produce ‘paradoxical’ outcomes.

Merton (2016) also considers the “[p]erceptions of latent functions can complicate the picture because they can introduce moral judgments” (p. 73). Such judgments are underpinned by professional codes of ethics, which may inadvertently and subtly be
breached. The breaches can lead practitioners to question the therapeutic endeavour, the utility of their own practice, the feasibility or applicability of their professional codes of ethics, or perhaps paradoxically for a health professional, to inadvertently blame the client. Therefore, the level of analysis of manifest and latent functions of meaning-making affords this study a systematic and empirically relevant mode of analysis (Merton, 2016).

**Literature Review**

Within this thesis, the Literature Review (pp. 12-69), which is here revisited to explore a different yet complimentary pathway to the previous mapping of the psychological literature regarding iatrogenesis, considers further gaps in our knowledge regarding iatrogenesis. The literature review ended by suggesting that qualitative research is an effective method for exploring and extending awareness of the identified gaps. The review was followed by a phenomenological ideographic study, to which the reader is referred for the comprehensive conceptual definition of iatrogenesis, and the explication of the phenomenon of iatrogenesis. Here, greater focus is given to the practitioners’ perspective, levels of formal complaints, and what the literature reports in terms of how these issues are being managed. The management of the issues may itself reveal a latent function, and engender unintended consequences.

The mapping of the psychological literature regarding iatrogenesis is in its infancy (O’Hara et al., 2011). Based upon a comprehensive review of the literature, Cox (2012a) reported that irrespective of presenting issue, therapeutic modality, research methodology or context within the Western world, around 10% of the public report their psychotherapy as harmful (Boisvert & Faust, 2003; Lambert, 2010; Lilienfeld, 2007; Linden, 2013; Scott & Young, 2016). Importantly for practitioners reporting on their personal therapy, the figure approaches 27% to 40% (Macaskill & Macaskill, 1992; Williams, Coyle, & Lyons, 1999). Since Cox’s (2012a) review, the literature evidences some unexplained trends, including the rising level of formal complaints and a shift in journal publications.
Where the issue of iatrogenesis has been addressed in the literature, the research tends to report positivist-oriented studies that typically use research methods such as questionnaires and factor analysis, which are considered to produce objective results (Pope & Tabachnick, 1994; Williams et al., 1999). Current positivist-oriented research intends to develop tools to help prevent harm (McGlanaghy, 2017; Parry, 2015). These tools include the uses of algorithms and session-by-session feedback data gathered from the client and the therapist, to highlight deviations from statistical norms (Saxon, Barkham, Foster, & Parry, 2016; Schiefele et al., 2017). While useful clinically, the focus on survey data collection methods to understand a client’s or practitioner’s experience of the negative effects perhaps caused by psychological interventions (Crawford et al., 2016; Lambert, 2013), may miss the experiential aspect of what the statistical data aims to represent. This is to say the qualitative experience of providing or receiving psychotherapy deemed to have engendered harm. Research positioned within a different paradigm might offer a broader view and deeper view of the topic.

Complaints

All the key professional registration bodies report an increase in the number of complaints. The most recent available figures for the British Association of Counselling and Psychotherapy (BACP), report that 71% of complaints are made by people associated with counselling (Raffles, 2015), and most complaints are made by women (Khele, Symons, & Wheeler, 2008). O’Dowd’s (2017) recent analysis of BACP data confirms that complaint levels continue to rise, although the level is unstated. Also, a disproportionate number of complaints (48%) are made against accredited counsellors, the more senior members who are also typically male (Khele et al., 2008). Following multiple concerns in the public domain regarding harmful practices and failed regulatory procedures, the number of complaints against the United Kingdom Council for Psychotherapy (UKCP) members 2014-15, rose by 48% (UKCP, 2015). However, UKCP recently changed its data
collection methods, which may account for the significant increase.

The Royal College of Psychiatrists (RCP; GMC: General Medical Council, 2015) offered a unique cultural perspective. The RCP reports that a significant number of upheld complaints were against non-UK born psychiatrists, and concluded that different understandings of inter-personal boundaries and so competing cultural norms, led to some complaints. This accords with the experiences of a BACP (2016) complaints assessor who considered all complaints involve various boundary issues (anonymised personal communication, 4th April 2016). (For a discussion of the differences between clients and therapists who have not complained about harmful experiences see Symons, Reeves, & Wheeler, 2011).

The registration body for applied psychologists, the Health and Care Professions Council (HCPC), is explored in more detail. The public account for almost half of all complaints made to the HCPC (2015a). Annual recorded complaints against the total HCPC membership are: 2010-11, .35 of the total membership, which in 2014-15 rose to .66 of the total membership (330,887 with total number of complaints, 2,170). Many complaints do not relate directly to harmful acts towards a client, for instance; men are more likely to be sanctioned for interpersonal boundary issues, and women for administrative issues such as poor record keeping. There seems to be no data for non-binary gender options (i.e. beyond cisgender). Practitioner psychologists are the seventh largest professional group (of 16) on the HCPC register, but the second largest group complained about. Practitioner psychologists number 6.3% of the total membership register, yet account for 14.3% of all complaints. Complaints against practitioner psychologists are rising at double the rate of new practitioner psychology registrants (HCPC, 2015b). It may be significant that only one registered counselling psychologist has been removed from the register (HCPC, 2015c).

Also, there has been a publication shift towards the topic of iatrogenesis, and
particularly within *The British Journal of Psychiatry* (Bhui, 2017; Crawford et al., 2016; Parry et al., 2016). Although these publications inform the debate, their discourse emerges from the medical model (Prilleltensky, 2008). For example, Parry et al. (2016) reported a negative effect size of 5%, which does not accord with the decades of robust research that posits a figure of around 10% for the public who experience harm by attending psychotherapy (Bergin, 1966; Strupp & Hadley, 1977). Additionally, when the topic of iatrogenesis is explored from a quantitative perspective of therapists in the role of client, reports of harm by attending therapy range from 10% to 40% (Cox, 2012a; Macaskill & Macaskill, 1992; Williams et al., 1999). Further, much of the literature does not consider the intersection of issues that render some client populations at greater risk of unintended harm, which is beyond the scope of this paper (see Cox, 2012b; Crenshaw, 1991; Moos, 2012; White & Kleber, 2008; Ussher, 2010).

**Choice of Method**

Braun and Clarke (2013) credit Merton (1975) with naming Thematic Analysis (TA) as an identifiable approach with its own method. TA is a method for identifying, analysing and reporting patterns (themes) within data (Braun & Clarke, 2006). Also, TA is a useful method for summarising, organising and understanding large bodies of data (Braun & Clarke, 2006). Of the various forms of TA, this paper applies the approach posited by Braun and Clarke (2006) in their highly influential paper, Using thematic analysis in psychology. Braun and Clarke’s (2006) flexible method was chosen for this study because it is considered, “essentially independent of theory and epistemology” (p. 78). This means it can be applied across a range of theoretical and epistemological approaches (Braun & Clarke, 2006), and across a range of practitioner groups. Typically, TA is applied within the essentialist (realist reporting of the participant’s reality, experience and meaning) or constructionist (examination of how discourse structures the way an event, ‘reality’, experience or meaning is understood), paradigms. A third
possibility is rarely applied in TA; a contextualist method (Braun & Clarke, 2006). The choice of method was informed by the aim of the research question: *What are therapists’ perceptions of unintended harm within their practice?*

In the previous study in this thesis, Kazdin (2008) justified building a bridge between the quantitative and qualitative paradigms, to connect clinical research and practice. Kazdin (2008) intended to enhance knowledge and to improve client care. This paper applies a contextualist method to bridge the gap between the theoretical and epistemological spandrels of essentialist and constructionist research approaches. The assumption is that by applying TA (Braun & Clarke, 2006) to the specific context of the consultation room, which sits within the wider theoretical frame of Merton’s (1936) social theory of purposive actions, any data or participant experiences that may have previously fallen through the literature, practice or research divide, can be brought into view. Being brought into view assumes they can be considered. The contextualist method as applied here, is supported by the theoretical perspective of critical realism. Therefore, the theoretical position of this study is critical realist (Willig, 2013).

**Thematic Analysis**

As the research question sought to explore the participants’ perceptions of delivering therapy, this paper sought a ‘big Q’ inductive method (Kidder & Fine, 1987). Braun and Clarke’s (2006) version of TA affords a relevant qualitative approach to applied research, which is one aim of this study. (The phases of applying the method are addressed in the study design section below). TA’s method can access the nuances, subtlety and interpretative depth of qualitative data. The method offers a robust and systematic framework for coding qualitative data, which in turn supports the use of the coding to identify patterns across the dataset in relation to this study’s research question. In this study, the themes were identified through an open inductive or ‘bottom up’ analysis.

A theme or patterned response, captures meanings contained within the data. TA’s
flexible method means the ‘keyness’ of a theme represents an important element in the way the participants experience, and talk about, the drawbacks or paradoxical outcomes of actions which have the potential to result in unintended consequences. In qualitative research this ‘keyness’ is not quantified, which means that salient points may appear frequently or rarely across the data set. Therefore, the ‘prevalence of themes, data items, or data units does not provide a quantified measure’ of their relevance to the analysis (Braun & Clark, 2006, p. 82). A qualitative approach allows for both therapist and client, or researcher and participant, to reflect upon the contextualised experience of a relationship which unfolds over time in the consulting room, so that potentially harmful experiences can be reported and discussed openly.

Defining data units, extracts, codes, themes and subthemes. Data units and extracts. Using Clark et al’s (2015) analogy, data units are the smallest coded pieces of data that are used to build a theme, which is a broader unit of analysis than a code. The data extract is identified as significant to help answer the research question within and then extracted from a data item (transcript). Data extract refers to an individual coded chunk of data, and can be a word or the short pithy and meaningful statement described below in Phase 2 (coding) of the analytic process. Braun and Clarke (2013) apply data extracts “to illustrate analytic claims or to further the analysis” (p. 199).

Codes. A code refers to “the most basic segment, or element, of the raw data ... that can be assessed in a meaningful way regarding the phenomenon” (Boyatzis, 1998, p. 63). A code appears interesting to the researcher and particularly the participant, and captures a single idea linked to a segment of data. Codes are named with a pithy label that identifies the idea of interest in the data, and each label relates directly to issues pertaining to the research question. The coding process may be data-driven (themes depend on the data) or theory-driven (the data is approached with a specific question to code around). Braun and Clarke (2006) conceptualise codes as the “building blocks that combine to create theme –
so multiple codes typically combine to create themes” (p. 207) during the analytic process. The difference between a code and a theme is that codes are more specific than themes.

**Themes and subthemes.** Thematic Analysis offers a method to identify, analyse and report themes. A theme is a unit of analysis that is broader than a code, and captures a common and recurring pattern across the dataset. Themes are organised around a central organising concept. A subtheme sits underneath the umbrella of a theme. Themes are differentiated from subthemes because while both share a central organising concept, subthemes are more specific. Subthemes focus on a single notable aspect of a theme, and one that has particular relevance to the research question. Braun and Clarke (2006) consider that through the naming and analysis of a specific subtheme, the analysis can show how a specific aspect of a theme is particularly salient in the analysis, and thus also towards answering key aspects of the research question.

**Domain summary.** The domain summary summarises what the participants said in relation to one area of the data (the domain of a particular topic), or an interview question. Unlike themes, which are patterns in the data set, there is no unification of the description of what participants said about the topic. There is no underlying concept that ties everything together and organises the analytic observations, which is the function of the theme. The domain summary helps the researcher articulate findings and tells the reader about the essence of the theme. The essence offers something specific, a distillation of what the participants said about an important area of the data in relation to the research question. For that reason, domain summaries provide a means for transparency by checking the significance and clarity of a theme during the analytic process (Sandleowski & Leeman, 2012). Also, when placed at the end of each theme readers can see how the theme fits well within the overall analysis including the process of and reporting of the theme itself.

**Central organising concept.** A central organising concept or key analytic point
captures the essence of a theme. Presented as an idea or concept, it captures and summarises the ‘keyness’ of a coherent and meaningful pattern. Braun and Clark (2014) advise that when the central organising concept of a theme can be identified the key concept of it has been captured. This enables a certain degree of clarity by establishing whether a theme is coherent. Coherence is assessed by meeting the requirements of Braun and Clarke’s 15-point checklist (Braun & Clarke, 2006).

**Semantic codes and latent codes.** Semantic codes and latent codes serve different purposes in the analysis. Semantic codes report “the explicit or surface meanings of the data” (Braun & Clarke, 2006, p. 84). At the semantic level the analytic process moves from descriptive accounts of participants’ experiences to interpretation. This level of coding supports the researcher to theorise the significance of the patterns in the data and relate their broader meanings and implications.

Latent codes allow researchers to go beyond the explicit (descriptive) semantic content of the data to “consider the frameworks the participant uses to explain her world” (Clarke et al., 2015, p. 235). Latent codes offer an elaboration of the participants’ words regarding their experiences. Latent coding supports the identification or examination of hidden ideas, assumptions and conceptualisations within the data. These become apparent from the vantage point of the researcher. This supports the researcher to theorise what shapes the semantic content of the data. Whether semantic codes, latent codes or both are used, the researcher still needs to interpret the data to make sense of the coding for the reader.

**Narratives.** While a participant’s narrative can reinforce a coded piece of data, short data extracts can be quite ‘bitty’ and interrupt a longer flowing narrative. This means that “individual narratives can get lost in the cut and thrust of the dialogue .... [when] researching sensitive topics” (Braun & Clarke, 2013, p. 113). For this reason, Braun and Clarke (2006) suggest a 50/50 to 40/60 balance between the participant’s narratives and the
analysis. They also recommend that all participants are represented in the overall narratives presented within the research.

**Status of the data.** The data corpus of this study is the entire data collected for this study, which includes the verbatim transcripts, research meeting notes and my reflective research diary. The data set is the verbatim transcripts, while data item refers to each individual transcript. For a rich thematic description, each complete data item was fully coded for multiple themes, and then analysed to accurately reflect the entire data set. Finally, a data extract refers to an individual coded piece of data, which was identified within and extracted from, a data item (Braun & Clarke, 2006). Only the most relevant data extracts have been presented in the final analysis. Every participant is represented in the extracts. While a laborious process, this approach provides an accurate breadth of reflection of the participants’ meanings at the manifest level of analysis. However, this means some depth and complexity was lost. My intention was to off-set this loss by applying Merton’s (2016) concept of ‘latent’ functions or inferences, to add depth. This study’s design choice is justified because it is, “a particularly useful method when you are investigating an under-researched area, or you are working with participants whose views on the topic are not known” (Braun & Clarke, 2006, p. 82).

**Semantic and/or latent theme identification.** Braun and Clark (2006) suggest that, “thematic analysis typically focuses exclusively or primarily on one level” (p. 82). Due to the complexity of the research topic and novel aim of the research question, several study design decisions were made regarding the ‘level’ at which the themes were to be identified: at an explicit (semantic, conscious and available) level, or at an interpretative (latent unconscious, hidden and unavailable) level (Boyatzis, 1998). Madill, Jordan and Shirley’s (2000) influential paper regarding the effect an analyst exerts upon research findings proposes, “the explication of meaning requires a certain level of inference however, and qualitative approaches can be criticized for the space they afford the
subjectivity of the researcher” (p. 1). To manage the space between the participants’ accounts and the research study needs, the themes were strongly linked to the data.

Also, to direct my passion for the topic, I borrowed a term underpinning the philosophy of information systems (Mingers, 2004). Epistemologically, the term ‘soft critical realist’ here functions to highlight a textual analysis that initially lent towards a soft critical realist position of the participants’ accounts. Applied to qualitative research and a practice setting, the term ‘soft’ critical realist position is here applied to denote where I as the researcher gave the analysis primacy to the participants’ manifest level reports. This is evident particularly in the early part of the results section. In contrast, I apply my term of a ‘firmer’ critical realist position to denote the part of the analysis where I as the researcher gave primacy to my interpretations of the data extracts (latent level). This is seen through the themed discovery process as the results section progresses, and in the discussion.

The soft critical position means the extracts presented at the manifest level (Merton, 2016), were accepted at face value as an accurate description of events that took place in the participants perceived realist world. My acceptance of the manifest content helped create favourable conditions to collect and produce the data, such as the participants feeling safe and non-defensive to openly discuss their experiences around this sensitive topic. The firmer critical position is where the analysis is pushed to a higher level. The higher level is where I interpret and link the significance of the patterns to their broader latent meanings, the extracts to theory and practice, and their implications for the therapists and clients (Patton, 1990). This links the rich description of the data corpus to a detailed account of one aspect hidden within the data set; the keyness of professionalism. The theory is linked also to the literature previously presented in this thesis, and reviewed above with a keen eye to the method of TA, and the choice of participants. The intention was to weave each of the three projects presented in this thesis into a conceptual whole.
Choice of Participants

Careful consideration was given to which group of participants had the knowledge to adequately answer the research question. Strupp et al. (1977) suggest that, ‘[o]nly by considering multiple perspectives will it be possible to derive a truly comprehensive definition of iatrogenesis, its meaning and to evaluate its impact in psychotherapy’ (p. 81). Merton’s (1972) ‘insider’ doctrine states that some groups have access to knowledge not available to ‘outsiders’, such as non-professional clients. The knowledge of the insiders in this study is accessed through the perceptions of practising therapists able to report upon their conscious manifest experiences (Merton, 2016). As therapists, the participants are likely to be aware of the concept that humans arguably have unconscious experiences, which Freud (2017) and Merton (2016) term latent experiences. Strupp et al. (1977) consider the views of clinicians, researchers and theoreticians are highly relevant to link theory, research and practice. While the methodological sampling in this thesis’ previous study accessed the experiences of therapists in the role of client, this study seeks to broaden the relevance of the previous study. To broaden the previous research beyond the study of only counselling psychologists in the role of clients, and to understand ‘what it is like’ to experience delivering unintended harm in clinical practice, this study sought a broader range of practitioners.

Several criteria were considered paramount to considerations of participant selection: the assumed ability to explore, “a broader definition of ‘evidence’ that synthesises research and practice [from different preferred modality perspectives] and encompasses the paradoxes and divergences encountered in a variety of research paradigms” (BPS, 2015, p. 17). This is particularly important because the phenomenon of iatrogenesis is not a property of the individual or a context, but appears at the point where people and context interconnect. This means the context, theory and practice need to be understood in-relation to the phenomenon. Also, therapists of different modalities and
from different professional registration bodies, which have different levels of registration requirements, were recruited to help answer the research question. The aim was to broaden and then deepen the reported quality and texture of experiences.

Further, this study sought to recruit participants who are concerned with meaning, which is to say people who are interested in how people make sense of the world, and how they experience events (Willig, 2013). As practitioners, the participants were assumed to have negotiated the experience of unintended harm during clinical practice. By being practitioners, they were also assumed to be advocates of therapy, and as professionals, have the capacity or psychological mindedness to reflect upon client-therapist interactions (Coltart, 1988). Further, they were assumed to be able to report ethical issues or dilemmas. Therefore, the participants in this study were assumed to be well-positioned to provide retrospective accounts of their perceptions of delivering therapy. I say assumed because being a therapist myself, I have experienced the difficulties of navigating or even identifying, drawbacks within the therapeutic relationship. Paradoxical outcomes may however be more evident.

Choice of counselling psychologists. Counselling psychologists were selected because they are trained to explore the unknown with a phenomenological attitude of openness and curiosity (van Manen, 2014). The pluralistic training and interdisciplinary attitude is core to the counselling psychology identity of the reflective scientist-practitioner, who is skilled “to investigate the human predicament as it unfolds within and outside the consulting room” (BPS, 2015, p. 16). This is particularly relevant because Lilienfeld (2007) considers the harmful effects of psychotherapy are most certainly multidimensional. Therefore, with their philosophical training rooted in phenomenology and humanism, counselling psychologists were considered one of the most suitable participant groups to help answer the research question. Also, only one counselling psychologist has ever been removed from the professional practice register, which was not
for clinical work. Plus, no record was found of a counselling psychologist being sanctioned by the professional registration body (HCPC, 2015c). Therefore, counselling psychologists may be in a position to make a valuable contribution to this study. My point speaks to my curiosity of what it is that makes counselling psychologists different in terms of rising complaint levels, when compared to other professional groups within the therapeutic field.

**Gender.** Following from the research question, the decision was made to recruit across genders. This was initially informed by this thesis’ review of the literature, which reported that women comprise most clients, practitioners and complainants. For example, in one of the few qualitative studies with practitioners, the sample was nine females, one male (Bowie, McLeod, & McLeod, 2016). Also, as noted in the complaints section above, there seems be an obscured contradiction regarding women’s over-representation in therapy, yet under-represented voice in publications regarding iatrogenesis. This would render women relatively unheard within the literature relating to iatrogenesis. This means we could speak of iatrogenesis as a taboo subject for specific groups of clients (Crenshaw, 1991). This aspect of the research will be reported upon elsewhere.

This thesis’ IPA (Smith et al., 2009) study recruited until its quota was filled, and an equal number of two women and two men took part. This seemed fortuitous as men, women, transsexual and other non-normative groups and people attend therapy. Therefore, two points are relevant: in this and my previous study in this thesis, no participant self-identified beyond binary cisgender terms, although the option was available. This was consistent with the literature review in this thesis, where the reviewed studies jointly recruited hundreds of participants, yet few to none self-identified by non-cisgender terms. Also, gender minorities consistently report higher rates of poor health service delivery, and lower rates of well-being when compared to hetero-normativity (Bhui, Warfa, Edonya, McKenzie, & Bhugra, 2007; Semlyen, King, Varney, & Hagger-Johnson, 2016). Here, I
seek to acknowledge yet not investigate how, “even research which challenges the origins or existence of gender differences or norms necessarily engages with cisgender as a social and psychological phenomenon” (McGeeney & Harvey, 2015, p. 153). The parallel is research regarding iatrogenesis.

Self-identified gender groupings were applied for several reasons: to reduce methodological gender bias; to avoid exaggeration (alpha bias) or minimisation (beta bias) of gender differences, whether ontological (the nature of being) or epistemological (context-sensitive knowledge); and to avoid unintentionally promoting emic constructs (culture specific) or etic constructs (universal factors that hold across cultures) (Berry, 1969). This was deemed important because therapy has its own culture (Furedi, 2004), and because we arguably live in an era where socio-economic powers shape therapy practice through the mechanism of an “obsession with theoretical risks” (Furedi, 2006, back cover). This seems reflected in the current trend for all the major registration bodies to be either reviewing or having recently introduced new codes of ethics. For transparency, as a male researcher there is also a potential that I may look at the data set through an “acculturated lens” (Bem, 1993, p. 2). This is to say my own white, middle-aged, middle-class, male gender and Western culture.

Addressing Tensions

The epistemological grounding and choice of method provide a good fit to address four tensions where the research question, theory and the research method meet epistemology within this research (Willig, 2013). The research question, from which design choices followed, is firmly grounded in the contextualist epistemology. This manages the tension of realism versus relativism when viewed through a critical realist lens. The contextualist approach can capture salient aspects of the complex interaction between the person of the therapist as an individual, or with the client, and the context. The tension of the role of theory is addressed through Merton’s (1936, 2016) unintended
consequences of purposive social action, which provides a meeting point for what happens within the consultation room, and the external pressures that impinge upon the relationship within therapeutic space. Braun and Clarke’s (2006) version of TA manages the tension of description versus interpretation, which sits at the heart of qualitative work, by providing a method to access both the description (manifest), and the interpretation (latent) of meanings. The latent meanings speak to the participants’ concerns over the role of politics as it impinges on the therapeutic space.

**Justification for the Research**

There appears to be little known about the experience of iatrogenesis within therapy sessions, although there has been some UK-based qualitative research from the client’s perspective (Bowie et al., 2016; Cox & Brown, 2014). Within the literature less is known about iatrogenesis within therapy sessions from the practitioner’s qualitative perspective (Bystedt, Rozental, Andersson, Boettcher, & Carlbring, 2014; Flor, 2016). Iatrogenesis remains an under-researched area with “lots of conjecture but few good empirical studies” (O’Hara et al., 2011, para. 1). An empirical qualitative research design could explore the phenomenon of iatrogenesis through the experiences of practitioners within their day-to-day practice experiences. This study intends to fill a gap in the literature through an exploration of the under-researched and under-reported phenomenon of iatrogenesis within the field of psychotherapy.

This study is also intended to fit with counselling psychology’s 2016-2017 strategic plan to promote the advancement of psychological knowledge and practice, to develop professional knowledge and skills, to contribute to society and to support practitioners (McIntosh, 2016). The research question is therefore: *What are therapists’ perceptions of unintended harm within their practice?* The objective is to fill a gap in the literature. The aims are to give voice to those who are keen to discuss and explore unintended harm when delivering therapy, and thereby increase the awareness and management of unintended
harm in order to enhance ethically-grounded practice.

Methods

Design. This study applied an inductive analytic discovery orientation. A qualitative design and in-depth interviews were used. The interviews were analysed using Thematic Analysis (Clarke, Braun, & Hayfield, 2015), which created a pathway for comparing the experiences between two professional groups (counselling psychologists vs. psychotherapists/counsellors), as well two gender groups (female vs. male). Whilst I kept a research rationale at the forefront, and mindful of the issues raised by the complaints in the background, I applied self-identified gender groupings to support the choice of participants. The reader is also invited to incorporate that knowledge whilst following my analysis of the data set. The semantically reported manifest extracts offer a descriptive insight into the speaker’s world. The additional latent interpretations are perceived by myself to uncover obscured assumptions across the narratives and I used this to help me link the meanings across the data set.

Participants. This study recruited 20 practitioners to purposively fill four groups; 10 (counselling) psychologists and 10 therapists; 10 female practitioners and 10 male practitioners. Within each group of 10 the genders were 5 females and 5 males. The therapist-psychologist group comprised 2 counsellors with 3 psychotherapists, and 5 psychologists. Practitioners from various professional backgrounds were recruited because I assumed their training would convey a high level of psychological mindedness (Coltart, 1988). I was of the opinion that the participants were people with the relevant skills to report on their clinical practices. The participants varied greatly by ethnicity, age, qualifications and years in practice (Table 1).

All shared one key requirement for selection; practicing a mainstream psychological therapy recognised by their professional registration body. Therefore, the sample was considered homogenous. The sample size was guided by multiple factors:
being able to access a range of experiences and views; aiming for saturation; not
overwhelming the research resources; and a gender balance. The sample was selected to
identify and broaden potential analytical themes beyond one type of training, membership
of a professional registration body, gender and so forth.

Table 1

*Participant Groups by Gender, Age, and Training*

<table>
<thead>
<tr>
<th>Participant Group</th>
<th>Mean</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychologists (n=10)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td>44.72</td>
<td>10.83</td>
</tr>
<tr>
<td>Years in practice</td>
<td>10.39</td>
<td>7.26</td>
</tr>
<tr>
<td>Therapists (n=10)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td>54.94</td>
<td>6.27</td>
</tr>
<tr>
<td>Years in practice</td>
<td>13.11</td>
<td>6.97</td>
</tr>
<tr>
<td>Females (n=10)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td>48.95</td>
<td>10.97</td>
</tr>
<tr>
<td>Years in practice</td>
<td>9.50</td>
<td>6.51</td>
</tr>
<tr>
<td>Males (n=10)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td>51.67</td>
<td>9.87</td>
</tr>
<tr>
<td>Years in practice</td>
<td>14.00</td>
<td>7.26</td>
</tr>
</tbody>
</table>

**Apparatus and materials.** Two Olympus audio recorders and two encrypted
USB’s; one to store the anonymised audio files, and one to store minimal coded participant
data. I used multiple coloured highlighters for data coding.

**Procedure.** The recruitment method followed a multi-stage snowball sampling
technique to locate participants for this sensitive topic (Silverman, 2013). Information was
provided by email one week prior to interview (Appendices A-F). A consent form
(Appendix B) was signed pre-interview and support information given when debriefing post-interview (Appendix E). The interview schedule was piloted (Appendix C). Stage 1:
From within my professional network, I emailed two practitioners, one a counselling
psychologist and the second a psychotherapist. They were invited to participate because some years ago at conferences, they had expressed interest in the research topic.
Table 2

Participants by Case and Interview Order

<table>
<thead>
<tr>
<th>Participant</th>
<th>Gender</th>
<th>Age</th>
<th>Years in practice</th>
<th>Psychologist</th>
<th>Therapist</th>
</tr>
</thead>
<tbody>
<tr>
<td>P1: Pam</td>
<td>F</td>
<td>28</td>
<td>5</td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>P2: Alan</td>
<td>M</td>
<td>54</td>
<td>10</td>
<td></td>
<td>Y</td>
</tr>
<tr>
<td>P3: Sean</td>
<td>M</td>
<td>52</td>
<td>18</td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>P4: Pat</td>
<td>F</td>
<td>51</td>
<td>5</td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>P5: Amy</td>
<td>F</td>
<td>51</td>
<td>18</td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>P6: Mary</td>
<td>F</td>
<td>52</td>
<td>5</td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>P7: Alex</td>
<td>M</td>
<td>28</td>
<td>5</td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>P8: Dale</td>
<td>M</td>
<td>53</td>
<td>10</td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>P9: Gale</td>
<td>F</td>
<td>51</td>
<td>5</td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>P10: Rani</td>
<td>F</td>
<td>52</td>
<td>12</td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>P11: Jamal</td>
<td>M</td>
<td>56</td>
<td>20</td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>P12: Jane</td>
<td>F</td>
<td>48</td>
<td>20</td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>P13: Elan</td>
<td>M</td>
<td>72</td>
<td>25</td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>P14: Ayo</td>
<td>M</td>
<td>34</td>
<td>5</td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>P15: Maya</td>
<td>F</td>
<td>57</td>
<td>18</td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>P16: Toren</td>
<td>M</td>
<td>47</td>
<td>8</td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>P17: Maya</td>
<td>F</td>
<td>42</td>
<td>5</td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>P18: Zoe</td>
<td>F</td>
<td>57</td>
<td>5</td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>P19: Luis</td>
<td>M</td>
<td>53</td>
<td>20</td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>P20: Anil</td>
<td>M</td>
<td>58</td>
<td>20</td>
<td>Y</td>
<td></td>
</tr>
</tbody>
</table>

| Total Participants | 10  | 10  | 10  | 10  | 10  |
Stage 2: both participants acted as recruiters by contacting from within their own network, two other practitioners from any therapeutic orientation who might be interested in participating. The recruiter asked the recruited person to opt-in through emailing me. Stage 3: the method was applied until the recruitment quota was fulfilled. A research diary was kept, which informed the data analysis and write-up (see personal reflective section).

**Inclusion criteria.** Practitioners with experience of private practice: needed to be registered with a recognised professional body such as the British Association of Behavioural Cognitive Psychotherapists (BABCP, 2010); BACP (2016); British Psychological Society (BPS, 2015); HCPC (2016); or UKCP (2015); needed to evidence competency by having 5+ years of professional practice experience; and interest in this study.

**Exclusion criteria.** Subject to a past or current formal complaint. This served to control for a confounding bias against a code of ethics, professional registration body or the research topic.

**Semi-structured interviews.** Semi-structured interviews lasted 30-45 minutes (Appendix C). Interviews were conducted either one-to-one or by Skype where meeting was problematic, and followed BPS (2012) e–Professionalism guidance on the use of social media. Interviews were transcribed by the researcher using Poland’s (1995) guidance to ensure maximum quality and rigour. This format is ideal in qualitative research because it allows participants “to think, speak and be heard” (Reid, Flowers, & Larkin, 2005, p. 22). The format applied here allowed the participants to follow areas of interest to them within the concept of ‘do no harm’. It also allowed the researcher to lead the interview flexibly without losing control of the interview situation. The level of flexibility in qualitative research methods can be a weakness or a strength, depending upon its application. A strength is the flexible approach to data collection confers the advantage of
real-time adjustment to, “unpredictable, interesting and important issues that come up during the interview” (Smith, 2004, p. 50).

A weakness was the potential to stray from the topic. Also, my interest in the topic and own experiences could unintentionally divert the interview towards my own fore-structure of knowledge or latent experiences, and so impact the analysis (Denscombe, 2002). Interpretations were shared with a supervisor to check the potential impact of my worldview upon how the data was used. Also, a research diary helped me remain grounded in the thematic process, and the data. The research diary at times helped me see blind spots or make connections across the data set.

**Ethics.** Favourable ethical approval was given by the University of Surrey’s Faculty Ethics Committee (Appendix G). The method of Thematic Analysis (Braun & Clarke, 2006) requires a transparent mode of disclosure, which in this study was coupled with the research topic of unintended harm within personal practice. Therefore, care was taken to maintain a research rather than a therapeutic focus. Participants were provided with a copy of their transcript and it was agreed we would negotiate deletions prior to submission. Participants were debriefed post-interview and provided with support contacts. BPS professional conduct and research ethics were followed throughout (BPS, 2014a, BPS, 2014b).

**Reflexivity.** As a reflexive researcher, I acknowledge and own my current position: I select and edit the reality I see to conform to my beliefs (Engel, 1987). As I bring my assumptions to the data, the world and what reality seems to be, a qualitative thematic analysis has the ability to make these beliefs transparent to the reader. I feel this to be highly important because: “To discover this inner dynamic of society ... [and psychotherapy, we] must frequently disregard the answers that the social actors themselves would give ... and look for explanations that are hidden from their own awareness” (Berger, 2011, pp. 40-41). I believe iatrogenesis to be an obscured topic. My interest arose
through my identification with counselling psychology’s competence to ‘strive to do no harm’ (BPS, 2015, p. 15) and thus to explore an obscure and complex topic that is difficult to uncover and to discuss openly within the field.

**Evaluation.** This study can be evaluated through Braun and Clarke’s (2006) 15-point assessment guide. Also, if the research aims are met through dissemination to academics, mental health professionals, training institutions and the public, then this study could be evaluated in terms of its key aim; to expand the discussion of iatrogenesis in psychotherapy, and to impact upon training and practice. Additionally, for full consent, clients may need to be informed of potential negative effects. This is not yet routine practice.

**Data Analysis**

The data was analysed using Thematic Analysis (TA; Braun & Clarke, 2006) because the method is theoretically flexible. This means it does not come with a set of *a priori* theoretical assumptions (Vossler & Möller, 2015). TA also has a clearly described analytic process (Braun & Clarke, 2006), and this has been further developed (Clarke et al., 2015). From the data analysis, two thematic maps of candidate themes and key themes were produced, with the aim of showing the main themes with clarity (Appendices H and I, respectively).

**Phase 1.** Interviews were transcribed orthographically. Familiarisation with the narratives involved repeated re-reading/re-listening to the dataset. I acknowledge that the previous literature review in this thesis meant I held some initial analytic interests and thoughts. As I had selected and produced an overview of the papers in the literature review from my mainly outsider position, I was careful to note and manage my potential inclinations. In this study, I aimed to immerse myself in the data. Clarke et al.’s (2015) approach enabled me to find a balance between intimate connections with the data, yet be far enough removed from the data to avoid becoming enmeshed with it, which tends to
present when one is passionate about a topic. I noted and regularly reread entries in my research diary to ensure the reflexive process.

**Phase 2.** The coding stage and the familiarisation stage involved a recursive process. Each data item was worked through manually and systematically. Codes were colour highlighted for ease of reference. The codes were revisited repeatedly for consistency within each data item (transcript) and across the dataset (all transcripts). Segments related to the research question were tagged and enough of the surrounding data retained to inform the context. These were organised into theme-piles, which included codes for features of the data that caught my interest, and crucially for this qualitative study, appeared interesting to the participant. Basic elements of the data that showed tensions or inconsistencies within a data item, or between data items, were retained. A pithy label captured the essence of each short segment (extract). This supported “a semantic and conceptual” reading of the data set (Braun & Clarke, 2013, p. 120). This coding stage was extensively revisited to tag for manifest content, and upon subsequent consideration, latent content.

**Phase 3.** Following identification, descriptive (manifest level) patterns were conceptualised as themes. A theme “captures something important about the data in relation to the research question, and represents some level of patterned response or meaning within the dataset” (Braun & Clarke, 2006, p. 82). Codes with similar meanings were clustered to produce potential themes. Miscellaneous themes were retained in a separate file. During this phase, it was important to “start thinking about the relationship between the codes, themes, and between different levels of themes” (emphasis added; Braun & Clarke, 2006, p. 89). As in phase 2, this coding stage was extensively revisited to identify interpretative (latent level) patterns in the data set.

**Phase 4.** Through the recursive process provisional candidate themes became evident. These were reviewed and refined at two levels. Firstly, the coded data extracts
were collated for each theme to form a coherent pattern. A candidate ‘thematic map’ was developed to show the main themes (see Figure 1; Appendix H). This map was simplified to show the key themes (see Figure 2; Appendix I). The candidate themes were assessed for a ‘good fit’ with the other themes and the research question. Subthemes clusters evolved to show distinct aspects of interest within each theme. Two potential themes were discarded; statutory regulation because it is a topic with its own literature (see House 2016; Mowbray, 1995), and iatrogenesis within personal therapy from the client’s perspective, which has previously been explored in this thesis.

**Phase 5.** The writing phase further refined the themes, which were named. This situated the data within an analytic narrative. The narrative relates the story that each participant tells in relation to the research question. The subthemes gave structure to the large volume of 20 data items regarding the complex topic of iatrogenesis. They also demonstrate a hierarchy, which led the narrative from the manifest level to the ‘keyness’ of the latent level. Each theme was tested to ensure it gave a clear sense of its scope and diversity (Braun & Clarke, 2006), which means it could be described in a brief sentence. This broadened the analysis to look beyond the descriptive to the interpretative level.

**Phase 6.** The analytic report was written. At each stage the analysis was discussed with my supervisor, who acted as a check and balance for coherence. Additionally, and particularly as the study developed, my research diary was reviewed regularly to check for any blind spots. This served to check that my illustration of the story was grounded in the data. It also served to check how the narrative shifted beyond the surface semantic descriptive level, and towards the deeper analytic latent level. I have linked these to the key arguments made in relation to the research question.

**Epistemological Critique of the Method**

Braun and Clarke (2006) claim that due to its flexible method, TA comes without its own set of ontological and epistemological assumptions; I venture that their claim
merits a finer-grained distinction. By its own nature, TA seeks to explore and present the object or phenomenon of enquiry. Braun and Clarke (2006) apply the term ‘potential’ theme, which suggests the potentiality of a theme to come into being; here the term provisional theme is applied. This is because within the recursive analytic process, by Phase 3 the theme is provisionally held in mind. This means it is no longer a potentiality; epistemologically it exists, if only cognitively as a working structure. The evidence to support this claim is that potential or provisional themes can be retained or discarded.

Additionally, TA typically suggests using a thematic map to show the “‘top level’ of overarching themes, which correspond to a central point” (Clarke et al., 2015, p. 193). However, counselling psychology’s philosophy values each voice or perspective equally (BPS, 2014b). Rather than a top level theme this study reveals one obscured theme that transcends the dataset. This is intended to move beyond research based on visible ontological and epistemological positions, or assumptions, to reveal a deeper narrative hidden within the dataset.

Results

The interviews were analysed using TA to consider the research question: What are therapists’ perceptions of unintended harm within their practice? This analysis identified three themes relating to: Preparation for practice; Boundaries; and Issues of safety. Overarching these themes was the theme of Professionalism. Transcending each of these themes was the notion of tensions, which will be explored in the discussion. Extracts from each of the interview transcripts were used to give voice to, and support, the combined narrative of the participants. The participants’ stories increasingly developed from the descriptive level through Themes 1-3 (Table 3), to an interpretive and deeper level of analysis in the overarching theme of Professionalism.

Each participant contributed to the topic through his or her own unique perceptions. This allowed for convergent and sometimes divergent voices to be heard. Yet always the
participants’ voices served to demonstrate the interpretative process at work, and the adequacy of the analysis (Clarke et al., 2015). To facilitate the impact of the previously untold stories within the topic of ‘do no harm’, each of the four themes have subthemes. Each subtheme shows the ‘nitty gritty’ of an aspect of a theme in the context of their real-life practice and its consequences, drawbacks or paradoxical outcomes (Merton, 1936), intended or otherwise. The participants were given pseudonyms.

Table 3

*Themes and Subthemes*

<table>
<thead>
<tr>
<th>Theme</th>
<th>Subthemes</th>
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| Preparation for Practice | Training re: “do no harm”  
Supervision (training to practice) |
| Boundaries            | Subjectivity of boundaries  
A right or wrong way to practice?  
Code of ethics: What is wrong?  
The notion of harm and identity  
Outcomes |
| Issues of safety      | Seeking support  
Psychotherapy: Supportive or punitive?  
Potential consequences for safety |
| Overarching theme: Professionalism | Balance of making errors vs. not making errors  
Shame of accepting errors  
Disclosure; dishonesty vs. safety |

**Theme 1: Preparation for practice**

I think that [the topic] should be the ground, like inbuilt within the foundations of our practices’. (Pat, counselling psychologist).

At the manifest level (Merton, 1972), the participants described the key role of preparation for practice in terms of two subthemes: Training regarding ‘do no harm’, and supervision (training to practice). Curiously, the participants seemed to find this more factual type of information relatively easy to detail during the early stage of the interview process.

*Training re “do no harm.”* Central to the notion of preparation for practice was the
role of training. The participants all talked about the lack of training regarding the specific concept of ‘do no harm’. Although this study explores UK based practitioners many of the participants originate from beyond the shores of the UK. Jamal, wondered if the lack of training in the concept of ‘do no harm’ is a UK or international phenomenon:

to what extent this is [unintended harm] part of the core curriculum across our countries, all countries. (Jamal, counselling psychologist).

Pat, who is British born and trained exclusively in Britain as a counsellor and then as a counselling psychologist, explained:

The interesting thing is that in 12 years of training in the fields of psychology and counselling um, I have yet to have any training around it [do no harm] and I in a sense that’s some kind of unintended harm. (Pat, counselling psychologist).

During his training, John described an occasion when he struggled with something that happened during supervision at the training institution. As he spoke and looked ashamed, I noticed my own parallel process of feeling shame, because I have experienced a similar issue during my own training. We were caught in the same dynamic; the underlying fears and anxieties of those involved leading to ever more fears and anxieties until the topic is taboo. This may well be why I was drawn to this extract of feeling the shame of talking about erotic transference during training, and so seek to bring it into the open.

While John and I felt talking about this form of transference takes the power out of a fantasy, we both struggled at the reaction of others who seemed unable to manage the topic. I deeply empathised with John when he looked puzzled, which I interpreted as being that we both believe in a field about being open, yet paradoxically (Merton, 1936), we were shut down.

in group supervision, I brought a client with erotic transference and I got torn apart and everyone found it quite difficult. (John, counselling
Although still bruised emotionally by his training experience John did not attack his training course. Instead, he expressed an unsolicited constructive problem solving perspective. However, the fine line between whether ‘problem-solving’ may actually be engaging in ‘puzzle solving’ (Khun, 1962), will be explored in the discussion. This extract is one of the few times a participant referred to different levels of experience, which seemed surprising for professionals trained to work on the multiple levels of conscious-unconscious awareness (Freud, 2017; Merton, 1972):

there needs to be a really clear lead, and that can come for the Director of the course to say “You know what? Mistakes need to be normalised”, and it needs to be a very clear message at all different levels that it’s a learning profession and people have got to bring mistakes; and they get protected.

(John, counselling psychologist).

Anil described one way that trainees and qualified practitioners could feel supported to explore the topic of unintended harm, yet described simultaneously his dilemma of whether they would accept such support. Yet, he did not include himself and spoke of himself as though an ‘outsider’ to training workshops, which other ‘insiders’ could attend (Merton, 1972). I found this to be one of the most intriguing pieces of data. This was partly due to the power of the expression during the interview, and partly that this extract seemed to hold great potential for a single and extended latent interpretation.

Unfortunately, my reflexive attachment to this single extract within a study working to identify themes across the data set, meant it was tagged yet left as a descriptive data item:

Well, I guess you could almost imagine, workshops … I must say these aren’t the sort of workshops I go on voluntarily … it sounds rather Maoist, training camps where we train to think right. (Anil, psychotherapist).
Curiously, while Anil spoke to the ethics of workshops about ethics, Strawbridge (2016) argues that “[l]earning from experience with a community of practitioners is crucial to acquiring competence” (p. 28). This represents the paradox between the spoken meaning seen at the manifest level, and the latent aspect, which is discovered by being actively sought. Anil seemed to be suspicious about the support offered through attending workshops, whereas others found workshops furthered their knowledge and competence as practitioners.

Supervision (training to practice). A further issue discussed by all the participants was the use of supervision, which virtually all the participants expected to facilitate their transition from trainee to newly qualified practitioner. The literature reports that supervision perceived as harmful can parallel the harmful effects of therapy to clients (Barlow, 2010; Mays & Frank, 1985). Interestingly, Ellis et al.’s (2014) review of the codes of ethics regarding inadequate and harmful clinical supervision reported little information on the topic. In this study, many of the narratives spoke of accepting unsafe practices when newly qualified, and of feeling shame when taking such issues into supervision, where they expected support.

From Anil’s perspective, there seemed a broad concern with what level of transparency new professionals encounter. However, the concern was left unstated:

I think a lot of people sit on feelings of being quite afraid, because we just get qualified, and, and we’ll put up with whatever (Anil, psychotherapist)

From Mary’s perspective, there seemed a broad concern with the profession, and Mary began to drill down into what was behind her concern:

I have a bit of an issue with our profession as a whole because I think it’s incredibly shame based … and this is the problem with the do no harm, is that, even in supervision … you think, well, how are you ever going to talk about where you’ve totally cocked up, and done the wrong things, said the
wrong thing at the wrong time, you know? (Mary, counselling psychologist).

The participants described how training and supervision around iatrogenesis could be achieved to liberate rather than shame during an exploration of the topic. Yet, as the participants described feeling fear and shame, the analysis began to shift from the manifest level to the latent level. Something unspoken seems out of place because the therapeutic endeavour typically values speaking openly and honestly about fear and shame. There was an incongruence sitting behind the words, which offers a reflexive clue. The practice of delivering therapy seems mismatched with the perceptions of receiving therapy, related activities such as training, workshops and supervision. We do not yet know why.

**Theme 2: Boundaries**

“Never take a risk” (Gail, Humanistic counsellor).

As the interviews progressed, participants discussed increasingly the perceived risks and dilemmas of clinical practice in terms of: Subjectivity of boundaries; A right or wrong way to practice?; Codes of ethics: what is wrong?; The notion of harm and identity; and Outcomes. Codes of ethics are encompassed within this boundaries theme because the codes define attempt to define what is acceptable. Codes of ethics can help explicate practices that may lead to subtle drawbacks (Merton, 1936), particularly where purposive actions are considered ethically acceptable, or even in some contexts constitute normal practice.

**Subjectivity of boundaries.** While the code of ethics for each professional registration body is designed to support ethical practice, most of the participants considered that some boundaries are too subjective to codify adequately. A participant, who helped formulate a professional code of ethics and adjudicates on a formal complaints panel, unequivocally stated that all issues of reported harm concern boundary violations
(anonymised personal communication, April 4th, 2016). This accords with the literature (Cox, 2012a; Symons, 2012).

Jamal described his uncertainty about where the subjective boundary edges are:
when I first came to this country, my sense of personal space was different
than the next person so when what was normal distance for me, would be
too close, I would be invading their personal space … the cultural norms
and cultural expectations and cultural are often linked with gender. (Jamal,
counselling psychologist).

In the complaints section, we saw that when each professional body analysed their
complaints data, only the Royal College of Psychiatrists (GMC, 2015) reported that a
significant number of successful complaints were against non-UK born professionals
(psychiatrists). The RCP concluded that different understandings of inter-personal
boundaries and so competing cultural norms, can lead to complaints. This conclusion is
provided to the RCP’s membership, and it was the only professional body found in this
thesis’ literature review to advise its members of this area of risk. Therapy has its own
culture (Furedi, 2004), which sits within wider socio-economic powers that shape
research through government funding (for an excellent contemporary example in this
thesis, see O’Hara et al.’s (2011) AdEPT research), and therapy practice through
regulation.

As a scientist-practitioner, I reflect that at the manifest level I was surprised that this
risk area was not spoken of more, particularly as the UK workforce within and beyond
therapy is multinational. At the latent level, I wondered why, particularly as all the major
registration bodies are either reviewing or have introduced new codes of ethics. This area
of enquiry seems muted. One explanation is our personal counter-transference and that of
our profession (Shohet, 2017). From the perspective of counter-transference we could
extend Merton’s (1936) theoretical frame as applied to this study. The extracts from Jamal
(above) and Gail (below) can help us to reflect on our attitudes to such boundary issues, and the process of complaints. If we ‘think it is about understanding ourselves and our clients, rather than occupying a fixed position, then we create an opportunity to reflect. A complaints process in the helping professions could then go then go down the route of reflection rather than pursuing the right or wrong process’ (Shohet, 2017, p. 69).

This highlights the tension of the role of power in qualitative research (Willig, 2013). It also highlights the tension between descriptive and interpretive research (Willig, 2013). For this study, this translates into the balance between initially presenting broad singular descriptive and superficial data items that stay close to each participant’s seemingly objective account, with the gradual shift towards the deeper interpretive subjective level that is discovered when we look across the data items, and knit the extracts together. The shift in focus is from accepting the participant’s realist-based perspective, to looking with a critical realist eye for the hidden meanings. This perspectival shift towards interpretations is supported by Merton’s (1972) manifest-latent theory and TA’s method, to engage with “nuance, subtlety and interpretative depth” (Braun & Clarke, 2014, p. 1). The interpretative depth can access the subtle ways in which the purposive actions of therapists can engender drawbacks or paradoxical outcomes (Merton’s, 1936), and thus provides some answers in relation to my research question.

Through a metaphor, Gail described the effect of trying to find her subjective borderline, and where other people or the codes draw fixed boundary edges:

Well, it’s so subjective, how would maybe others interpret this? And then would there be a conflict. So sometimes I would tie myself in knots looking at it from other perspectives ... so it’s my interpretation. (Gail, Humanistic counsellor)

Based on the training and supervision extracts, the narrative leads us towards accounts of how mental health professionals recognise what is deemed professional, or recognise the boundary between good practice, risk and harm.
A right or wrong way to practice? Several participants also discussed whether there is a definable boundary between a right or a wrong way to practice. Maya, for instance, a psychotherapist with 20 years’ experience, suggested that the right way for a therapeutic model or service provider can sometimes be the wrong way for the client:

When this very profound message of “do no harm”, “do no harm” happens, and we’re expected to, we’re not, we’re expected to deliver highly contained, wrapped up therapy in 8 to 12 sessions. I mean, the therapist needs to be, as a learning experience, as a developmental experience for the therapy, we need to learn from our mistakes. We have to fail, or we’re not going to get better as therapists if we don’t. (Maya, psychotherapist).

As stated in this thesis’ literature review, many therapists have considerable difficulty recognising client deterioration, or any adverse effects arising from an intervention (Hatfield, McCullough, Frantz, & Krieger, 2010). For instance, Walfish, McAlister, O’Donnell, and Lambert (2012) reported that “25% of mental health professionals viewed their skill to be at the 90th percentile when compared to their peers” (pp. 644-645). None self-assessed as below average. As this is statistically impossible a significant degree of self-deception seems evident.

When self-assessing for harm Rani’s measure of good practice is an informative outlier amongst the narratives. It also seems to carry a deeply flawed assumption:

I’ve never had a complaint launched against me so I’m assuming that’s the concrete way of knowing. (Rani, Humanistic counsellor).

Of interest in this study is whether Hatfield et al. (2010) assumed that there were difficulties recognising drawbacks (Merton, 1936), or whether the therapists were unsure how to manage drawbacks. Perhaps the ‘keyness’ of this issue is one of limited experientially learnt skills rather than Merton’s (1936) theory, which posits that self-deception is a significant cause of drawbacks. In short, some practitioners may not have
been self-deceiving and may have been without a space in which to own feeling deskill, or shamed around the topic of iatrogenesis. The issue of recognising drawbacks seems less concrete than professionals might assume.

Toren, one of two CBT counsellors in the sample suggested there is a right way to practice therapy. Yet he also acknowledged Maya’s point. He explained this by employing the positivist scientific term of “cure”:

that kind of clash of expectations can be problematic. I’m trying to treat, and if possible, to cure them, I’m putting inverted commas around the word “cure” but they’re looking simply for somebody they can speak to each week, and then you get to the end of the 12 sessions, and suddenly you’re saying, “you can no longer speak to me each week”. (Toren, CBT counsellor).

Following on from the ‘keyness’ of the point above, if socio-economic powers shape therapy practice through the mechanism of an “obsession with theoretical risks” (Furedi, 2006, back cover), which is to say that therapists are not allowed to fail, to be human, a latent theme relating to professionalism can be developed. Within the miscellaneous file of data extracts, Toren and Dale, who are both CBT practitioners, offer a potentially challenging perspective to the keyness of managing theoretical risks. Diverging from the other 18 practitioners, both Toren and Dale consider the right way to practice is supported by a realist epistemological position, rather than the critical realist or perhaps relativist positions of some other practitioners. However, it may become apparent that through the lens of any epistemological positions, the ‘keyness’ to unlock the latent themes is one of perceived risks to clients, rather than epistemological positioning:

...counselling is very much based on the medical model. (Dale, CBT counsellor).
At the manifest level, Dale’s words disclose a conceptualisation of psychological distress through the lens of the medical model. This approach, which arguably isolates and medicates distress to reduce debilitating and upsetting mental health episodes, and by extension potentially well-being, sits at the heart of the ever-developing discourse around how public health programmes should treat distressed individuals. Hidden behind the words is the issue of how the discourse serves to “perform an ideological [latent] function ... in the medicalisation of everyday life” (Strawbridge, 2016, p. 28). We could also add to this, the individualisation of everyday life. Individualisation may create an impact whereby some therapists may find themselves feeling isolated, particularly if they do not attend continuing professional development (CPD) events, or interact within a community of colleagues. This can result in a relatively unquestioning stance towards both clients and Self.

**Codes of ethics: What is wrong?** What is or is not included within a code of ethics was also discussed. While the codes of ethics define boundaries, the horizon between some acceptable-unacceptable practices or behaviours may curiously be less visible. A significant minority of participants considered their professional code to be so abstract or subjective that they were unsure of its relevance to their practice:

I think there’s massive subtle effects … across most of the areas of difference and diversity there’s a lot of shutting down. Shutting down of gender, shutting down of sexuality, shutting down of disability, shutting down of illness, over diagnosis, reliance of diagnosis over relationship, referral to client resistance where its normally therapist resistance in the room … naivety around power dynamics in relationships and how erm whether we like it or not our role is situated in a dynamic of power and therefore we are already in an abuse and … it’s all legal, it’s all within the code of ethics if you like. (Pam, counselling psychologist).
Pat extended the discussion and offered a fine-grained illustration of the tensions when working with competing codes of ethics, and how they impact upon the concept of ‘do no harm’. Pat’s extract diverges from all the other participants, yet develops another aspect of risk management; the tension between incompatible professional obligations, with a resultant clash. (A clash was also mentioned by Toren in the previous sub-theme). The obscured clash is how to engage with conflicting codes when the hierarchy of codes shifts between professional contexts, and how to self-protect if or when, dilemmas develop. I wrote in my reflexive journal extensively on this, because I had not considered this aspect of iatrogenesis, and because it felt like a double-bind: how could a professional navigate being caught between two or even three conflicting codes of ethics?:

I don’t just have the ethics, the code from the HCPC, I’ve also got my organisational policies and guidance, and I’ve got legal requirements, and I think sometimes they can all combine and can clash, it wouldn’t be in my client’s best interest to breach confidentiality, for example, but I’m required to do so because of the organisation I work for. (Pat, counselling psychologist).

The psychotherapists and counsellors seemed generally to consider the issue of what is right or wrong with their professional codes of ethics as less relevant. Anil spoke of the impact of isolation with a fear of shame, which may mask an even deeper communication; without ‘an inner professional compass’ (Corrie & Lane, 2010), distinguishing moral injunctions such as ‘do no harm’ may become confusing and thus remain unacknowledged. To counter this, Corrie and Lane (2010) promote the scientist-practitioner model, and specifically that “ethical and effective practice is dependent upon practitioners keeping themselves informed about theoretical and empirical development” (p. 88).

We’re very isolated, we’re increasingly, over the years, we can become our
own compass, which can get very dangerous … you don’t need ethics. No, you do, you do. Because one of the errors is ethics won’t go, “Oh you didn’t did you?” You read this in Therapy Today. (Anil, psychotherapist).

By linking the context of Anil’s extract above with an earlier context where he likened ethics workshops to “Maoist, training camps … where we train to think right”, we can look below the surface at the importance of CPD. CPD events bring people together to discuss topical theoretical, research and practice developments, and was where I first began to think of this research topic. In addition, the utility of Braun and Clarke’s (2006) flexible method is seen here; Anil’s data extract at the beginning of Theme 1 (Preparation for practice) links to the above data item near the end of Theme 2 (Boundaries).

As we progress through the themes and sub-themes, the hidden shame which has become increasingly prevalent across the data items, turns to anger. The anger seems to sit at the point where shame, professional identity and the identity of the person overlap, or clash. Curiously, this conflict was seen in the previous IPA study in this thesis as: ‘Competing world views: clashing epistemologies’.

*The notion of harm and identity.* Following the subtheme of ethical codes, the notion of what constitutes harm, and by whom to whom, was a tension across the narratives. The HCPC (2016) states it exists to protect the public and ensure that no harm is done. However, one participant questioned the HCPC’s position on the basis that he wouldn’t know whether he had done harm or not:

I think do no harm is very interesting because we don’t always know whether or not we’re doing harm, but harm often is caused. So I think it’s a tricky one. I think it should be ‘attempt to do no harm’. (John, counselling psychologist).

Revisiting the notion of practitioners having difficulty recognising adverse effects (Hatfield et al., 2010), or generally lacking realistic self-assessment skills (Walfish et al.,
one hidden aspect is that few participants voiced a perspective that harm is openly shared among professionals. Those few who did voice the issue almost invariably spoke of private shame. This seems paradoxical in a field where the practitioner’s intentionality is to work openly and transparently with others (Merton, 1936). Luis was more vocal:

I have a bit of an issue with the idea that a code of ethics is there primarily to protect clients. I think the code of ethics needs to consider … we need to protect clients and in the process of protecting clients we need to protect practitioners. Because actually a practitioner who causes harm in many ways is harming themselves. (Luis, counselling psychologist).

The HCPC has moved on from past adverts on the sides of buses, on trains and the radio promoting the slogan, ‘No joke, games up for health professionals with false credentials’ (HCPC, 2005a), and ‘Is your health professional genuine?’ (HCPC, 2005b). The more recent 'Be Sure' campaign (HCPC, 2008/2013), shifted the campaign towards protecting the public from unregistered practitioners by tackling misuse of protected titles (HCPC, 2010). The advertising campaigns have now developed further into the more benign sounding Public Information Pack titled, ‘Is your health professional registered?’ (HCPC, 2017). In 2017, the BACP surveyed its membership regarding, “safeguarding the public and protecting the reputation of the profession” (para. 1). After many complaints about the survey questions, intended to better understand poor practice and rising complaints, the survey was withdrawn. Controversial questions included, ‘Would you support mystery shoppers calling therapists to ask about their practice’, and about mandatory ‘supervisors informing on supervisees who make errors’ (BACP, 2017, para. 3). This exemplifies Merton’s (1936) theory of paradoxical outcomes. In a field constructed upon ethics and trust, this approach was ethically questionable.

More pointedly, these campaigns and the survey shape the debate around who or what constitutes a professional. The HCPC has arguably promoted latent distrust in health
professionals, which clients and practitioners may unconsciously bring into the consultation room. We can wonder how the discourse of care and what it means to be a professional, is shaped by such “exposure to negative campaign messages ... [in terms of] psychological and relational well-being” (Frost & Fingerhut, 2016, p. 488). We can also wonder about the impact of these outward facing campaigns upon the inward facing stakeholders, the clients and practitioners, and what messages they may receive from such public communications. As Luis commented, ‘to protect clients ... we need to protect practitioners’. Under the surface the practitioners in this study were saying they do not feel protected by their professional registration bodies. I believe this is an important concern because the more research I have conducted on this topic, the more these concerns are echoed across the professional bodies. This suggests that it is not isolated to any one body or process, with the result that it was noticeable how incongruent the processing of complaints seems to be.

I suggest the participants are speaking of a subtle message that is only discovered when we dig deep into the data for hidden meanings. It seems curious to me, and this is what has motivated me to conduct this research, that the professional bodies have produced complaints procedures which do not seem therapeutic (Shohet, 2017). As I have researched this topic and developed with it, I have come to realise that once a complaint is registered, there seems no space for practitioners to be transparent and acknowledge an error, without it potentially being used against them. In another role, which was an unexpected development in parallel with this research, and which furthered my interest in the topic, I assist and represent members of the Psychotherapy and Counselling Union (PCU, 2016) in complaint procedures.

It seems incongruent for a professional body to have the dual role of supporting their members and also prosecuting the complaint. Many cases are dealt with in a punitive manner, yet occasionally some are collaborative. My PCU (2016) role is to engender,
where possible, collaborative efforts to serve all the stakeholders towards a mutually beneficial process. This ‘does not mean a procedure where we do not look at the behaviour of the therapist, but we recognise that relationships are also co-created’ (Shohet, 2017, p. 69). The approach affords the opportunity to move beyond becoming caught up in the same dynamic through consideration of what is the need of the complainant, what is wanted? Often it is an apology and recognition, which some complaints procedures do not have space for.

The incongruity, as I see it, of seemingly incompatible dual roles, and/or the parallel process of therapy as a healing art that can paradoxically be applied in a punitive manner, needs to be understood from different perspectives. Therapy seems to have a need to be accepted within the mainstream of the healing professions, and the cost of this may be reflected in incongruent approaches, whereby there is a conflict between exploring a complaint, and offering practitioner support (Shohet, 2017). Also, the dubious regulatory issues of UKCP (2015), the HCPC (2008/2013) campaigns and BACP’s (2017) recently withdrawn membership survey, suggest attempts to get their own professional houses in order. I suggest this is part of a wider social discourse and shift in the field of therapy, which is unpacked in the discussion. Additionally, during my research the manner of prosecuting complaints over-identifies with the complainant, and at the expense of all. Further, complaints could be an avoidance of working through difficult material within the therapeutic relationship, Finally, I am concerned that complaint procedures may parallel the dynamic of the therapeutic relationship perceived as harmful, and so engender further harm.

By this I mean that there is no resolution for any stakeholder, because the underlying fears and anxieties remain unaddressed, as the emphasis is on examining the complaint and not the interaction in the consulting room. The potential is for this to engender increasingly vigorous complaints procedures, which in turn serve to further fuel
the fears and anxieties of health professionals (Shohet, 2017). This circular process will hopefully gain some relief from an intervention originating outside of our field. While beyond the scope of this study, it is worth noting that the Professional Standards Authority (PSA), which oversees all the regulatory bodies, has drawn up a Bill to put before Parliament that intends to change the landscape of complaint procedures. Titled, Right-touch regulation, the PSA (2015) considers “[t]here is a real need for legislative reform ... [because] The confrontational nature of proceedings and the stress that hearings engender can affect the health and wellbeing of all concerned ... [and] runs counter to our growing understanding of the situations where things go wrong, and the inter-connections” (PSA, 2016, p. 1). I am confident that this research adds to this more open regulatory understanding for addressing complaints as and when they arise within the therapeutic profession.

Outcomes measures: For whose benefit? A contentious thread throughout the interview narratives concerned unsurprisingly, questions of how, or even if, to measure benefit vs. harm. One way to follow the narrative thread is ‘top-down’, via policy makers (macro level), through to registration bodies and services where therapists are positioned in the field of therapy (meso level), to the relationship within the consultation room (micro level). Curiously, from this ‘top-down’ view, the client’s subjective experience often seems absent.

Toren, who only provides short-term manualised therapy said:

the Commissioners say that 12/14 is the maximum number of sessions ...

[with the] target of getting the patient into recovery. (Toren, CBT counsellor).

Strupp et al. (1977) highlight that, “while research plays an important role in the evaluation of outcomes, empirical research cannot relate to issues of human values, meaning-making and how these relate to public policy” (p. 116). Luis puts this into a
practice context, and questions who benefits from outcome measures. The subjective question, ‘how can harm be measured?’, seemed very present by its absence:

at what point is it caring for the service and our income and as opposed to patient care? … I am worried when manualised therapy becomes the only thing that is on offer by the practitioner because it is the only thing they know … there is no possibility of engaging in a different approach. (Luis, counselling psychologist).

Rani, with 20 years’ experience, described an iatrogenic use of short-term therapy outcome measures:

I think it all comes down to the power dynamic, the clients’ scores are high all the time and the therapist is being case managed by a case manager who is only interested in scores going down. (Rani, Humanistic counsellor).

The literature review in this thesis highlighted the clear trend towards evidence-based practice (EBP) and the further development of outcome measures (Ladwig, Rief, & Nestoriuc, 2014; Parry, 2015; Rozental, Kottorp, Boettcher, Andersson, & Carlbring, 2016; Schiefele et al., 2017). The previous IPA also highlighted studies with an interest in the topic of iatrogenesis that apply, or are developing, algorithms to measure perceived therapist and client performance (McGlanaghy, 2017; Saxon et al., 2016). As a therapist using such measures, I was curious if Toren had considered that if the patient fails to show improvement, it may not necessarily mean that they have been helped or harmed by the therapy. The aim of my spontaneous question was to reflect and respect Toren’s reality, while simultaneously lifting the curtain to look behind his words (Braun & Clarke, 2006).

When I asked Toren spontaneously what happens to clients when the minimum dataset shows that symptoms are increasing because the client is working hard in therapy, yet looked to be performing poorly, he pondered then replied:
as this interviews proceeded … I’ve realised that there are one or two aspects of my work that can be problematic towards patients. (Toren, CBT counsellor).

I felt there was an undercurrent across some of the narratives of “normative conceptions of proper functioning [or] well-being” (Sharpe & Faden, 1998, p. 119-120). The undertow is reflected by those practitioners who believed in applying perceived objective outcome measures to record a client’s subjective experiences, as a key part of their practice. It also reflected an undercurrent for those who questioned their use, or rejected outcome measures. The philosophy of counselling psychology values subjectivity and trains practitioners to think beyond a reliance on Likert (1932) scales, forced choice questionnaires, algorithms or binary constructs such as good or bad. Counselling psychologists are trained to appreciate the impact of the wider social environment upon people, rather than a philosophy of individualism. The training also teaches counselling psychologists to value multiple ways to understand well-being, and the wide range of human functioning across the life-span.

This position, albeit wide-ranging, is mirrored in Luis’ broad perspective, which has fundamental implications for practice when a rigid measure is applied to record psychological recovery. The issue of outcome measures is important because this thesis’ literature review highlighted that the field of therapy is moving towards measurement of the client and therapist, to improve outcomes. For instance, counselling psychology has introduced the use of psychometrics as a core competency (BPS, 2015), and IAPT, which is constructed upon psychometrics to evidence its effectiveness, is planned to greatly expand (Clarke, 2016). Some practitioners are uncomfortable with this expansion, and voiced concerns about the potential for unforeseen consequences (Merton, 1936):

Luis’ broad perspective has fundamental implications for practice if a rigid measure is applied to ostensibly measure psychological recovery:
a colonisation [of therapy], this idea that there is one way to be psychologically healthy. (Luis, counselling psychologist).

What is considered to count as an outcome has an impact, which seems to vary between the short-term practitioners and long-term practitioners. This has consequences for whether people consider there is only one way to conduct therapy, or a multiplicity of ways to practice. This is to say in terms of public access to therapy, the UK governments Improving Access to Psychological Therapies (IAPT: Layard, Clark, Knapp, & Mayraz, 2007), initially treated over one million patients over three years (DoH: Department of Health, 2012; NHS, 2016a), and from 2017 plans to scale-up treatment to 1.5 million patients annually (NHS, 2016b). This is likely to have consequences for which interventions are available, and how a successful outcome is measured.

These developments may also impact upon what is considered safe therapy, and how top-down targets are met. Of note, all bar two participants were either critical or highly critical of CBT, and considered IAPT engendered more drawbacks than benefits (Merton, 1936). This seems important because to create the necessary number of new practitioners, or to retain those practising manualised therapy, IAPT will be expanding its scope of influence across the provision of public healthcare and into education (NHS, 2016b). This study’s continued analytic shift from the broad descriptive level to the deeper latent level, will speak to ways the impact could exacerbate issues already being perceived as problematic, and experienced by practitioners as tensions within the consultation room.

**Theme 3: Issues of safety**

“If nothing iatrogenic is going on it takes [the] ... therapeutic aspect out of it”

(Elan, psychotherapist).

The participants discussed ‘Issues of safety’ in terms of: ‘Seeking support; Psychotherapy: supportive or punitive?’; ‘Potential consequences for client safety’, and the
‘Safety of the practitioner’. One key issue maybe whether supervision is a safe place to explore difficulties while developing personally, and professionally. Also, an issue is whether supervision intended to be safe is experienced as unsafe because cooperation can subtly turn into collaboration. Perceived safety and collusion offer two levels of analysis; paradoxically (Merton, 1936), the ‘keyness’ of this theme is that perceived safety suggests the supervisee and supervisor are potentially misattuned, while collusion suggests a deeper level of unconscious attunement, which results in a misleading interaction and thus can be considered harmful to transparent clinical supervision.

**Seeking support.** Across the interviews participants spoke of a range of ways to work with what they perceived to be safety issues. These ranged from supervision as a safe place to explore difficult issues, and supervision as an unsafe place where safety issues are exacerbated.

Firstly, Mary described how a personal experience of support was positive, and how she felt safe to take difficult issues into supervision. She described her supervisor’s positive purposive action (Merton, 1936):

> So, my current supervisor … will say it's a mistake, we all make them, here's what you could have done differently. What's happened? How's the relationship now? (Mary, counselling psychologist).

Secondly, Alan described how supervision that feels unsafe can parallel issues experienced at the practitioner-client level, and thus compound the lack of safety:

> you know the supervisor can collude with the therapist who’s colluding with the client … [and] I think there’s less of a danger of colluding with the people that you don’t like. (Alan, psychotherapist).

Alan’s emphasis is curiously on collusion with disliked clients. During the interview, as Alan spoke of this situation, I noticed what seemed like a change in his perception towards his supervisor and client; while Alan seemed initially to experience a
conflict with his supervisor, I noticed how he seemed quietly angry at his client. In my research diary, I wrote of my reflexive change in perception towards Alan, a sudden feeling of discomfort. My intuition is that my researcher-oriented perceptions were influenced by the practitioners positive or negative feelings towards their client (Strupp et al., 1977), or feelings of ambivalence.

My point is to wonder which comes first, the feeling or the change in perception. I wonder this because how I read and then interpreted Alan’s extract was influenced by how I felt. At one read my perspective wavered between feeling empathy, and upon another read I felt irritation at Alan for colluding. This counter-transference informed my interpretation, which speaks to safeguarding. Alan’s extract emphasised the paradoxical outcome of collusive supervision, namely that the client, supervisee and the supervisor seemed unlikely to be well-served by the very process intended to safeguard against a practitioner delivering harmful therapy.

**Psychotherapy: Supportive or punitive?** Amy described how she can work flexibly and take what she said some might consider risks. She explained that she meets with Asian service users in ways that others may consider ethically questionable social spaces, such as community meals. This provides a curious reflection of the GMC (2015) comments regarding misunderstandings around cultural boundaries. This was not considered a risk by Amy but appropriate to the culturally-based client population:

that flexibility is because I’m protected by an agency, that’s the umbrella, you know, I’m almost shielded. Would I have those same kinds of flexibilities if I was working privately, on my own? (Amy, person-centred councillor).

Jane, having over 20 years of practice experience, echoed the participants’ concerns about seeking support, and how far practitioners are shielded:

BACP only publish if the complaint has been upheld … Well if you look
at HCPC which is the psychologists’ governing body you’ll see that not only do they publish the names of people who have had complaints upheld against them but they publish the names of people who are about to have complaints heard. (Jane, Humanistic counsellor).

Most of the participants in respect of their professional roles, sometimes experienced psychotherapy, an endeavour intended to be underpinned by caring, as punitive rather than supportive. Again, we see the latent meaning that the profession’s governing bodies, which state their aim is to protect the public and support practitioners, may inadvertently be undermining their key aim because some therapists feel unsupported. It seems reasonable to link several data extracts and interpret them; a ‘supervisor may collude with a therapist who colludes with a client’ because when working with someone that ‘you don’t like’ (Alan, psychotherapist), it feels safer than taking a theoretical or actual risk (Furedi, 2006). This seems contradictory to the essence of psychotherapy, which aims to do no harm.

**Potential safety consequences.** Whether psychotherapy and/or supervision are perceived as supportive or punitive has consequences for the practitioner, and consequences for the client:

- it offers me a safe space to be able to explore actually, “What was my part in that?” … I’m not absolutely convinced that I have done any harm, but for me, I felt the guilt because I had this double quandary. (Gail counsellor).

Gail’s notion of a ‘double quandary’ captured my imagination, and I would have loved to explore these objects in her world. Yet, as this is a Thematic Analysis (TA: Braun & Clarke, 2006) and not ideographic IPA (Smith, 2015), I had to bracket my curiosity because the TA method works across the data set rather than a single item or single extract. Alex articulated Gail’s two quandaries, or conflicting aspects of safety. Indeed, many
participants expressed these dual concerns: firstly, working in a field that seeks publicly to protect one identifiable group rather than the whole; the clients rather than the professionals who are its members; and secondly, the lack of clarity through subjective perceptions of ‘top-down’ driven codes of ethics:

the topic of do no harm typically looks at therapist caused harm, what of to the therapist? (Alex, counselling psychologist).

Mary then linked Alex’s concern to the therapeutic relationship. This also links to John’s practitioner extract in Theme 1, which focused on how John felt shame. Here, in a similar supervisory situation where Mary also sought support, the analysis shifts to the impact of supervision upon clients:

I felt publicly humiliated in front of my peers. There's the difference. I think it's harmful to me and the client actually, to work in that way, in a more punitive way. I'm bringing this to supervision because I realise the mistake I've made, you get the sense that these people never make mistakes; that can't be ethical surely? (Mary, counselling psychologist).

Mary’s implicit quandary was that not sharing errors is unethical; yet sharing errors can feel wrong and be humiliating. Also, participants questioned whether professional bodies ‘naming and shaming’ practitioners is ethical. There were concerns about not caring for therapists caught in ethical dilemmas, and so by extension, the professional bodies may not be fully caring for clients. Mary’s latent meaning is here interpreted as a double-bind that seems to be perceived by most, if not all, of the participants when they discuss delivering psychotherapy in their day-to-day practice; not sharing errors is unethical and sharing errors feels wrong. I suggest this is a key unintended consequence of the quandaries faced by professionals (Merton, 1936).

**Overarching theme: Professionalism**
“You shouldn’t need to be told as professionals to do no harm” (John, counselling psychologist). Participants described the key role of professionalism through: the Balance of making errors vs. not making errors; the Shame of accepting errors; Disclosure; dishonesty vs. safety; and Living with myself. The thread of professionalism highlighted strong feelings and insightful contributions.

**Balance of making errors vs. not making errors.** Most participants commented that errors are inevitable because practitioners are human. Sean and then Zoe did not measure or grade an error; instead they considered that errors can manifest as ruptures in the therapeutic relationship.

Sean draws attention to the fine line between being clumsy and harmful, plus temporary and permanent ruptures:

The point I'm working to is, that's when the harm becomes harmful as it were. Up to that [a relational rupture] you've done something clumsy and its harm but it's something you can work with. If you don't work with it, then it becomes harmful and it persists, and it's another issue that possibly someone's left with. (Sean, counselling psychologist).

Zoe further explained how:

we learn from every client that we work with, so we will never be experts, we will never be perfect because there’s always a risk. (Zoe, counselling psychologist).

Based on their experiences, all the participants expressed directly or indirectly that therapy holds inherent risks. Additionally, all but one of the participants directly or indirectly expressed that therapy needs to be balanced. The art of psychotherapy seems at least in part about achieving the balance between working with errors vs. not making errors, and the impact this can have upon the professional.
Toren brought his CBT perspective to this subtheme. His words reveal the deep latent meanings hidden within the narratives. All the participants have converged to speak of difficulties. However, what is striking is that only the two CBT practitioners found a ‘comfortable’ resolution, and we see their divergence within the data set; in Toren’s words, when difficulties arise, ‘I don’t go there’. For example, in CBT language Toren indirectly tells us that his locus of control is externally focused on what his employer thinks, and he compartmentalises or avoids how his client feels. In psychodynamic language, we can interpret his ‘thick skinned’ stance as a defence against inter- or intra-psychic conflict. The point is we see how his perception of what occurs when he delivers therapy may engender unintended harm, even though we can assume he is well-trained and means well:

over the years, I have become quite thick skinned about it ... speaking honestly, I get to the point that my concern is whether I am perceived to have done something wrong by my employers as opposed to being perceived to have done something wrong by the patients. And, I suppose, as I hear myself saying that it feels a little bit uncomfortable, but saying it, it feels quite realistic and it’s a way of protecting myself. (Toren, CBT counsellor).

This extract highlights Toren’s realist perspective, which seems less relational and more oriented to the science of evidence-based practice underpinning CBT. Toren summed-up his way of accepting errors:

I look to get on with my day and don’t dwell on it. (Toren, CBT counsellor)

The participants all stated that professional practice is risky and errors occur. How, or even if they dealt with errors, seemed to anchor the extremes of how errors were managed; or not. This is the essence of Merton’s (1936, 1972) theory, for when purposive social actions produce unintended consequences, the result may well be iatrogenic practices. These practices may be embedded in the delivery of psychotherapy itself. As
recorded complaints continue to increase across the registration bodies, the issue is clearly more serious than one practitioner or one modality. To develop further insight, we need to look deeper into the latent meanings across the data set, and begin to wonder if there is a key tension hidden within all the themes presented thus far.

**Shame of accepting errors.** Sean, with 15 years’ experience mentioned new guidelines regarding a professional’s duty of candour (HCPC, 2016). He considered that owning errors and working with shame is, ‘something that’s useful’. Yet it seems that buried in his narrative sits the shame of owning errors openly:

> it would be good to be open about it, and also it would be good if we can be open, not just in private, to be open as a profession, but ... I’m not sure that members of the public or clients it’s something they’re ready to hear, or want to hear, but certainly as a profession, within the profession, to be open. In the BPS guidelines, it’s something that’s come recently, to be open and transparent when handling mistakes, or something went wrong. (Sean, counselling psychologist).

Luis’ stance was by contrast uncompromising:

> I was appalled … looking at the code of practice of the BACP, and the BPS are a bit better but perhaps not much, a whole document about code of ethics etc. I think the last section in BACP is about self-care and it’s about several lines long. I think it’s it’s shameful if practitioners don’t self-care; how the hell are they supposed to manage caring, I would say even loving their patients! (Luis, counselling psychologist).

Loving patients, or agapé (selfless love: Clarkson, 1998), was another data item that captured my imagination, and which I would have loved to explore. Again, I needed to bracket my own desire to explore this in depth, to stay with the subtheme regarding the shame of accepting errors, which sits under the central overarching theme of
There seems an unspoken yet inherent philosophical tension between a field that is constructed upon fidelity and beneficence, with having to mandate ethical candour yet, sometimes seems to hide shame. The lack of protection of the practitioners was also mentioned with some force and perhaps anger behind the words. I suggest that self-care of the practitioner extends to the care of the client, which is the overriding intention of practitioners.

**Disclosure: Dishonesty vs. safety.** Multiple Cartesian splits presented within this subtheme. Ayo echoed the sentiments of fear. He described his lived experience of the dishonesty-safety dichotomy:

people are really quite scared about feeling exposed, and being judged, and in an environment where we’re supposed to come together to learn. (Ayo, counselling psychologist).

Gail related a real-life situation that echoed the sentiments of all the participants. While in the staff room at work, and as part of the snowball recruitment procedure and with her lecturer-counsellor colleagues, Gail related angrily:

no one wanted to take part, and the reaction was very, “Oh, oh no I don’t harm anyone, no I don’t.” It’s very defensive. (Gail, counsellor).

Defensiveness was described by many practitioners who feared being honest and felt unsafe to disclose because, “the professional body, they don’t actually want to take any responsibility” (Gail, counsellor). This professional concern wove throughout the narratives, as seen in the interpretation of ‘thick skinned’ as a possible defence mechanism. The practitioners also held personal beliefs around the codes of ethics. Braun and Clarke (2014) consider that the latent meaning is uncovered where a participant is emotionally conflicted, such as Anil’s “Maoist workshops”, Alan’s anger at “collusion”, and Gail in the “staff room”. Gail’s meaning is interpreted on two levels: the apparent denial; and feeling
that practitioners are entitled to the protection of their professional bodies, yet feel they are not receiving it. Both levels seem incongruent in a field dedicated to well-being and care, and particularly the latter.

From her experiences, Pat offered one way forward:

In the same way, we might talk about ethics, but we don’t talk about the nitty gritty as much, maybe, at the same time. Because, I think, you know, it’s an uncomfortable topic, sometimes, for people to say, “Well actually, on that occasion, that wasn’t the most helpful thing” or “On that occasion I do think there was some harm on some level of this spectrum”. (Pat, counselling psychologist).

The extract, ‘it’s an uncomfortable topic’ seems to encapsulate the issue regarding iatrogenesis from the perspective of those who deliver psychotherapy.

**Living with myself.** The practitioners go home when their work is finished, yet they need to then live with their errors. Five use personal therapy to live more comfortably with themselves. One, Amy, uses a 12-Step Fellowship programme (Alcoholics Anonymous, 2016). Gail explains how she is sometimes left “feeling guilty” yet does not explain what she does, if anything, with these feelings. Three participants use nature to live well (some self-care strategies overlap). The value of personal therapy is described by Alan:

it’s very important that you have a therapy training that insists that you confront your own demons and work on your own stuff, otherwise, I think there’s a danger of working that out in clients. You know it’s very very common that … therapists are damaged people, you know, we do it to kind of to make ourselves feel better and … the potential to do harm is grave.

(Alan, psychotherapist).

Zoe also described using “personal therapy” to live privately and comfortably with herself. Yet professionally she seemed to live uncomfortably within the field of
psychotherapy because:

The whole issue with therapists in this country, it’s a bloody disaster, and I think it’s just wrong. (Zoe, counselling psychologist).

Sean showed the reflection-on-action of his counselling psychology training (Schön, 1983):

a kind of philosophic understanding of what to do harm is. I think there is a tension there … from the outset you're saying, well what is harm? What is not harm? What's kind of harm? It really could open up a whole pattern or whole area within psychology, within open-minded psychology. My fear is the more that we become a profession, it sounds a bit odd, then the more we have professional defensiveness. (Sean, counselling psychologist).

Sean hints at what may lie ahead for practitioners if the field of therapy continues its trend towards professionalisation. Professionalisation, particularly the changes enacted by the professional regulatory bodies, risk unintended outcomes. As Sean intuits, the more that we become a formalised profession, the greater the risk that the skilful freedom to be creative is factored out of the professional equation. I suggest this would harm the profession, and so clients. The last words in this results section are left to two senior counselling psychologists, who are reflexively and philosophically trained to consider deep and abstract levels of contradiction:

 counselling psychology is not only about practice because it is the link between field theory and practice. (Jamal, counselling psychologist).

The link connects the art of psychotherapy to practising with clients relationally, rather than a science of manualised psychotherapy to be applied to patients. Luis’ meaning is latent within the text; introducing a post-positivist science to manage or limit unintended harm within therapy actually risks causing greater harm. Therapy is an art because: all human relationships are complex and I am not sure if it is possible to have any
relationship in which there is not a degree of harm … or degrees of harm? (Luis, counselling psychologist).

**Summary of the Themes**

To answer the research question: *What are therapists’ perceptions of unintended harm within their practice?*, in theme one the participants talked initially about preparation for practice, training issues, good and difficult supervision and what more could be done to support them. The second theme of boundaries began to unpack the participants’ perceptions around the subjectivity of relationships. This second theme is also where the shift from the descriptive manifest level to the interpretative latent level became noticeable, because the participants began to question the value and impact of their professional ethical codes. The notion of what is or is not an error, was also said by these participants to be unclear, because no one could say fully where the boundary sits within their clinical practices. Working with or managing ‘errors’ was perceived to be a core aspect of therapy, and there was a general concern that short-term therapies may avoid the issue of unintended harm, and so paradoxically seem relatively safe. The paradox was highlighted by most of the participants who considered these short-term interventions may not address many issues that clients routinely bring to therapy. There was also frustration for all but one participant concerning the drawbacks of the perceived drift towards manualised practices.

For the third theme, issues of safety, participants described no longer feeling safe in their clinical practices. Here, the descriptive level and interpretative level overlapped, because the professional bodies were perceived to act in increasingly punitive ways towards their members who were perceived to have made errors. Several participants described concerns about the vagueness of the new ethical codes, which was interpreted as obscuring how this left them pondering future uncertainties in their clinical practices. A key issue was the gap between client safety and practitioner safety. Each theme was
considered to have unintended consequences for psychotherapy (Merton, 1936). The three themes describe the latent overarching theme of professionalism. These professionals seemed to say, “we’re already in a field of harm so it’s the denial of unintended harm that is the key issue” (Pam, counselling psychologist). The ‘keyness’ of this theme is seen through the lens of the professionals’ concern that by trying to manage or minimise the risk of harm, they unconsciously feel that harm may be embedded and perhaps even expanded in the work. In the long run, this risks doing harm to the profession.

**Discussion**

The aim of this study is to increase the awareness and management of unintended harm, and to enhance ethically-grounded practice. Little is known about how practitioners experience doing perceived harm in their day-to-day therapeutic practice (Bowie et al., 2016; Bystedt et al., 2014; Cox & Brown, 2014). The practitioners in this study experienced a need for a broader training in terms of preparation for practise, and to explore boundaries and concerns about issues of safety. The participants’ narratives enabled this study to explore the day-to-day management of the therapeutic relationship; both through reflections of what occurs in the therapy room, and through influences beyond the therapy room, which impact upon the work in the room. The three themes and their subthemes challenge the notion of what it means to be a professional. Transcending all the comments is the notion of tensions: is therapy an art or a science?

**Interpretation of the Findings**

Parry et al. (2016) suggest that it is now time to move on from iatrogenic practices within psychotherapy, but to move on we need to gain a deeper understanding of unintended harm and address the issues described by the participants, and interpreted by myself whilst carrying out this research study. Yet, any reference to the term iatrogenesis or its synonyms seems almost absent from key counselling psychology training handbooks (see Brown & Lent, 2016; Douglas, Woolfe, Strawbridge, Kasket, & Galbraith, 2016).
Parry et al. (2016) consider the sporadic mention of adverse effects in standard textbooks on psychological therapies represents professional complacency. Whether such a training gap even exists is highly topical and debated hotly. Gkouskos (2016) for instance, is a supporter of professional regulation and codes of ethics. He proposes two insightful arguments to counter this study’s claim of a training gap. While there may not be a dedicated lecture or training regarding the topic of iatrogenesis, he suggests it is embedded within trainings. There is a strong argument that the suggested gap does not consider that professional and ethical standards are designed to ensure effective, ethical and safe practice, and that training is designed around these standards.

Yet, even if accepted, the first argument seems flawed because when trained to be reflective or boundaried, students internalise a reflective process or boundary rules. Yet these may still be in the rough stage of development. This means they can be applied quite rigidly, as opposed to with sophistication. The student has cognitive understanding yet still needs to develop the affective skill of navigating and finding solutions to difficult encounters or ethical dilemmas. The point is that unless potential misapplications of a concept are considered openly they risk becoming part of an embedded learning. So, to learn the ‘art of the work’, Shaw and Carroll (2016) suggest that training in ethical maturity requires experiential learning, challenging … [and] the capacity … to think flexibly and responsibly when they encounter new situations” (p. 245). The results of this study suggest a need for the topic to be incorporated into training curricula.

The new codes of ethics speak to the second argument. Perhaps in part to address the rising level of complaints, new ethical codes have recently been introduced by the two largest registration bodies (BACP, 2016; HCPC, 2016). However, the participants expressed three concerns. The new codes seem to offer less guidance than the previous codes. This means they may be applied more arbitrarily and so rely on the practitioner’s judgment. Research evidences that practitioners have difficulty recognising adverse effects
(Hatfield et al., 2010), and often lack accurate self-assessment skills (Walfish, McAlister, O’Donnell, & Lambert, 2012). Also, many practitioners reported a shift towards practising defensively, which may curtail the art of therapy. Further, most of the participants had not read the new code for their registration body. Concerns regarding the lack of protection of the practitioners was also mentioned. Therefore, the new codes may resolve some issues, or may exacerbate inadvertently some existing issues considered to engender iatrogenic practices.

It is also suggested that as the level of recorded complaints is low statistically, this could be interpreted as questioning their importance and significance, and so of this research (Gkouskos, 2016). From an alternative critical radical practitioner and anti-professional regulation standards position, House (2009) also argues the statistical level of complaints is very low. However, derived from the same argument yet opposed diametrically to Gkouskos (2016), House (2016) considers the codes themselves undermine therapeutic practice by restricting therapeutic creativity. While one perspective argues the low level of complaints evidences the codes work, the other perspective applies the same logic to conclude the low level of complaints means the formal codes and registration bodies are unnecessary. The claim that iatrogenesis is so marginal that it does not merit investigation, itself merits investigation, because the position may hold unforeseen drawbacks (Merton, 1936). This rarity argument of iatrogenic practices becomes skewed if it can be shown that the number of formal complaints does not reflect accurately the prevalence of unintended harm as reported informally, and anonymously, to researchers.

Gkouskos’ position (2016) and House’s (2009) position both seem to be supported. However, for counselling psychology there may be a space in-between because unlike all the other identifiable practitioner groups, only one registered counselling psychologist has been ‘struck-off’ the professional register (HCPC, 2015c). For all practitioners, when
around 10% of the public and up to 40% of therapists in the role of client report harmful experiences because of attending therapy, there would seem to be an issue that requires addressing. This seems compounded by Raffles’ (2015) report that 71% of BACP complaints originate from people within the field of therapy. Also, over half of the complaints lodged with the HCPC (2015a) are not made by the public. This means the people practising therapy may be able to shed light on such trends, and the breadth and complexity of the issues supports a thematic method of enquiry (Braun & Clarke, 2006). These are the dilemmas facing the regulation bodies and practitioners who seek to be accountable.

Tensions

Each participant-practitioner related their unique narrative regarding the topic. As a group, they are aware of their perceptions relating to the polarised options they face in the day-to-day struggle to manage the perceived right way to practise, versus a perceived wrong way to practise. A key tension is that the group seemed aggrieved at being publicly held to account for their choices in a field that all acknowledged is inherent with risks. In short, they say the more scared they become, the less creative they are. These participants, in a profession where the codes of ethics value openness and honesty, say they are fearful. This exemplifies Merton’s theory of drawbacks because ethical codes are meant to make therapy safer. This also exemplifies Merton’s theory of paradoxical outcomes (Merton, 1936), because the codes seem to be creating the opposite of their intended function. Within Merton’s (1936) theory there is no mention that a context can produce both unintended outcomes and paradoxical outcomes simultaneously as a function of purposive action. These tensions are subsumed within a bigger tension, which transcends the whole narrative; the tension that pulls between whether psychotherapy is an art or a science.

The Notion of Psychotherapy as an Art or a Science?

The notion of art vs. science explains how, by attempting to avoid harm, people
lose the creativity in their training discipline, and their practice. Ultimately, this does harm
to the client because the therapists say they cannot fulfil their potential to be the best
practitioners they can be to serve the client. This finds reflection in the notion of
professionals vs. technicians (Friedson, 1994). It finds reflection in the struggle that has
been going on within medicine in terms of defensive practice. Also, it finds reflection in
the discussions around psychology regarding the systematising of practices that impact the
hidden theme of professionals vs. technicians as practitioners.

**Professionals or Technicians: Implications for “Do no Harm”**

This study’s overarching theme speaks to the unintentional undermining of
professionalism by the professional bodies. Freidson (1994) argues that through
“hierarchical forms of control, professional elites exercise considerable influence over the
technical, administrative and cultural authority previously held by professionals” (p. 9).
Thereby naming and applying the tensions, Friedson’s (1994) theory is given flesh on its
bones. The codes of ethics are stated to protect the public, to limit harm. However, they are
also applied inadvertently to shame members who commit human practice errors. This
makes professionals hesitant to acknowledge errors; these participants are fearful, and this
inhibits their artistry. While ostensibly protecting the public, it seems the codes may reduce
variability, and so increase conformity. Conformity is not the intended aim of the codes of
ethics.

In relation to the increasing level of complaints, the codes themselves are under
growing pressure (PSA, 2015, 2016). The new codes, intended to limit risk, may increase
risk. There seems an increased risk that the codes may become interpreted so rigidly, and
perceived as punitive, that the profession’s freedom to accommodate the needs of diverse
clients is being curtailed. This is a key unintended consequence. It is particularly serious
within a topic that argues therapy can function to further marginalise diverse groups, as
shown within this thesis’ review of the literature. At a time when the BPS ethical code is in
consultation, the BPS ethics committee has published the Declaration on equality, diversity and inclusion (BPS, 2017).

The declaration intends to, “[a]dvocate for the importance of equality, diversity and inclusion and being accountable for improving practice and communicating psychological knowledge of equality, diversity and inclusion to our membership and other stakeholders” (BPS, 2017, point 2). This study suggests that care be taken to pre-empt the risk of a paradoxical outcome; that the declaration intended to reduce marginalisation and increase accountability may function to produce the opposite outcome (Merton, 1936, 1968). To achieve this, “the salient elements of a situation [need to be recognised and explored] to prevent the inadvertent oversight of these elements” (Merton, 1968, p. 71). Highlighting these elements is one of the aims of this research.

Kuhn (1962) describes how those practising ‘problem solving’, such as John, who “in group supervision brought a client with erotic transference and got torn apart, and everyone found it quite difficult” (Theme 1) and Mary who using anger tried to resolve feeling “publicly humiliated” (Theme 3), are engaging in ‘puzzle solving’ because they work from within their own paradigm (Ogden, 2016a). Translated into a psychological concept, the elite only see the world from their own position. This is the critical realist overview because, “we create the world we perceive [and] … select and edit the reality we see to [manage tensions to] conform to our beliefs” (Engel, 1987, p. vi). This explains the inherent contradiction that a field dedicated to keeping the public safe does not seem to fully extend the same philosophy to its own members. When its practitioner members report not feeling safe and secure in their chosen profession, it is reasonable to ask how the practitioner members can take risks to work with emotive material, while remaining professionally and personally safe. In summary, the very top down pressure to ensure ‘do no harm’ may engender greater harm (Merton, 1972). An interesting observation is to note the correlation between the increasing top-down pressures on professionalism, and the
Professionals or Technicians: The Impact of “Do no Harm”

Government policies such as IAPT are increasingly being used to expand the scope of the technicians (NHS, 2016b). The framework of IAPT’s purposive social action (Merton, 1936) is not hidden. IAPT’s objective is to “develop a systematic approach to assuring [the] sustainability” of itself (DoH, 2012, p. 12). In brief, IAPT as it is practised in the field arguably offers mostly systematised, manualised, short-term therapy to the public. On one level, systematising psychotherapy by reducing theory variability, practitioner variability and even client variability can reduce harm (Ogden, 2016b). Yet, what are the tensions and consequences? Where there are a limited fixed number of structured sessions, then the systematic approach risks factoring out the needs of some clients; to explore the difficult aspects of their life with a creative and flexible professional. This was highlighted by Toren’s comment; “I get to the point that my concern is whether I am perceived to have done something wrong by my employers as opposed to patients” (Overarching theme of Professionalism). Therefore, systematised approaches to psychotherapy can produce ‘paradoxical effects’ (Bonell, Jamal, Melendez-Torres, & Cummins, 2015; Merton, 2016). The potential effect is that despite the intention to ‘do no harm’ the impact may be to inadvertently ‘do more harm’.

However, at a deeper level of impact and reminiscent of Kuhn (1962), I suggest the rapid impact of systematised therapy is akin to a colonisation of the field. Here colonisation means the propagation of the idea there is only one way to practise, or to be healthy. Gergen (2007) proposes the greater the harm the higher the stakes, which shapes the discourse to control professional resources. As increasing levels of perceived harm are reported through complaints procedures, it is becoming more apparent that the technician elite are inclined to use the codes of ethics to manage the harm. The parallel is if professionals themselves are being harmed within the field itself, the potential to harm

bottom-up increase in reported complaints.
clients must also increase. As Luis (counselling psychologist) highlighted; “I am worried about when you have therapists required to prescribe some very rigid routines, being monitored by anxious managers, how are we supposed to be fostering psychological flexibility?” Instead of celebrating the variability of art and science, the topic presented here remains taboo.

**Professionals or Technicians: Implications for Practise**

While medicine has faced its tensions, and addressed critiques openly about defensive practices (Illich, 1995), ‘do no harm’ remains a relatively taboo topic within psychology and counselling. The trend for complaints is upwards, and the implication for a responsible and ethical profession is that we need to explore the phenomenon of iatrogenesis. The implication of colonisation also needs to be spoken about. The NHS 5-year plan (NHS, 2016b) evidences the technical drive is going to expand and will further embed itself in mental health services. Professionals may as a result practise ever more defensively until many become technicians by default.

**Recommendations**

Here it is recommended that to counter defensive practices, we need to train practitioners that it is alright to disclose their errors. Only by feeling free to disclose our errors are we then free to make them, and reflect upon them. The choice between being a professional or being a technician seems initially to be black-and-white. Here, I prefer to talk in terms of a balance between these potentially competing positions. Counselling psychology offers one potential way forward through the reflective scientist-practitioner model by drawing upon scientific knowledge and artfully applying it (Corrie & Lane, 2010). The model also supports counselling psychologists to reach out to other health professionals, and so resist the move to take the art out of the science of the helping professions.

This purposive social direction could balance the tensions that I have presented
throughout this study. Therefore, the key recommendation is to introduce the topic of unintended harm into training programmes to help professionals integrate theory and field practice. Without specific training or workshops, some practitioners could continue harming their clients, and may not even recognise that they are doing harm. Also, the word ‘harm’ itself might mean different things to different people, which underlines why transparency is so crucial. These recommendations could be introduced via a discussion around Merton’s (1936, 1972) key theories.

**Interventions**

The airline industry is one profession that has introduced top-down interventions which the codes of ethics could model. Another example is the House of Commons Public Administration Select Committee (2015), which has provided the NHS with a ‘top down’ framework to reduce clinical incidents. Both interventions are relevant to psychotherapy practitioners because they introduce a ‘no blame culture and open process’. The intention is to manage, avoid or minimise reputational damage to the individual or an organisation, so that mistakes can provide an opportunity to learn. Additionally, and occupying the middle ground, use of Alternative Dispute Resolution (ADR) could be extended. Further, and from the ‘bottom-up’, the grassroots Psychotherapy and Counselling Union (2016) supports its members when they receive complaints. This takes the form of liaison with the professional bodies and insurance companies to support members to resolve complaints at the earliest stage, or to limit professional damage.

**How to Offer Clients Better Support**

Several pathways could offer better support to clients. Practitioners could become more informed about the potential for unintended effects. For instance, when assessing American psychologists’ familiarity with the research into iatrogenesis, Boisvert and Faust (2002) reported that about 30% of their sample lacked any knowledge that around 10% of clients report negative effects from therapy. In a review of the literature, Cox (2012b)
found that 0% to around 10% of practitioners had knowledge of negative effects, and few had training around the topic. This suggests there is a science-practice gap. Another pathway to better support clients is through the dissemination of research so that they also are more informed about the potential for adverse effects. This could be achieved through improved informed consent, such as informing clients about the benefits and potential risks of therapy.

Once students graduate they tend rarely to engage with research (Hanley, 2014). Therefore, training programmes offer a pathway to increase awareness of current research findings and to develop the skills to identify negative effects. Training could acculturize practitioners to the notion that it is unethical to hear the others’ narratives, yet fail to apply the messages from them. The core finding of this study is the need for training institutions and practitioners to engage with a module or workshop to explore this complex topic. By supporting the practitioners, we support the clients. A second core finding is the need for training institutions, practice settings and workshop providers to create a safe place to explore the complex issue of iatrogenesis. A safe place is defined as a context where curiosity and not shame is experienced when practitioners share their experiences, ideas and solutions.

Limitations

The findings from the present study should be considered in light of the following limitations, which are presented in the areas of: Merton’s (1972) theory, Context issues, The method of Thematic Analysis, Sampling issues: participation bias, Role conflict of the researcher, Reflections on my developing identity: personal reflexivity, Epistemological reflexivity, Iatrogenesis: cultural, social, discourse implications and using reflexivity.

Merton’s theory. By borrowing from Freud’s (1899/2017) theory of latent meanings in dream analysis, Merton’s (1936, 2016) theory of unintended consequences
may itself have an unintended consequence. This is to say that the practitioners’ narratives might be what they retrospectively remember, and not an accurate representation of the reality they experienced when the reported sessions occurred. This is the argument presented by Berger and Berger (1972), who consider that manifest as well as latent functions can be unconscious. However, for this study, the same argument could be extended to undermine the value of all retrospective recollections. It could also be applied to undervalue the contextually relevant contributions of a realist reality, or a socially-oriented consensus reality. Further, Freudian psychoanalysis typically spends years analysing the unconscious to study the function of latent purposive actions, while this study had a limited timeframe. Therefore, I will focus on a critique of Merton’s (1936) theory itself.

Campbell’s paper, An inquiry into the value and use of Merton’s concepts of manifest and latent function, critiqued the concepts of manifest and latent functions for rarely being used in research (Campbell, 1982). Campbell (1982) and Elster (1990) claim Merton (1972) omits to clarify whether he posits an explanatory or casual theory of latent functions. This is highly relevant because it speaks to the function of Merton’s (1936) theory within this thesis; an explanatory or casual model of purposive actions that bring to the fore unintended harm. In this thesis, Merton’s (1936, 1972, 2016) theory is applied to “explain social phenomena ... and to identify and describe phenomena that might otherwise be overlooked” (emphasis original: Elster, 1990, p. 130). I suggest there are more choices than Campbell’s (1982) or Elster’s (1990) binary choice offers. I suggest also, when the theory is applied to a context, Merton’s (1972) theoretical aim becomes clear.

Elster (1990) appeared to observe a gap in Merton’s (1972) theory: “if there can be stable bad situations, there can also be unstable good ones, like cooperation in a Prisoner's Dilemma” (p. 132). In the application of this research, I have argued elsewhere that the observed gap supports Merton (1936, 1972), because during complaint procedures
practitioners have reported experiencing the Prisoner’s Dilemma (a forced choice when working in a pair between a greater or lesser negative outcome); there is a stable negative issue where some practitioners have admitted to a lesser charge they considered unjust to avoid the fear of being found liable for a greater, yet more unjust, professional issue (PCU, 2016). This explains a potential paradoxical outcome for the implementation of codes of ethics, particularly when involving a public ‘name and shame’ or ‘name, shame and struck off’ process. In this study, the dilemma and experience of shaming explains how some practitioners perceive their professional registration body as acting in the client’s and registration body’s interests, and at the expense of the practitioner’s interests (PSA, 2016). This explicates the tension of power between the different stakeholders explored in this study (Willig, 2013).

As Merton (1968) articulated, the manifest-latent theory offers a mechanism for the “systematic observation and later analysis [towards the explication of the] salient elements of a situation [to prevent the] inadvertent oversight of these elements” (p. 71). Critics also question Merton’s (1972) perspective of intentionality within the frame of latent (unconscious), unintended or paradoxical outcomes. In response, we need to first connect the critique to the definition of Merton’s (1936) theory, as applied in the previous (IPA) study; “those elements in the resulting situation which are exclusively the outcome of the action, i.e., those elements which would not have occurred had the action not taken place” (emphasis added: p. 895). Then second, we can see the explanatory strengths rather than the casual limitations of Merton’s (1936, 1968, 1972, 1975, 2016) theory. We can see that the ‘insider and ‘outsider’ concepts with the ‘latent’ and ‘manifest’ process needs to be situated within a context, such as the consulting room, to explain how well-intended professionals can inadvertently engender harm. In this specific context, we can appreciate the elegance of Merton’s (1936) theory to help prise open Pandora’s box, and for us to examine and question unintended harm within the consultation room.
**Context issues.** Two key potential limitations have not been referred to anywhere in the data corpus; the issue of the context of the therapy, and the potential impact of publicly free or privately funded therapy. A common criticism of thematic coding is that the context is lost (Bryman, 2001). In this study, all the practitioners were working privately or self-employed, and as such, the participant sample mostly comprised privately funded clients. There is some literature to support that some privately paying clients use therapy in ways different to clients receiving free therapy (BACP, 2014: MIND, 2014). For instance, client choice is associated with a better response to treatment (MIND, 2013), and paying clients typically have more choice than non-paying clients. Also, paying clients may be treated differently by some practitioners, and private clients may have different expectations of their therapy. As someone who has received therapy within the NHS and currently privately, I have some experience of this, and have spoken with others about it. Underpinning the literature in this area, there may be some tangible differences between therapy delivered to the client without charge, and those who pay to be in the consultation room, and so may be more invested in a ‘good’ outcome.

From the practitioner’s perspective and within the context of private therapy, practitioners are likely to have more freedom to structure sessions as they consider suitable, which is to say without reference to a manual, management hierarchy or public health care system. Paying clients are more likely to have more freedom to choose their goals. Also, practitioners such as Toren and Dale, who work with CBT, will be trained to use the minimum data set of outcome measures. In contrast, the remaining 18 practitioners and their clients may use different criterion to assess what is felt to be positive, negative or neutral. Indeed, outcome measures may not form part of the therapy. Therefore, the context can arguably impact upon what level of subjectivity is considered appropriate to the setting (Strupp et al., 1977). Finally, private clients who dislike the therapy may have chosen their therapists, and have more freedom to move contexts if negative effects are perceived.
While the aim of using Merton’s (1972) manifest and latent concepts was to broaden and then deepen the reported quality and texture of experiences, it is questionable whether the findings of this thematic analysis will generalise to other contexts, such as publicly funded therapy where choices may be restricted. However, I have submitted a proposal to the New Savoy/BPS (2016) collaboration Steering Committee to apply this research within the public healthcare system. An alternative approach to manage potential limitations regarding generalisation of the findings is to narrow the sample of participants and therapeutic contexts, in order to access the experiences of the specific marginalised groups highlighted within this thesis’ literature review. Any results could then be generalised to other marginalised groups. The research could also be developed to inform the designs of quantitative research such as a more focused IPA study design than my Study 1, a qualitative study or mixed-methods approach to explore the intersection of practices that result in unintended harm within and beyond the consultation room (Merton, 1936, 2016).

The method of thematic analysis. Braun and Clark (2013) acknowledge that TA has limited interpretative power unless it is applied within an existing theoretical framework. To address this potential limitation, all the elements of the research must be conceptually compatible, which means a ‘good fit’ (Braun & Clark, 2013). Here, we can consider any limitations of the study design, through the lens of epistemology, method and sampling issues, and in relation to this study’s research question.

Epistemologically, Braun and Clarke (2013) consider that “member checking of the data items is situated in the realist framework, and so underpinned by an assumption to seek ‘the truth’” (emphasis original: p. 85). Member checking was applied in this study. My broad perspective of the data corpus was unavailable to the participants, which formed the exploration of my interpretations of the participants’ perceptions of iatrogenic practices. I applied one of Tracy’s (2010) eight key markers of quality in qualitative
research, member checking, to support the meaningful coherence of the research. From the critical realist perspective of this study, my interpretations of the participants’ perspectival meaning-making process intended to reflect their truth; which I recognise may be one of many truths.

Braun and Clarke (2006) propose their method is epistemologically neutral and that it can be applied to quantitative or qualitative research. In the earlier epistemological critique (see method section), I suggested that by Phase 3 a theme is provisionally held in the researcher’s mind and so epistemologically exists, at least as a cognitive working structure within the researcher’s mind. I found a key weakness of the method is Braun and Clarke’s (2006) lack of clarity in specifying the point at which their epistemologically neutral method becomes committed to a paradigm, or research project application. Upon reflection, I now suggest this may be prior to Phase 3.

Phase 2 of data coding involves a recursive familiarisation stage. The researcher perceives and processes the data, which means she/he/they uses past experiences that have an established epistemological grounding. Phase 1 begins with the interviews being transcribed orthographically. The conceptual compatibility of the study design begins with the research question. This study sought to explore: What are therapists’ perceptions of unintended harm within their practice? The structure of the question means ontologically a Being (Heidegger, 1962) can be harmed; this suggests harm is more than a construct because harm exists, and that harm can epistemologically be perceived. Psychotherapy practice locates the topic of iatrogenesis within a context, and with a context comes knowledge of what is expected to happen in that context. This knowledge also differentiates it from other contexts, such as a medical practice.

Thus, perceptual filters are opened or closed in association with pre-conceived social norms, identities, roles and so forth. To understand these aspects of experience requires foreknowledge that precedes the formulation of the research question and the
method applied to investigate it. The point is that once the research question is formulated, I suggest the following phases or stages of research are not epistemologically neutral. How a method is applied is shaped by the researcher’s previous knowledge, experiences, skills and interests. This point may extend to the motivation for conducting the research. For instance, I bought my own history and perceptual filters to how I view the topic of iatrogenesis. This background is the reason I am doing this study, rather than another study.

In practice, TA recommends that where possible the researcher transcribes the interviews. As any transcription involves where to place punctuation it is a meaning-making process. Conversation analysis demonstrates one’s positionality in relation to the data, and reflects also one’s interpretative repertoire (Wetherell, 1988), which is shaped by previous experiences. For instance, Braun and Clarke (2013) state that very simple transcription errors can radically alter the meaning of the data. Arguably, errors can be explained by one’s unconscious (latent) perspectival position regarding what they see, hear or read. I noted in Alan’s extract about collusion (Theme 2), how my mood changed my interpretation of his meaning.

In this simple and effective example, a minor punctuation change creates a fundamental change in meaning; ‘I hate it, you know. I do’ versus ‘I hate it. You know I do’ (Poland, 2002, p. 632). My point here is that once the research question is decided, to create a coherent study researchers need to acknowledge the subsequent use of TA is epistemologically framed. In short, “if themes ‘reside’ anywhere, they reside in our heads from our thinking about our data and creating links as we understand them” (Anzul, Downing, Ely, & Vinz, 2005, p. 208). What we each understand frames how we perceive and interpret the data.

**Sampling issues: Participant recruitment.** The more sensitive or threatening the phenomenon under study the more difficult sampling will be (Browne, 2005). The
snowball sampling technique is ideal to recruit hard to reach or hidden populations, such as practitioners talking about unintended harm in the consultation room. However, as the snowball sampling recruitment technique uses interpersonal relations and connections between people, it both includes and excludes individuals (Browne, 2005). Snowball sampling can be seen as a biased sampling technique because I selected participants embedded in my social network. Therefore, in Merton’s (1936) terms, my snowball sampling paradoxically excluded particular individuals or marginalised groups through the recruitment process.

Practitioners are not a homogeneous group. While 18 of the participants self-identified as psychologists, counsellors or psychotherapists, two self-identified as Cognitive-behavioural Therapists (CBT). As my social network barely overlaps with CBT practitioners, such as IAPT therapists, the CBT perspective was almost absent from my research account. Also, it is possible that some practitioners were self-screening and preferred not to be involved. The point is that while the sampling technique can access hidden and hard to reach populations, it can also recreate hidden populations. Also, perhaps some practitioners took part because they have an axe to grind, although overall that was not my experience. This, in turn, can bias the findings. However, research can be a messy process and the sensitivity of the topic meant the design of my study was always going to get biased results. Yet there did not seem any other feasible way of accessing the data to answer the research question. The limitations regarding the recruitment process and the impact of this upon the findings, arguably do not invalidate the study or render it so biased as worthless, because through reflexivity I was able to position the findings within the context and limitations of the design.

**Sampling issues: Participation bias.** The way the participants were recruited likely had an unknown influence upon the findings. The influence may have been on at least three levels; my own, the participants, or an interaction between us. Seeding of the
snowball recruitment strategy began with a request to two practitioners within my network; a counselling psychologist and a psychotherapist. Both had shown interest in this research topic when I presented the findings of the previous study at conferences. My choice and their interest could have biased this initial recruitment step because I appreciated their interest in my work. Both were asked to forward the participant information sheet (Appendix A), to two people in their network. This could have engendered other unknown drawbacks (Merton, 1936) because I had no influence over the ongoing quality of recruiters. In hindsight, an interview schedule question asking: ‘What is your motivation for participating in this research?’ could have yielded highly useful data. It would also have been interesting to know, particularly, if our motivations overlapped.

Some trends seemed to develop from within the data set. For instance, I noticed a trend that those practising for 15+ years (9 of 20 participants), to recruit other practitioners with many years of experience. This may have skewed the recruitment process, the provision of the data, and my perception of the data. For instance, of the nine, only one was a BACP member. Six were trainers. Therefore, there is a possibility that some of the participants formed a sub-group with a story to tell, and used the research to tell it. It was noticeable that the most senior figures in terms of years of practice, and seniority in the field of psychotherapy tended to be speak more forcefully, and at times angrily. After many interviews, I noted in my research diary a qualitative sensibility (Braun & Clarke, 2014), regarding how these senior practitioners subtly guided the interview process. I took this to be a sign of Merton’s (2016) ‘latent’ functions, or an unconscious process. On reflection, my findings may have been influenced more than I had realised, at least until this write-up.

One recruitment criteria, the assumed ability to explore “a broader definition of ‘evidence’ that synthesises research and practice” from different preferred modality perspectives (BPS, 2015, p. 17), may have had an unseen influence. Twenty practitioners
of different modalities and several different professional registration bodies were recruited. A large minority of participants were registered with more than one professional body. The demographics form (Appendix F), which requested the primary professional registration body, and any secondary registration, revealed a pattern. Of the seven participants registered with BACP and another body, typically UKCP or the BPS, BACP was consistently listed as their secondary body. This could be relevant because 5 of the sample were BACP registered only. It is my presupposition from training as a counsellor, then psychotherapist and subsequently psychologist, that BACP registered counsellors may generally have a narrow repertoire of skills to draw upon than counselling psychologists who are trained to apply multiple models.

A major point of relevance is that I did not explore the importance of social status or perceived professional status (Walfish, Barnett, & Zimmerman, 2017). For example, the 10 counselling psychologists each hold a doctorate, and the non-psychologist therapists and psychotherapists hold lower levels of formal qualifications. Professionally, this means there seems a hierarchy that may be of significance as to how the practitioner sees their self, what is attributed to the views of others, including clients, or how the clients perceive the practitioners. In terms of identity, this could be a salient yet unexplored aspect of the research topic. Further, the research reported in the literature review regarding practitioners’ failure to reliably notice and address harm within the consultation room (Hatfield et al., 2010; Walfish et al., 2012), did not always record the practitioner’s level of qualification. Therefore, qualifications could impact the findings in terms of self-perception, or practice outcomes. Simply put, the level of qualification is unlikely to guarantee safer practice, yet may initially create a sense of safety. In the BACP complaints literature (Khele et al., 2008), higher levels of qualification correlated with higher levels of reported harm (for male counsellors). For this reason, gender was considered appropriate to include in the study design and sampling decisions.
The gender and/or registration point may also be important because the phenomenon of iatrogenesis is not a property of the individual or a context, but appears at the intersection of the practitioners, clients and the context. As this intersection needs to be understood in-relation to the phenomenon (Merton, 1968), the type of training or registration body may have influenced the practitioners’ perceptions of iatrogenesis within the consultation room. Also, where the negative effects of therapy were reported, it remains unclear whether such effects were due to the type of intervention, the characteristics of the professional, a poor client-practitioner relationship, therapy in general, or some other influence (Mays & Franks, 1985). Additionally, this study utilised a sample of practitioners working in different therapeutic modalities, or from different epistemological positions. This is important as what constitutes harm or its occurrence could be interpreted differently as a function of different theoretical or knowledge positions.

Further, although the participants reported drawbacks or paradoxical outcomes, this “cannot be taken to signify that the psychotherapy has caused the deterioration – any more than one can rashly presume that positive changes observed during and after psychotherapy are necessarily the result of that treatment” (Rachman & Wilson, 1980, p. 100). Finally, Rachman and Wilson (1980) expound a realist argument as their position effectively questions the whole endeavour of psychotherapy, because arguably no one could know if the benefits (or not), are the result of the therapy. To accept their viewpoint seems disingenuous as it discounts the participants’ personal reports of benefits, or experiences of iatrogenesis, from attending therapy. From my experience, the participants felt safe and were non-defensive during the semi-structured interviews. My experience was of people speaking their truth, as they perceive it, honestly and openly. The participants seemed keen to engage with a potentially taboo topic, and used the safe space to open up their experiences to me.
However, it is crucial to appreciate that this study relates a therapist-centric understanding of iatrogenesis and pathways of change (Cooper & McLeod, 2011). This raises two important concerns. Firstly, the client and practitioner may feel there are competing normative aspects to their views of, “the cognitive, specifically epistemological aspect” (Merton, 1972, p. 110) that shapes the experiences of different stakeholders. This is because the insider doctrine (Merton, 1972) presupposes a particular view of the social and therapeutic structure within the consultation room. Similarly, while the philosophy underpinning counselling psychology training and practice prioritises the equality of viewpoints over a hierarchy, this may not be the view of the non-counselling psychology practitioners, or their clients.

Secondly, the impact upon the therapeutic relationship of paying for the relationship remains unknown. The sampling approach did not consider asking if the clients’ fees were always in a form of a financial exchange. This means alternative payment methods such as barter (Zur, 2016), which may be more common and a cultural norm within some communities, and the impact this might have upon the therapeutic relationship, was not considered. Other groups, and perhaps researchers, perceiving the issues from other perspectives or levels of analysis, would likely have much to add to this research topic.

**Role conflict of the researcher.** I experienced a conflict between my role as a scientist-practitioner researcher with my experiences of being a client. As an active researcher, I come with my own worldview, which manifests in my purposive social actions in my daily life (Merton, 2016). My actions and choices can manifest unconsciously, which means I may not always have been aware of them. Braun and Clarke (2014) offer researchers a word of warning that was particularly pertinent to me; “not to get over-enthusiastic with endless re-coding” (p. 92). The advice kept me mindful of my research role to report the data faithfully, rather than according to my personal interests.
Yet, as an active researcher in a dynamic process, intersubjectively as practitioner, client and researcher we effectively engaged in a triangular relationship, and so shaped each other’s experiences. I doubt that I can ever be sure of the full extent of my latent functions, which underpin the purposive social actions and importance of social justice, in my daily life. The power of this triangular conflict to shape unconscious conflicts and behaviours is the essence of Freudian psychoanalysis. Yet curiously, in my introduction I stepped aside from psychoanalytic concepts, which may have shaped my interpretations more than I can realise. I hope that by stating this, the reader can consider its relevance.

Reflections on my developing identity: Personal reflexivity and epistemological reflexivity. Braun and Clarke’s (2014) method is considered separate from a theoretical orientation, which left me free to choose the level of patterns to explore and report upon. Yet, I felt uncomfortable that TA seemed “devoid of [an] inherent philosophical position” (Brooks, McCluskey, Turley, & King, 2015, p. 206). I say this because my dual focus as a practising therapist and a current client surely shaped my perspective. However, I recognise that my history and interest in the topic influenced my own perceptions of the data set, and the extracts, to which I was emotionally drawn. I remain mindful of Lilienfeld’s (2017) comment that good intentions and face validity may appeal to our emotions and intuitions, but they can mislead us.

One of my most powerful reflections is that the story within this study is my story about the data, and not the participants’ story as related in the previous IPA paper. As ‘big Q’ research emphasises the active role of the researcher, and TA emphasises the organic approach to coding and theme development, from start to finish this research has developed from my own unique standpoint. Intuitively, I sense a paradoxical influence because my perspectival position seems both a strength and weakness (Merton, 1972). My point is that I am attached to the topic, for which I have a passionate interest. To manage this I kept a detailed research diary where I explored my dilemmas. I took these to a
supervisor and a personal therapist. The reflections on and use of my research diary became the gift that kept giving to the research process, my developing identity, my personal reflexivity and my epistemological reflexivity.

**Iatrogenesis: Cultural, social and discourse implications.** The context and practice of psychotherapy, and what is considered a good or a negative consequence, are “embedded and intertwined with the culture and social values in which the therapy is situated” (Strupp et al., 1977, p. 23). From a cultural overview, binary judgements of what is good or bad, and how we define mental health, have implications that influence practices within the consultation room. The issues that people bring to therapy and the outcomes they expect are interwoven with socio-cultural values and norms. For instance, the literature review in this thesis reported that the trend of research and practice, particularly when publicly funded, which is arguably how most clients access therapy, can promote forms of therapy or behaviour modification “designed to move the patient towards a particular ideal, standard, or norm” of functioning (Fowers, Anderson, Lefevor, & Lang, 2015, p. 187). This was reflected in the discussion regarding the PSA’s (2016) planned intervention to change the landscape of how codes of ethics are applied. It was reflected also in the discussion of the professionalisation of therapy, and the tension between whether therapy is considered an art or a science.

As cultural members of the world of therapy, and the wider social world that therapy inhabits, we practitioners and researchers are in a potentially unique position to be socio-cultural commentators; and activists. In their paper, Beyond harms: Exploring the individual and shared goods of psychotherapy, Fowers et al. (2015) suggest, “focusing entirely on reducing negatives is a very incomplete portrayal of the goals of psychotherapy” (p. 382). I agree, and suggest we need to look at the discourses that have developed from the duty of care of professionals to do no harm. A key discourse here is the need to protect the public from inept or harmful therapists. This discourse is subscribed to
by all the major professional bodies, and is evidenced by the need for new codes of ethics, at least in part intended to control the increasing level of complaints. However, as Merton (1972) noted, one implication of such a discourse is to, “ferret out the standardised practices among the workers, which are instituted by wise administrators of large programs” (p. 72), and then extend the use of the standardised practices to further support dominant or prevailing discourse. This speaks to the expansion of IAPT and its arguable colonisation of psychotherapy. This speaks also to therapy’s evolving discourse and expansion of individualisation.

Merton’s (1936) theory also noted the unintended effects of purposive social actions are difficult to recognise. I suggest that they are particularly difficult to identify precisely because practitioners and the professional registration bodies, acting through codes of ethics, intend well towards others. It is our raison d’être. It is this intentionality that adds to the importance of this thesis, because when 10% of client’s report feeling harm by attending therapy, particularly if they identify with marginalised groups and we neglect to explore this area, then it seems incongruent with our intention towards well-being. To support the policy makers, the findings from the present study and the thesis as a conceptual whole, indicate that researchers and practitioners must, “take action to better understand and document the potential negative psychological impacts of emerging social discourses” (Frost & Fingerhut, 2016, p. 490). This action is enshrined in counselling psychology’s core competency to ‘strive to do no harm’ (BPS, 201, p. 15).

Research Decisions

Some of the dynamics we research are so strong that we enact them in the research. That has played out in this Thematic Analysis study. To unpack this, it helps to revisit the research question: What are therapists’ perceptions of unintended harm within their practice? The question builds upon what I added to the traditional definition of iatrogenesis, which was originally unintended harm. This term could be misinterpreted as
suggesting that I consider all perceived harm is the practitioner’s fault; for clarity, I am not saying that. The lack of clarity offers me the opportunity to add my own reflections in order to understand the decisions I made, and why. I will certainly use this experience to inform future choices.

In the design of this Thematic Analysis study I made decisions early on that left me open to subsequent difficulties. My exclusion criteria stated not ‘subject to a past or current formal complaint’. This now seems a little loose because I had not considered workplace reprimands. Once included in the study, I faced the decision of keeping or removing the participant’s data, which means I had inadvertently opened the door to potentially engendering unintended harm. In hindsight, I have developed my thinking, and gained a deeper understanding of my own reflexive self.

**Conclusion**

The topic of ‘do no harm’ and iatrogenesis is complex. In their day-to-day practice of psychotherapy, the practitioners are concerned about the health of the field. The participants would like to see a way to engage with their professional registration bodies without fearing a punitive response. The practice of shaming those who make errors is causing distress, which could drive an open and honest debate around iatrogenesis underground. This means the very codes of ethics meant to protect the public or practitioners together with facilitating being able to complain, could themselves have an unintended and harmful impact.

From the findings of this study, complaints themselves offer up opportunities for both practitioners and clients to consider engaging in more therapy, not less. The finding that there seems an unconscious decision-making process where the practitioners may or may not attempt to judge whether something would be useful to clients, and whether clients are aware that their practitioners were trying to match something, merits further research. Unintended harm seems core to therapeutic work. This means it cannot be
factored out of good therapy. The field of therapy needs to talk about the tensions of competing positions and viewpoints. The space in-between may be challenging yet it seems rich with potential.

Also, the field needs to actively and directly introduce the topic into training programmes to acculturate practitioners to accept that causing unintended harm, and seeking support, are normalised. The field’s shift towards manualised therapy to control for harm or variability is de-professionalising psychotherapy, and increasingly turning well-intentioned practitioners into technicians. This trend, at least in public health care provision, is planned to expand. Therefore, to counter these shifts and for our profession to thrive, we need to celebrate our differences and variability. So, to thrive in the face of the current socio-political pressures we could reach out to join with other mental health disciplines and voice the paradox; the way to avoid harm and so reduce it is to talk unashamedly and more openly about harm.

It is hoped that this study will fit with counselling psychology’s 2016-2017 strategic plan, so that we can work together to promote the advancement of psychological knowledge and practice, to develop professional knowledge and skills, and to contribute to society while supporting practitioners and clients who are at the heart of therapeutic endeavour (McIntosh, 2016). Counselling psychology’s ‚strive to do no harm‘ offers a pathway to open the debate and dialogue in the service of all. The skill set of counselling psychologists suggests we are well-placed to lead the way forward on this complex topic.

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Appendix A

Participant Information Sheet

Research question:

*What are therapists’ perceptions of unintended harm within their practice?*

Introduction

I would like to invite you to take part in a research project. Before you decide you need to understand why the research is being done and what it will involve for you. Please take the time to read the following information carefully and ask questions about anything you do not understand. All the participants will be psychotherapists. Talk to others about the study if you wish.

Introduction to the lead researcher

My name is Philip Cox and I am 3rd year trainee Counselling Psychologist at the University of Surrey. This study will be submitted in part fulfilment for the Practitioner Doctorate in Psychotherapeutic Practice and Counselling Psychology. The training is self-funded and I declare no known conflict of interests.

What is the purpose of the study?

This study will explore the topic of unintended practitioner-caused harm in the health professions, also known as iatrogenesis. The aims are to extend understanding of the phenomenon of unintended practitioner-caused harm; and, to improve the effectiveness of mental health professionals. The objective is to empower marginalised sub-groups, whether clients or practitioners.

Why have I been invited to take part in the study?

You have been invited to take part in this study because you are a qualified psychotherapist. I am seeking to recruit 15-20 psychotherapists located in the United Kingdom.

To be eligible to take part in the study, you must meet the following criteria:

i. Be a psychotherapist with experience of private practice
ii. Be registered with a recognised professional body such as the British Psychological Society, United Kingdom of Psychotherapists, British Association of Counsellors and Psychotherapists, British Association of Behavioural Cognitive Psychotherapists, Royal College of Psychiatrist, British Psychoanalytic Association or another similar organisation.

iii. Have 5+ years of professional practice experience.

iv. Have an interest in this study.

**Do I have to take part?**

No, you do not have to participate. There will be no adverse consequences in terms of your legal rights or employment status if you decide not to participate, or withdraw at a later stage. You can withdraw your participation at any time by making a written request either by letter or e-mail. The lead researcher will provide written confirmation that this request has been received and acted upon either by letter or e-mail. We recognise that phone calls are sometimes an easier form of communication than letters or email. For there to be a clear record of contacts we ask that phone contact is used only if there is an urgent issue. Urgent issues are where harm or injury might be caused. Replies to phone calls will be made by email unless the matter is urgent. The interview schedule will be provided to you by email within 48 hours of the interview being arranged. You can request for your data to be withdrawn until 01.06.16 without giving a reason and without prejudice. To withdraw contact the researcher who will confirm in the same medium the request was received that the request has been actioned. If you withdraw from the study this will mean the following for your participation and data; all data will be destroyed.

**What will my involvement require?**
If you agree to take part, the lead researcher will arrange to contact you at a mutually convenient time and location. The semi-structured interviews can be either face-to-face or via Skype. You will then be asked to sign a consent form. If you do decide to take part you will be given this information sheet to keep, and a copy of your signed consent form. The interview is expected to last between 30 and 40 minutes. During this time, you will be asked some questions from the interview schedule, which will be provided. As the audio recorded interview is integral to the study it is not possible to opt-out of it.

**What will I have to do?**

If you agree to participate you will not have to do anything beyond sign the consent form, meet or Skype for the interview and respond to any questions, or not, as you like.

**What will happen to data that I provide?**

Your details such as name and contact details will be retained by the lead researcher only on an encrypted USB, which will be securely stored. This data will be destroyed when the final mark for this Doctoral research is received from the University of Surrey. The audio recording data of your interview will be stored on a second encrypted USB, which will be securely stored. It will have no identifying information on it. Only the lead researcher will have access to this data. This project data will be held for at least 6 years and all research data for at least 10 years in the strictest confidence, and in accordance with the UK Data Protection Act (1998).

**What are the possible disadvantages or risks of taking part?**

There is a low-level possibility that discussion of the topic of unintended practitioner-caused harm and/or any experiences of this topic in your practice could engender some uncomfortable experiences. There will be a post-interview debrief. Your well-being will be monitored. Also, information regarding support will be provided.

**What are the possible benefits of taking part?**

Potential benefits include:
i. Add to the growing interest within mental health care of unintended practitioner-caused harm

ii. Gain insight into practice dilemmas

iii. Improve own practices

**What happens when the research study stops?**

When the study ends, it will be submitted to the University of Surrey as part-fulfilment of the Practitioner Doctorate in Counselling and Psychotherapeutic practice.

**What if there is a problem?**

Any complaint or concern about any aspect of the way you have been dealt with during the study will be addressed; in the first instance please contact my Supervisor, Professor Jane Ogden, University of Surrey, tel: 01483 686929 and/or email: J.Ogden@surrey.ac.uk. You may also contact Professor Derek Moore, Head of the School of Psychology, Surrey University who is independent of the research team: tel: 01483 68 6933 and/or email: d.g.moore@surrey.ac.uk. If you remain unhappy you can file a complaint using the complaint procedure of the British Psychological Society, **Member Rules and Standards Officer**, St Andrews House, 48 Princess Road East, LEICESTER, LE1 7DR: tel:+44 (0)116 252 9919, email: conduct@bps.org.uk.

The University of Surrey holds insurance policies which apply to this study. If you experience harm or injury because of taking part in this study, you will be eligible to claim compensation. This does not affect your legal rights to seek compensation.

If you are harmed due to someone's negligence, then you may have grounds for legal action. Regardless of this, if you wish to complain, or have any concerns about any aspect of the way you have been treated during this study then you should follow the instructions given above.
If you are harmed by taking part in this research project, there are no special compensation arrangements. If you are harmed due to someone's negligence, then you may have grounds for legal action. Regardless of this, if you wish to complain, or have any concerns about any aspect of the way you have been treated during this study then you should follow the instructions given above.

**Will my taking part in the study be kept confidential?**

Yes. Your details will be held in complete confidence and we will follow ethical and legal practice in relation to all study procedures. Personal data (name, contact details, audio recordings) will be handled in accordance with the UK Data Protection Act 1998 so that unauthorised individuals will not have access to them.

In certain exceptional circumstances where you or others may be at significant risk of harm, the researcher may need to report this to an appropriate authority, in accordance with the UK Data Protection Act 1998. This would usually be discussed with you first.

Examples of those exceptional circumstances when confidential information may have to be disclosed are:

- The researcher believes you are at serious risk of harm, either from yourself or others
  - The researcher suspects a child may be at risk of harm
  - You pose a serious risk of harm to, or threaten or abuse others
  - As a statutory requirement e.g. of a criminal act
  - We are passed information relating to an act of terrorism

**Full contact details of researcher and supervisor**

Lead researcher: Philip Cox, School of Psychology, Faculty of Health and Medical Sciences, University of Surrey. p.cox@surrey.ac.uk
Supervisor: Jane Ogden (PhD), Professor in Health Psychology, Department of Psychology, University of Surrey, Guildford, Surrey, GU2 7XH. Tel: 01483 686929.
Email: J.Ogden@surrey.ac.uk.

Who is organising and funding the research?
This research is organised and funded by the lead researcher who is a student at the University of Surrey.

Who has reviewed the project?
This research has been looked at by an independent group of people, called an Ethics Committee, to protect your interests. This study has been reviewed by and received a favorable ethical opinion from the Research Ethics Committee, University of Surrey, Faculty of Health and Medical Sciences Ethics Committee.

Thank you for taking the time to read this Information Sheet.
Appendix B

Consent Form

Study title:

First do no harm:
A thematic analysis of therapists’ perceptions of unintended harm

Please initial each box

- I have read and understood the Information Sheet provided (v2, date 24/11/15). I have been given a full explanation by the researcher of the nature, purpose, location and likely duration of the study, and of what I will be expected to do.

- I have been advised and understand that participation is entirely voluntary.

- I have been advised about any disadvantages, risks, and/or discomfort on my health and well-being which may result.

- I have been given the opportunity to ask questions on all aspects of the study, and I have understood the advice and information given as a result.

- I agree to comply with the requirements of the study as outlined to me to the best of my abilities. I shall inform the researcher immediately if I have any concerns.
• I understand that in accordance with the English law, insurance is in place which covers harm that is likely to result from my participation in this study as detailed in the participant information sheet.

• I agree for my anonymised data and samples to be used for this study and any future research that will have received all relevant legal, professional and ethical approvals.

• I give consent for the semi-structured interview to be audio recorded.

• I give consent to anonymous verbatim quotations being used in the study and any publication

• I understand that all project data will be held for at least 6 years and all research data for at least 10 years in accordance with University policy and that my personal data is held and processed in the strictest confidence, and in accordance with the UK Data Protection Act (1998).

• I agree to the researcher contacting me to provide me with a summary of the results should I request such a summary.

• I agree for the researchers to contact me about future related studies.

• I understand that I am free to withdraw from the study at any time without needing to justify my decision, without prejudice and without my legal rights and studies/employment being affected.
• I understand that I can request for my data to be withdrawn until 01.06.16 and that following my request all data already collected from me will be destroyed.

• I confirm that I have read and understood the above and freely consent to participating in this study.

• I have been given adequate time to consider my participation.

• I consent to my personal data, as outlined in the accompanying information sheet, being used for this study and other research. I understand that all personal data relating to volunteers is held and processed in the strictest confidence, and in accordance with the Data Protection Act (1998).

Name of participant (BLOCK CAPITALS) .............................................

Signed: ........................................................................

Date:
Appendix C

Semi-structured Interview Schedule

1. I’m interested in your thoughts about your professional Code of Ethics and in particular the notion of ‘Do no harm’. Can you tell me which ways this influences your mental health practice?

2. What, if any, are some of the subtler effects of unintended practitioner-caused harm?

3. What is your experience of unintended harm; have you seen any unintended harm?

4. Have you done any of those?

5. How would you deal with / how have you dealt with unintended practitioner-caused harm?

6. Thinking about what you have said, have you any suggestions to limit unintended practitioner-caused harm?
Appendix D

Recruitment Information

Dear (name),

This study seeks to recruit 15-20 psychotherapists with experience of practice private, to explore the topic of unintended practitioner-caused harm (iatrogenesis) within the field of mental health treatment.

The interview is expected to last between 30 and 40 minutes and will be held at a mutually convenient location. You will be asked to provide 2 names of psychiatrists from within your network who might also be interested in participating and inform these named people that the lead researcher will be contacting them.

Thank you for your consideration.

Philip Cox
Trainee Counselling Psychologist
University of Surrey
p.cox@surrey.ac.uk
Appendix E

Personal and/or Professional Support Services

To ensure your well-being details of the following organisations are offered in case you require social or psychological support arising from participation in this research. These organisations provide confidential personal and/or professional advice and support. They are not connected to the research project or the researchers.

1. Your professional registration organisation.
2. The British Association of Counselling and Psychotherapy
   British Association for Counselling and Psychotherapy
   BACP House, 15 St John's Business Park, Lutterworth, Leicestershire LE17 4HB, United Kingdom
   **Telephone:** 01455 883300 Monday-Friday, from 9.00am until 5pm
   Fax: 01455 550243 Text: 01455 560606
   **Email:** bacp@bacp.co.uk
   **Website:** www.bacp.co.uk

3. United Kingdom Council for Psychotherapy
   2nd Floor, Edward House
   2 Wakley Street
   London EC1V 7LT
   **Telephone:** 020 7014 9955
   **Email:** info@ukcp.org.uk

4. The British Association of Cognitive Psychotherapists
   Imperial House, Hornby Street, Bury, Lancashire BL9 5BN
   **Telephone:** 0161 705 4304   Fax: 0161 705 4306
   **Email:** babcp@babcp.com

5. British Psychological Society
Telephone: 020 7330 0890
Website: www.bps.org.uk/

6. Psychiatrists’ Support Service

To contact the Psychiatrists' Support Service please telephone: 020 7245 0412 or e-mail: pss@rcpsych.ac.uk

The Psychiatrists' Support Service is a free, confidential support and advice service for members, trainee members and associates of the Royal College of Psychiatrists who find themselves in difficulty or in need of support. There is a dedicated telephone helpline, where calls are kept separate from the main College phone line, and this will be answered by the service manager. If appropriate, you will be put in touch with another psychiatrist who will be able to talk through the issues with you and offer support or signpost you to appropriate services.

7. The Royal College of Psychiatrists also provides links to independent peer support and/or counselling at the following page: www.rcpsych.ac.uk/work in psychiatry/psychiatristssupportservice/usefullinks.aspx

8. The British Psychoanalytic Association (BPA)

37 Mapesbury Road
London NW2 4HJ

Telephone: 020 8452 9823
Email: info@psychoanalysis-bpa.org

9. Your General Practitioner

10. Information regarding free counselling is available at:

+44 (0) 1208 220485 or +44 (0) 843 636 5211

+44 (0) 843 636 5210 (Fax) or Text INFO to +44 (0) 7516 440 324
Appendix F

Demographics

Please complete the following and leave blank any areas you prefer not to answer.

Age: ………………

Gender: Female ☐  Male ☐  Transgender ☐
Other ☐ (please explain)  Prefer not to say ☐

How many years have you been practising: ………………

How many years have you been practising since professional registration: ………………

How would you describe the theoretical orientation or main influence that guides your professional practice: …………………………

Which is your main professional registration organisation e.g. UKCP, BACP, BPS
……………………

If you belong to any additional registration organisations, which: ………………………

Have you read your main registration organisation’s Code of Ethics?
Yes ☐  No ☐  Other ☐ (please explain) ………………

What if any potential conflicts have you noticed between the Codes of Ethics of different registration organisation: …………………
Appendix G

Ethics Committee Approval

Faculty of Health and Medical Sciences

Ethics Committee

Chair’s Action

Proposal Ref: 1142-PSY-15

Names of Student/Trainee: PHILIP K COX

Title of Project: First do no harm: A thematic analysis of therapists' perceptions of unintended harm

Supervisors: Professor Jane Ogden

Date of submission: 4th November 2015

Date of re-submission: 24th November 2015

The above Research Project has been re-submitted to the Faculty of Health and Medical Sciences Ethics Committee and has received a favourable ethical opinion on the basis described in the protocol and supporting documentation.

The final list of documents reviewed by the Committee is as follows:

Protocol Cover Sheet
Detailed protocol for the project
Participant Information sheet
Consent Form
Risk Assessment (If appropriate)
Insurance Documentation (If appropriate)

All documentation should be retained by the student/trainee in case this project is selected for an audit.

Signed and Dated: __27/01/2016___________________

Dr Anne Arber, Professor Bertram Opitz
Co-Chairs, Ethics Committee

Please note:

If there are any significant changes to your proposal which require further scrutiny, please contact the Faculty of Health and Medical Sciences Ethics Committee before proceeding with your Project.
Appendix H

Diagram 1: A Conceptual Map of ‘Do no Harm’

- Preparation for practice
- Supervision
- Training
- Subjective
- Right vs. wrong
- Codes of Ethics
- Boundaries
- Professionalism
- Professional vs. technician
- Impact: ‘do no harm’
- Implications: for practice
- Issues of safety
- Seeking safety
- Support vs. punitive
- Consequences
- Balancing errors
- Disclosure
- Living with self
- Shame of errors

What are therapists’ perceptions of unintended harm?

The notion of psychotherapy as an art or a science?

Indicates potential links
Appendix I

Diagram 2. Final Thematic Map

Preparation for practice

Training

Supervision

Support vs. punitive

Seeking safety

Shame of errors

Implications: for practice
Appendix J

Transcript of Participant 19 (Anonymised)

Transcript: Participant No. 19 (anonymised)

Clt: Participant

Int: Interviewer

Int: So I’m interested in your thoughts about your professional Code of Ethics and in particular the concept of do no harm and I’m wondering if you could tell me about the ways your professional Code of Ethics and this do no harm concept influence your mental health practice

Clt: Umm, well I think that do no harm is (pause), it’s (pauses) I think it’s a huge responsibility because err err in my role as a private practitioner but also as a manager in a clinical service, in a large charity providing psychotherapy, do no harm is a huge preoccupation and I’ll tell you why. In in my personal capacity as a psychotherapist, a psychologist then it’s about acknowledging then (very slight pause), it’s mainly about acknowledging limits of competence and (slight pause), beyond which, I think I think of harm in two ways: one is more active harm if I, say, to put it in one, am overly aggressive in my intervention, if I don’t get my intervention right then I push somebody, say, towards self-harm or my my intervention is misinterpreted and the person decides to follow my lead or what they think is my opinion rather than employ their own thinking. Um, that is the most active yeah as in stirring up the traumatic material again. Stirring up the traumatic material isn’t always a bad thing but it can lead to harm, particularly self-harm; the other aspect is the more passive and it is when you can actually be very safe in therapy and actually do more harm and actually do nothing

Int: Which in a sense could be taken as a form of harm when someone comes to therapy
Which then, which then becomes a form of harm because if somebody is (brief pause) it is a big question of how do you position, how do you (brief pause), what do you challenge, what do you not challenge? When is challenging useful and when is challenging actually (pauses) colluding with a patient’s or client’s negative behaviours, self-harming behaviours or actually maybe nothing to do with self-harming but failures to care for themselves. Um, and again, if I think of another speciality that I have which is couple work, when you work with a couple you can be, you can collude in harm. Yeah. There is something that can be about allowing a couple to demonstrate what they do to one another (pauses) but at some point, if it is too silent, if one is too submissive, then you actually (brief pause) in a way accepting or justifying, say, the degradation of one to the other. Also, working with families, at what point do you intervene and stop a parent from cutting into a child? (Pauses) Verbally cutting into a child. Um, and intervening can be damaging because it can escalate tensions and potentially lose the therapeutic alliance, so it’s a big (pauses) that’s one aspect. On a more managerial level I think it is actually a dilemma. I was actually talking to a to a colleague of mine today. Isn’t, and perhaps it is what we spoke about earlier, is the idea that most of the time damage it is done by students. The reality is that, I think for for managers at least, the big anxiety is students. So, when I am allocating a case to a trainee, and maybe it is not because a student is more damaging, often they are not more damaging they are just less effective or less pushy. Umm, I think when I am allocating to a trainee, then um if something goes wrong then I’ll be carrying more of the responsibility for that impact. If I allocate that case to an experience clinician or a fully qualified clinician, if something goes wrong they actually carry the responsibility through and through. Or largely. So the big issue for me is how do you how do you come to, in a way it is similar to private practice, what is the difference between the
Appendix K

Journal Submission Guidelines

Psychology and Psychotherapy: Theory, Research and Practice

**Author Guidelines**

Psychology and Psychotherapy: Theory Research and Practice (formerly The British Journal of Medical Psychology) is an international scientific journal with a focus on the psychological aspects of mental health difficulties and well-being; and psychological problems and their psychological treatments. We welcome submissions from mental health professionals and researchers from all relevant professional backgrounds. The Journal welcomes submissions of original high quality empirical research and rigorous theoretical papers of any theoretical provenance provided they have a bearing upon vulnerability to, adjustment to, assessment of, and recovery (assisted or otherwise) from psychological disorders. Submission of systematic reviews and other research reports which support evidence-based practice are also welcomed, as are relevant high quality analogue studies. The Journal thus aims to promote theoretical and research developments in the understanding of cognitive and emotional factors in psychological disorders, interpersonal attitudes, behaviour and relationships, and psychological therapies (including both process and outcome research) where mental health is concerned. Clinical or case studies will not normally be considered except where they illustrate particularly unusual forms of psychopathology or innovative forms of therapy and meet scientific criteria through appropriate use of single case experimental designs.

All papers published in Psychology and Psychotherapy: Theory, Research and Practice are eligible for Panel A: Psychology, Psychiatry and Neuroscience in the Research Excellence Framework.


Cox, P. K. (2014b). To DSM or not to DSM: That was the question. *History & Philosophy of Psychology*, 15(1), 49-50.


Cox, P. K., Ogden, J., & Semlyen, J. (under review). First do no harm: A thematic analysis of therapists’ perceptions of unintended harm. *Counselling Psychology Review*. 
Philip K. Cox

**Presenting a PetchaKucha**

PetchaKucha presentations are concise, to the point and great fun. I will try to parallel the style with this brief outline of my experience of presenting PetchaKucha style. Held at Surrey University and titled ‘*Using and Abusing the Impact Agenda*’, the South East and Oxford Doctoral Trainings Centre’s (DTC) graduate school day took place on All Hallows Day (1st November). The DTC is accredited by the Economic and Social Research Council (ESRC), and so has great relevance to researchers in training.

Originating in Japan as a way for people to showcase their work, PechaKucha translates as ‘chit chat’. Although I have seen the term in a few research papers I had to Google ‘PechaKucha’. PechaKucha is a presentation style in which 20 slides are shown for 20 seconds each, making the presentation fast-paced. At Surrey the concise was made more concise with 10 slides of 20 seconds each. The auto-forward means you get straight to the point, and requires thought and discipline. These are skills useful for any researcher (especially if like me they need developing). The day was student-led to explore examples of impact in key areas such as academic, economic, and societal contexts. Three key aims were to identify impact, take a critical angle on impact and identity ways to increase impact in research.

Presenting science concisely is an art. I found deciding what the central points of my research are and how to rapidly deliver them brought out my creativity. Preparing my slides and practicing 10 slides in 20 seconds also got me to think how I intend to research
my subject. As I listened to the other researchers present I continued to develop my own ideas. This type of collaboration was new, at least to me, and by the time of my own PechaKucha presentation I had already changed my idea on what my last slide meant. The post-presentation questions and mingling in breaks were great ways to cross-fertilize ideas and generate something new. Chit chat can make research a lot of fun, and fun makes it all so much easier. As we end it occurs to me that I now feel more confident about concisely explaining my research when it comes to the viva.
Projective identification in the analytic relationship: Phantasy, or the symbiotic dance of the Eloi and the Morlock's?

Philip K. Cox

Content & Focus: H.G. Well's novel The Time Machine shows how art imitates reality and brings to life Klein's concept of projective identification. Using a composite example of sessions from a Humanistically-oriented addiction service and subsequent psychoanalytic training, supports how the process of projective identification can be understood as a communication. The concept of projective identification is developed from an intrapsychic to an inter-psycho process. In this reciprocal relationship projective identification is the therapy. How the philosophical underpinnings of each service and their competing approaches can lead to very different outcomes, is also explored.

Conclusions: Klein's theories have multidimensional implications and the concept of projective identification is easily misused. Rather than conceptualising projective identification as a psychotic or malign defense, the emotional tug of intersubjectivity are a key to effective therapy. Patient and practitioner essentially become co-operating parts of the whole, and so develop together by working through the symbiotic dance that is projective identification.

Keywords: Projective identification; intersubjectivity; philosophy; H.G. Wells.

There is no such thing as a Morlock... A Morlock cannot exist alone, but is essentially part of a relationship
(adapted from Winnicott, 1960)

In H.G. Wells' (1895) post-Armageddon world of dying mother Earth and annihilation, the survivors have seemingly resolved their archaic conflicts by splitting the world to peacefully co-exist. In this wishful world of symbolic representations, the graceful Eloi live above ground, while their envious counterparts the Morlock's reside deep underground in the bowels of the Earth. Yet each is symbiotically linked in a primitive alliance of mutual intersubjective needs. Occasionally the surface is punctured and the Eloi become the Morlock's staple diet, swallowed up into a dark pitiless underworld from which few return.

Writing in the same era, Freud (1967; 1991) utilised an ancient Greek fable, developing the Oedipal complex (the child's primitive unconscious wish to kill the opposite sex parent and possess the same sex parent). Developmentally, between 3- to 4-years-old, Freud suggested that the child is driven to resolve the triangular relationship between itself, mother and father (or caregivers), with the father playing the central role. In contrast, Melanie Klein (1946) suggested the most significant developmental stage is pre-Oedipal, with the mother playing the central role (Rank, 1924, cited in Rank & Kramer, 1996). From the beginning, the intense mother-child interactions are object seeking, such as the breast, rather than drive gratification. Therefore, object seeking underpins Freud's structure of drives. Indeed, the Oedipal complex follows the need to regulate emotionally intense interactions (Shore, 2012).
In phantasy (the unconscious symbolism of biological processes and relations), another figure from antiquity, Plato (424–378 BC), considered how art imitates reality (Young & Saver, 2001). Plato represented how literature can describe something so terrifying that few practitioners willingly enter its conceptual netherworld. Yet Klein (1946) entered, developing the term projective identification as we know it today (Spillius, 2012, cited in Spillius & O’Shaughnessy, 2012). The term describes the infant’s aggressive discharge of split-off aspects of the ego into an external object, such as the mother. This devours or controls the object’s contents, incorporating such into the embryonic ego’s own internal structure (Mills, 2000), which is continually and mutually shaped (Stolorow & Atwood, 1996). Paralleling infant-mother intersubjectivity (the right brain unconscious communications between the psyches), Pick considers the sometimes unrelenting ‘projecting by the patient into the analyst as the essence of analysis’ (emphasis added; 1985, p.37).

Analytically, Klein (1946) differentiated two overlapping stages of infant development, the paranoid-schizoid and depressive positions (Frost, 2013). The paranoid-schizoid position is characterised by persecutory feelings and the mechanisms of splitting (whereby a mental representation loses its integrity splitting into part-structures), of projection and introjection. The accompanying emotions are hatred, envy, love, fear of annihilation by the (m)other, and omnipotence. These may also be experienced by the practitioner. Objects as symbolic representations are experienced as part-objects such that the nipple is a part-object of the breast, the breast of the mother and so forth. In practice, a self-other relational dichotomy arises; the primary good object of the breast is internalised, and bad objects like the mother are excreted (expelled). The shift to the depressive position is characterised by experiencing whole objects.

Klein’s (1946) insight was to theoretically outline how the infants earliest life and death anxieties surface. However, in contrast to Klein’s belief that an infant’s first thought is aggressive, H.G. Wells illustrates how projective identification embraces the symbiotic dance of the mother-infant and practitioner-patient (or Eloi and Morlock). Transferring this process to clinical practice, some argue projective identification is itself a phantasy, better explained by the concept of transference (a defense mechanism of actual and fantasized relations from the past (Kernberg, 1988, cited in Sandler, 1988), counter-transference, or identification and projection (Joseph 1988; Meissner, 1988, respectively cited in Sandler, 1988). However, the concept serves a specific clinical purpose by highlighting how one penetrates under the skin of the other. This process of projecting into and then affectively controlling the (m)other is inadequately explained by the alternative transference concepts.

A composite of sessions with three clients (all data anonymised: Division of Counselling Psychology, 2009) is accompanied by a commentary to explore how I intellectually understood projective identification, yet not how to fully apply it in the experiential netherworld of clinical practice. The extracts show a development shift to what I would now add or do differently, aiming to bring to the surface how, where and why projective identification adds to the clinical literature and therefore my practice. This is facilitated by interpreting projective identification within an intersubjectively-based frame.

The clinical contexts
The initial context is a Humanistic addiction treatment centre where the staff are located on the first floor and clients are seen in the basement. Both use the same door to enter or exit the premises. The structure is similar in my subsequent psychoanalytic setting, where the third client was seen. While in the former a maximum 20 sessions is permitted, the latter is open-ended. The addiction centre self-identifies as having a Humanistic theoretical-orientation, yet potentially pro-
bjects a dystonic message by teaching clients to ‘live fully present-in-each-moment’ (Rogers, 1989). Temporally and philosophically, I suggest that primitive past-in-the-present re-enactments are more clinically and conceptually useful than living-in-the-moment irrespective of other dimensions of existence (Nietzsche, 1986). This understanding supports working through material by not falling into the Morlock’s lair of a temporal Cartesian ‘now-then’ spilt (Domasio, 1994), or conceptualising the present without reference to the past.

Conceptualising projective identification as a primitive form of affective communication (the projector’s unconscious need to make the other aware of her needs, and engender a response), the process develops in four stages: 1. the experience of unmanageable feelings; 2. the unconscious wish to put such feelings into another and evacuate (dispose) of them, or make them manageable; 3. an unconscious interactional ‘hook’ such as a cry to make the other have the feelings; and 4. if the projective identification is successful the recipient feels the affective resonance, an affective sameness of identification which can devour if uncongenised (Case ment, 1985). Paralleling the individual and increasingly recognised in the clinical literature, organisations can also engage in projective identification (Petriglieri & Stein, 2012).

It was while working in an organisation that a client stimulated the idea for this paper. On the surface an object-relations approach seems an unlikely position to adopt in a Humanistic centre. Yet when meeting Morag at reception the projections were immediately evident, for I felt an emotional tug and logged my counter-transference. Moraga considers one’s ‘immediate emotional reaction to the patient’ paramount (1994, p.3); I was hooked by Morag’s projected affect, the emotional pre-verbal, deeper communication of the lost and angry child. My counter-transference was experienced as the father figure in reaction to this confused child-client seeking a parental good-object. Indeed, part of my role was to represent the authority and conscience (superego) of the centre. I noted my frustration when reading the quasi-diagnostic judgment concretised as ‘psychosis’ in the urgent Social Services referral. My perceptual phantasy was live before we had even physically met. Yet beyond pathology such ‘projective identification establishes intersubjectivity’ (Maroda, 1994, p.100), and intersubjectivity opens the door to enter the clients’ (and I would argue diagnosticians’), shadow-world.

Some staff suggested that Morag, the youngest of three siblings, had a Borderline Personality Disorder (BPD; APA, 2013). BPD is characterised by dramatic shifts between neurosis and psychosis, particularly manifesting as a difficultly maintaining relationships and an unstable sense of identity (self). Morag’s symptoms included emotional instability, anger, envy, feelings of abandonment and emptiness. On the Diagnostic and Statistical Manual of Disorders (DSM-5; APA, 2013) severity scale Morag experienced multiple mental health problems including anxiety, depression, self-harming, bulimia and substance misuse. I formulated that alcoholism filled Morag’s emptiness of her-Self (Balint, 1963), burying her symptoms underground until angrily vomited into the world.

Paralleling patients, many practitioners fear the draining expulsions of BPD work, yet the only way to get clinical experience is to do the work. The trend of mentalisation, the capacity to use and reflectively operationalise symbolised emotional experiences (Fonagy et al., 2004), has proved increasingly relevant (National Institute for Health and Clinical Excellence, 2009). While Brown considers the colluding analytic couple ‘keep the fears in each partner unmentaliséd’ (emphasis added; 2010, p.676), the symptoms are the symbolic primitive pre-verbal mode of communication and represent a different language to decipher.

Regarding the composite of the three clients, rather than evidence of psychosis this work conceives projective identification as an infantile pre-verbal mode of communica-
tions. Infants cry; it is the role of the parent-practitioner to engender the infants capacity to emotionally self-regulate (self-soothe) in the face of good or bad objects. By differentiating the client’s hidden symbolic meanings we can work though early trauma engendered by the deep narcissistic wounds of separation. Applying Klein’s theory of projective projection while working within a contained intersubjective relationship supports the developmental shift from the paranoid-schizoid position to the depressive position (Bion, 1962, cited in Mills, 2000). Yet whatever theoretical beliefs we hold about therapy, ‘the real value of the theory lies in its relations to practice’ (Dorey, 1988, cited in Sandler, 1988, p.89).

**Legend**

C1 = Client (Morag)
C2 = Client (John)
C3 = Client (Mary)
P = Practitioner
(C1 and C2 are from the Humanistic center and C3 a psychoanalytic service)

In the initial therapeutic exchange I felt a deep anger and knew it wasn’t mine, which in the process was offered as:

C1: What are you thinking about? (Unsure of the others subjective world and perhaps checking the safe container)

P: (Using the counter-transference process I authentically replied): I’m wondering when you’ll complain about me – how does it feel to hear someone say that? (moving to the intersubjective)

C2: … my dad’s always having a go at me, you kinda look like him…

P: Something about me reminds you of him (inviting the projection)

C2: (Exaggerated sigh) Ex, nufink, well I’m wanderin’ when you’ll dump me…

At the heart of the paranoid-schizoid position is the infant’s fear of annihilation (here symbolised by abandonment). Intersubjectivity shifts the analysis from a theoretical intrapsychic process to an experiential intersubjective process. This could develop Morag’s (C1) primordial set of emotions such as hate and anger, and in-turn increase her co-operation and development of a capacity for empathy plus adaptation to social rules. John (C2) shows how the experience of otherness can be regarded as a persecutory mechanism, a splitting of the internal world into component of me and not me. This represents an objective identificatory mode of relating without the counter balance of subjective identificatory relatedness. His contradiction of extremes eschews the array of subtleties that sit between the extremes of both unconscious and conscious levels.

**Projective identification:**

**An intrapsychic or intersubjective process?**

Klein (1946) conceived projective identification as an intrapsychic process, whereby the infant phantasises ridding itself of unwanted feelings by projecting them into the (m)other (disavowal of affect). Implicitly involving another person develops Klein’s concept into an intersubjective process, which can guide the analysis. This shifts the concept from a negative one based on the infants desire to destroy into a fundamental therapeutic phenomenon, an intersubjective dance. The dance artfully communicates the ‘inescapable interplay of the two subjects in any psychoanalysis’ (Orange, Atwood & Stolorow, 1997, p.64).

Although psychoanalysis has traditionally been authoritarian, something done to someone with the analyst as the blank screen upon which to receive projections, experiencing projective identification as a communication preempts how “[n]eutrality could defend against affect” (Kuchemann, 2006).

Beyond Freud and Klein, Maroda (1994) adapted psychoanalytic techniques to embrace a reciprocal relationship whereby the projective identification is the therapy; the therapist’s emotional responses become an integral part of the process. Thus a patient reliving their past is afforded the opportunity for a new experience, and, therefore, memory (Diamond & Marrone, 2003; Hood, 2012). With re-enactment as the
goal of analysis all agree the patient must do something different, and I consider this can be equally true for practitioners. Prior to the session I had noted and logged my feelings, mood and preoccupation with a ‘niggling’ feeling that had really got under my skin.

We sat quietly as John regressed, and I felt a pain and frustration which did not belong to me. Supporting a spontaneous ‘benign regression’ John developed at his own pace. Awareness of the proactive concordant counter-transference of our sad infants was a useful process insight, helping John to express his infants rage:

P: I’m feeling a very young pain, does that mean anything to you?

C2: (Cathartic expression, kicking and hitting chair) Aaahhhhh...

Subsequently, John related being ‘dumped’ (abandoned as a child), conjuring-up a lost child’s imago (unconscious idealised parent). Shifting from seeing me as the idealised parent he began to speak into me as though to his ‘always angry’ father (projective identification of feelings into another). Like Morag, the ‘good breast’ of emotional nourishment seemed dry, and support from both their parental figures barren.

Parallelly John’s lost child, the projection moving into me also left me lost. I consider that while not wrong, the following intervention could have better utilised the projective identification. My personal development is to grasp how a fully-competent practitioner (via personal analysis and experience), can receive the patient’s communications and feed them back in a form s/he can tolerate (Bion, 1967, cited in Casement, 1985). I (unconsciously and perhaps defensively) avoided utilising the projective identification to delve into Morag or John’s ‘subterranean world’ (Maroda, 1994, p.100). Working with Mary, the third person (C3) in a psychoanalytic environment I utilised a psychodynamic approach. This employed the Gestalt ‘chair’ experiential exercise (speaking to the absent object):

C3: This feels really silly...
P: I’d like you to know that I can hold your anger. What would you like to say to your father?

As a primitive defense, the concept of projective identification is underpinned by the drives of phantasy and anxiety related to the paranoid-schizoid position. As the prototype of the aggressive object relationship, Hinselwood (1989) states projective identification represents ‘an anal attack on an object by means of forcing parts of the ego into it in order to... control it’ (cited in Forrester, 2006, p.788). Paradoxically, the process of expelling an intolerable ‘bad state’ is the basis of conflict, and conflict is essential to the stability of ego states (thereby balancing the competing id, ego and superego influences). Curiously, my saying I could hold the anger when it was an unknown was perhaps my own way of managing my internal conflict or even exercising power.

Within each session the interpersonal paralleled the client’s intra-relational roller-coaster effect. Thus the relationships and the session were filled with love and perfection, or perceived as useless and destructive. This is how Morag in particular had previously become violent to others such as social workers, and herself (self-harming). On one level this keeps the projectors state of mind pure, thereby engendering a pattern of communication that rapidly shifts to anger when faced with dilemmas or ambiguity.

Quietly simmering, Morag erupted:

C1: Why, WHY? You’ve never been there for me, you just look at me like I’m a piece SHIT, what’ve I ever done. I didn’t ask to be born

Klein’s theories have social and philosophical implications (Alford, 1982), including power relations and its corollary ‘justice’, representing Hegel’s dialectic of the master–slave (MacDonald, 2011). However practitioners approach it, therapy is an inequitable process, and I had to consider my role/s (as practitioner, theorist, social advocate, etc.):
GI: It’s so unfair, everyone’s telling me what I must do ‘n I’m NOT GONNA! Who the f**k are they to take my baby away, and you, I bet you’ve gonna tell ‘em stuff ‘bout me.

Self-aware of shame I was unsure if I was carrying Morag’s unnamed feelings. She was projecting (in phantasy) the unwanted parts (feelings of anger and annihilation), to ward them off and omnipotently control them (and me). This indicated an early narcissistic defense mechanism, consistent with her history and symptomology. My own feelings of infantile rage towards trans-generational abandonment were taken to personal therapy. My projective counter-identification later surfaced in supervision.

Supervision

At times overwhelmed and wandering lost in the underworld, I turned to the third person who completed the Oedipal triangle: the envied ‘father’ who ruled and the idealised ‘mother’ who nurtured; my supervisor. My supervisor was not raised on Kleinian breast milk and I initially spat out her words. Yet reflecting the clients were also doing the same with my interpretations, I began to chew on the supervisor’s words until they were soft enough to swallow and offer back to each client. While working through the process of the abandoned child abandoning her own child, a thread of supervision weaved into the maternal aspect of the therapeutic relationship.

In mid-stream I caught my own emotion of shame and intersubjectively and shared it in the service of the client, perhaps permission giving:

P: I’m wondering how you feel knowing what it is like to be abandoned and abandoning Morag (I wondered what she would do with the ambiguity)?

GI: (Sobs) Feel like I wanna drink to kill the pain.

I just live to see him but it’s so hard, people judge me ‘cause I’ve not been visiting him enough, don’t want no f’n Social Worker watching me play with my child (weeping), can’t bear to hand him back to strangers, just wanna go get Slaughtered. I feel so ashamed.

Sometimes wishful thinking becomes reality (the transpersonal; Jung, 1995). Attending a custody hearing, the Judge commented on Morag’s progress and opened the door to regaining custody. This archetypal wise man extended the work beyond the therapeutic setting; he was another ‘good’ object. Morag reported being ‘proud’ of herself. While aware of my own core process, Kohut’s (1971) twain-ship (one’s need to join with another; cited in Segal, 1996), I aimed to support the shift in Morag’s agency, self-empathy and identity. In hindsight, I feel Morag understood my authentic and affectionate empathy:

P: If you were my daughter I would be proud of you.

Reflecting back words offers symbols that represent subjective experience (Gendlin, 2012), while pre-Oedipal development requires what neuroscientists refer to as affect regulation (Phillips, Drevets & Rausch, 2003). Neuroscience evidences that this comes on-line years before the Oedipal complex (Shore, 2012). Affect regulation increases tolerance of ambiguity of the split world, and underpins the capacity for empathy. Neuroscience also supports the basic assumption that ‘the analyst’s unconscious understands that of his patient’ (Heimann, 1950, p.83), and that the practitioner’s emotional response is the key to unlock the patient’s unconscious. In essence, our right brain unconsciously communicates with other right brains (Shore, 2012). As such, the patient says something and the practitioner feels the emotional pull underneath the communication.

In my own potential phantasy I wondered if getting ‘slaughtered’ (annihilation), re-enacting abandonment, separation anxiety (see Bowlby, 1998), having an internal saboteur (Fairbairn, 1999), or inducing conflict to expel an intolerable ‘bad state’ could develop the capacity to self-care. In the addiction service staff tied to the philosophy of ‘living fully present-in-each-moment’ seemingly blamed clients for being ‘impetuous’ when they relapsed. In the
analytic setting I noticed how counter-intuitive to traditional psychoanalysis, the junior sibling may be born to rebel, with authoritative parent-offspring conflict producing ‘sibling conflicts over parental resources’ (emphasis original, Sulloway, 1996, p.353). It is curious that paradoxically, Morag’s conflict engendered her shift towards the depressive position.

Bringing the clients together, the mind of each is characterised by sharp and unpredictable shifts of mood and perceptions. The examples show how the contrast is often between a view of the self and those around that is optimistic and confident, and one dominated by anger and unhappiness. Thus, both the individual and his/her relationships are characterised by rapid shifts between contradictory states, and the lack of an individual or interpersonal multi-representational system. The process is that when in one state of mind the clients appear to have no access to other states. This is bidirectional, so that when feeling pessimistic and angry, good experiences are forgotten and angrily denied, and there appears to be little scope to consider some modification of that way of seeing things.

The lack of access to unconscious states also means the concept of projective identification is easily misused. At its most insidious patients are labeled disordered for ‘the emotions they stir up in us’ (Maroda, 1994, p.29). From their underground lair the Morock’s are communicating and it is not a blank screen intellectual understanding that functions to serve the patient, but the practitioner’s personal analysis and experiences. In my past therapy, my projection into a counsellor of his perceived incompetent self punctured his psychic membrane, and became mixed-up with his own feelings of professional incompetence (Pick, 1985). I was the Morrock who devoured an Eloi, and still have a bone stuck in my craw. Hence selection of the essay title to work through my own damaged object relations (Casson, 1985). This is the essence of the wounded healer, for we cannot guide patients on a journey we haven’t returned from ourselves (Sedgwick, 1994).

In conclusion, rather than conceptualising projective identification as psychotic or the malign defense of a Morrock, pre-verbal communications inherently evoke an affective response in others. These intersubjective emotional tugs are the key to effective analysis, thereby helping the client to move from the paranoid-schizoid position to the depressive position. While the Eloi’s staple food is also a regularly attending Morlock and Morlock’s love to devour an attendant Eloi, both are essentially part of the analytic relationship. They are co-operating parts of the whole, and so develop together by working thorough the symbiotic dance that is projective identification.

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About the Author
This paper was runner-up in the Division’s 2013 essay writing competition. My research interest’s centre on unintentional harm caused by practitioners who mean well (iatrogenesis), and how to increase therapeutic outcomes. Interests include whether training, practice and our professional bodies speak to the needs of clients, or may sometime become self-serving. Another interest is the impact of social forces upon clients and practitioners, and how to become more socially proactive. Each aspect is underpinned by an interest in philosophy, and whether what we believe we are doing accords with our often unstated personal philosophy.

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References


To DSM or not to DSM, that was the question
Philip K. Cox

The central theme of the History and Philosophy of Psychology Conference 2013 at the University of Surrey was the forthcoming DSM-5. I left this highly engaging conference wondering at the multi-dimensional levels of ambiguity and confusion that I was, and am, still feeling. By setting out my stall at the beginning I aim to offer clarity regarding my confused position. I am not a major fan of the DSM although it has served me well as a good doorstep. When the Chair of the DSM-IV (1994) Taskforce warns that the guardians of psychiatric care are about to ‘expand the boundaries of mental illness’ (not health), which could ensnare millions more, it pays to listen carefully (Francis, 2010).

Although apparently disparate, many presenters seemed to be collectively highlighting the existence of dsm5response.com, a petition to prevent DSM-5 from compromising patient safety and scientific integrity. Yet in an academic context I felt caution at a potential contagion (which by naming the site I am now spreading). One level of confusion was therefore the knocking down of a structure without anything to put in its place. Philosophically we might consider a void a suitable non-replacement, yet nature abhors a vacuum. One attendee (a trainee counselling psychologist) ventured a qualitatively-based system of personal experience, perhaps more dimensionally-based. Yet David Harper, co-presenting Psychopathology, disease, disorder and difference, confirmed that at least in principle this could merely exchange one construct for another.

As a counselling psychologist in training my course is less than enamored with categorising the experiences of others, and our Division’s philosophy negotiates between perceptions and world views without assuming the automatic superiority of any one way of experiencing, feeling, valuing or knowing (DCP, 2009). Yet my training mandates a psychoanalytic placement where typically we are taught the taxonomy of DSM. We learn to communicate in DSM-speak, so I now tell my friend she has histrionic personality disorder while she labels me as an obsessive-compulsive because I keep telling the same ‘joke’. Yet this isn’t funny, for the conference highlighted the flaws of diagnostic manuals yet offered no solutions. This leads me to a further level of confusion and ambiguity, for if ‘the means are the ends’ (Ghandi, 1947), what am I doing and where is my critical thinking?

At the deeper level of my personal philosophy I now feel even more confused (I hear some conferences can do that to you, no fixed answers in tidy boxes). Such ambiguities pervaded throughout the conference, perhaps with something of a personal resolution in a dream (or nightmare). Your perspective of my resolution may depend upon whether the DSM is your doorstep or clinical bible. Perhaps it is time to change the question from whether to DSM or not to DSM, and engage with a concept that for the time being my philosophically-based training has yet to plausibly replace. In summary, I’m wondering what kind of reality do we want to perceive in our lives or practices. And this brings me to how and why I valued the challenges raised at this conference, because bottom line, I just don’t know (yet).
Conflicts of interest
I confirm no conflict of interest with the APA or Big Pharma, and a conflict when I woke up just before the end of my dream, and so will have to return next year. As a student this was a wonderful and friendly conference where I felt free to ask questions and enjoy learning about the history and philosophy of psychology behind what DSM represents. I will never trip over my copy of DSM in quite the same way again.

References
'I've never been in the army, but you've got to stick together': Applying interpretative phenomenological analysis to unfold 'Being' in a mandatory personal and professional development group

Philip Cox & D. Brown

Personal and professional development groups are a mandatory part of doctoral counselling psychology training, yet seemingly run counter to its philosophy. The paradox of whether development can be mandated or may occur in spite of such groups is qualitatively explored.

COUNSELLING PSYCHOLOGY is characterised by 'a dual alliance between the scientist-practitioner and the reflexive-practitioner', requiring an empirical basis for practice and using the reflexive self (Rizg, 2010). Personal and professional development (PPD) groups offer a path to bridge these paradigms by offering an opportunity to develop a high level of self-awareness and competence, regarding personal and interpersonal dynamics. As such, PPD groups are an integral and mandated part of counselling psychology doctoral training (British Psychological Society, 2009, 2010; Health Professions Council, 2009).

Yet the literature regarding whether such groups facilitate personal change remains unclear (Avis, 2011). Doubt exists regarding whether personal development can be mandated (Simms, 2008; Lennie, 2008), and whether a greater degree of reflexivity (learnt in the style of one setting) automatically generalises to increased professional competency (Grimer & Tribe, 2001; Kumari, 2011). Reviewing the literature, Galbraith and Hart (2007) suggested further research of PPD groups within counselling psychology training.

This paper proposes that the personal and professional cannot be individually abstracted as though a Cartesian duality for they are dynamic intertwined parts of a reflexive whole. Philosophically, the paradox that counselling psychology engages with practices that appear antithetical to the ethos of the field merits exploration. In light of such apparent contradictions this paper aims to address the underexplored and underreported process of PPD from the subjective experience of co-collaborators. If the objectives of PPD and this paper both serve their function well, each will develop as an interconnected parallel process as the research is 'unfolded' (Ricoeur, 1974, in Colm, 1997, p.41).

Interpretative phenomenological analysis's (IPA) iterative method traditionally speaks to emergent themes and subthemes. IPA's methodology is inductive ('bottom-up'), it is description grounded in the data and constantly checked via returning to the transcripts. Major themes develop from the systematic application of the concepts of being-in-the-world, horizontalisation (rather than a hierarchy of themes) and awareness of epoché (bracketing personal meanings).
(See Smith, Flowers & Larkin, 2009, for IPA’s epistemology and Brocki & Wearden, 2006, for a robust critique.) Yet it is questionable whether these concepts as currently applied provide a good fit with the philosophical underpinnings of the method. Arguably, it is more appropriate to think of themes in terms of multiple strands reminiscent of a rope (Parfit, 2011). Smith suggests ‘categories may subsume common themes and patterns in several codes’ (2008, p.98). However, ‘Themes [or by extension subthemes] are not mutually exclusive but show the diversity of research’ (Silverman, 2010, p.14). Rather than a coded hierarchy I therefore apply the term ‘strands’ as each is of equal value, just as one cannot subsume anyone part of PPD to any other.

Method

Research design

Four researchers each conducted a semi-structured 30 minute interview which aimed to capture the richness and complexity of experiences during PPD. Credibility is established by transparency and a good fit between the fully transcribed transcripts as related to the extracts and the researchers interpretations.

Co-collaborators

The purposive sample was recruited from a cohort of 13 third-year trainees, and comprised three females and one male, age range 31–49 years. Culturally, all were pan-European. Two were non-native English speakers.

Researchers

The three researchers (two female, two native English speakers and one South East Asian) were first year trainees newly conscripted into PPD. The spark for this research occurred during a small group discussion with trainee clinical psychologists regarding the regimented similarities and differences of our PPD experiences.

Procedure

Following the request, the first four e-mails confirming interest were sequentially assigned to the researcher with first alphabetical surname initial, and so forth. A research diary was kept.

Ethics

The British Psychological Society (2009, 2010) research ethics guidelines were followed, particularly regarding anonymity and withdrawal not impacting upon training. A fourth researcher withdrew their transcript for an unknown reason.

Analysis

The text was coded in four stages:

1. multiple script readings and audio replays with bracketed comments recorded (left margin), based on extant psychological literature;
2. broad meaning-making of emergent themes by transforming initial notes into theoretically significant and flexible data (right margin);
3. chronological listing of themes identifying common links and master themes; and
4. a table of coherent named themes (combining the transcripts) linked to the original text by reference to quotes.

Reflection

Although IPA provided a useful concept to appreciate and analyse parts within the whole, our filtered epistemologically blurred lenses rendered epoché ultimately implausible. If bracketing personal meaning-making becomes potentially meaningless, perhaps greater clarity is instead afforded if writers state their own personal philosophy. Readers might then see the interpretative process at work.

Results and discussion

The four emergent master themes

Four interrelated aspects of each co-collaborator’s meaning-making within a PPD group are presented. The first themed analysis shows how the co-collaborators made sense of being in an environment specifically introduced to them as neither personal nor professional development; the second explored managing emotional ruptures, evoking the strongest experiential theme, and was reported as the most beneficial (although often distressing); in the third theme the intersubjective self appeared as part of the whole; and finally, the group process was explored.
Table 1: Themes

<table>
<thead>
<tr>
<th>Theme 1: The personal and professional aspects of development</th>
<th>Theme 2: Managing relational ruptures</th>
<th>Theme 3: The individual as a member of a group</th>
<th>Theme 4: The group process</th>
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<td>Strands:</td>
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<td>■ Problematic learnings engendering self-development</td>
<td>■ Coping with anger</td>
<td>■ Temporal referents</td>
<td>■ Facilitators and ambiguity</td>
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<td>■ Transferring learning into placement</td>
<td>■ Challenging difficult behaviours (self and others)</td>
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<td>■ Surviving and turning points</td>
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The themes are discussed using ‘three core levels of interpretation consonant with IPA’ (Smith, 2004, p.44): description, metaphor and the tension of temporal (verb tense) changes. A fourth, making sense of competing theories, was also explored.

Theme 1: The personal and professional aspects of development

The first order of analysis is the descriptive, which highlights the circularity of PPD. Extracts are offered to shine light onto the co-collaborators’ view of in-group learnings leading to self-development, how this was achieved on a dimension of in-the-moment to retrospective learnings, and taking the personal development into a professional context. It is crucial to capture that reality is a complex phenomenon which cannot be reduced to Cartesian dualisms of personal-professional or individual-group (Domasio, 2006).

Problematic learnings engendering self-development

Counselling psychology teaches powerful tools that are not neutral in their application. To offer insights beyond a person’s ability to cope risks ‘tipping’ them over an emotional edge. Understanding this is vital to using the self in practice:

We know how... how somebody is in the group, how to challenge them about what’s going on in their work... learning how the other is going to respond... and I think you do take those skills out; it certainly made me think about group dynamics... and how I respond... (Sophia, p.143-156)

It was a pretty new experience for me, I have quite different anxieties about... um... talking to a group... than I had talking to... aah... one person, basically, so it was an opportunity to try and experiment. (Alexander, p.139-140)

Transferring learning into placements

Underpinned by a doctoral training course, PPD implicitly affords the opportunity to embody and transfer the ethos of counselling psychology into placements:

...so much of our behaviour is influenced by those around us and how groups work; how the dynamics of one persona can really affect a whole lot of people and... concepts like scapegoating... not seeing it happen until it’s brought to your attention within the group, it’s very powerful. (Sophia, p.265-273)

Anastasia highlighted embodied learning regarding her communication style. She also supported the unspoken circularity of PPD, since the only way to bring out her individual self was in the group context. Simultaneously, she developed her self-being-in-the-world when in-the-world-with-others:

What’s my communication skills? It was only through actually bringing myself out there... I could observe my reaction... then seeing other people’s reaction to my reaction. (Anastasia, p.113-126)
Theme 2: Managing relational ruptures
Across the transcripts, anger and managing relational ruptures emerged as interconnected strands of the PPD experience. How the co-collaborators reported coping with anger, challenging difficult behaviours and learning how to manage with others became turning points in their experience. Metaphors afford a second level of analysis, shining light on the similarities between the differences. An ‘interactive view’ of metaphors is applied to ‘convey a metaphorical vehicle that produces an emergent meaning for an entire sentence’ (Gregory, 1987, p.478). Four forms of applied metaphor were explored: embodiment, the spatial use of an embodied animal (elephant) to symbolise the unspoken, movement, and togetherness.

Coping with anger
The co-collaborators revealed how different metaphors work to reinforce similar meanings. Each managed in their own unique way, so highlighting the similarities within the differences. Extending the metaphor, Sophia appeared able to ‘grin and bear’ anger while Alexander ‘rode’ the anger process wave:

At times it was very confrontational and quite explosive... all of us really did have to just grit your teeth. (Sophia, p.115–117)

It was a difficult ride sometimes. (Alexander, p.319–320)

Challenging difficult behaviours (self and others)
In terms of the reflexive practitioner (self) and working with others, how to challenge peers and survive was integral to the perceived benefit of PPD. Until others were challenged reflexive learning appeared limited. In the first extract the elephant in the room spatially symbolised the unspoken; the hidden aspect of working intersubjectively. Between the extracts a shift of register occurs, as though a bridge from social niceties to the rawness of group work:

There was a long period in the group where it wasn’t spoken about, like the elephant in the room... we spoke... all the way around it and we were all very nice to each other... then after that period it actually got spoken about, there was a sigh of relief in the group. (Sophia, p.276–281)

Surviving and turning points
Two trainees symbolically spoke of turning points, while Anastasia stayed with the intensity of PPD and learnt reflexively:

I was screaming at this person... it came out of nowhere... really quite shocking... erm, I was furious... and that felt like a real turning point because it caused a lot of controversy in the group, but erm, I found that personally a huge learning experience. (Sophia, p.224–232)

We see the interrelation of the four themes as Anastasia ‘steps back’, disembodied from the process, choosing to engage with her internal supervisor (Cassent, 1997) yet reflexively staying with the emotion:

Sometimes the arguments were quite, you know... heated... And my reaction to that... how much can I take?... What’s my relationship with anger?... That’s where my learning came from. (Anastasia, 107–112)

Attuned with the intentionality of those who created the UK’s first counselling psychology doctorate and how training inevitably raises complex personal issues, Alexander offered up a ‘gem’ (Smith, 2011). His powerful and evocative, even provocative symbolisation paralleled the tension of the developmental process:

I’ve never been in the army, but when you’re all kind of put together in the same place and you’ve got to survive together... (Alexander, 298–310) ...you have to find ways of supporting each other... how do you call it? Cam... camaraderie. (Alexander, p.373–375)

Theme 3: Temporal referents
Temporal referents afford an increasingly fine grained analysis as: ‘human potential
and development... [connects] the past with the present and future" (Eatough & Smith, 2006, p.118).

Sophia initially referred to her past ‘I’ then ‘we’, indicating a time when she was wondering about the point of PPD. Then, continuing with ‘I think’, Sophia reversed the shift back to the past:

\[ I \text{ think that came up, after PPD groups: What we are supposed to be doing? What is this? And again that’s something in retrospect that I’ve made sense of and... thinking of how two PPD groups run by different facilitators as well, the group in the first year was different to the group in the second year, was different with... with a psychodynamic facilitator... it had a different feel to it. (Sophia, p.93–101) \]

The shifts can potentially be explained by the temporal code key: ‘I’ve made sense of’ [PPD]’. Sophia struggled with multiple levels of tension, such as: her self versus other (symbolised by ‘I’ vs. ‘we’); her thinking (cognition) vs. feeling (affect); and the first year humanistic approach vs. the second year psychodynamic model. In Sophia’s lived-world these tensions signify a psychological battle as her identity shifts. This is directly represented by the temporal changes in the passage itself. We are privileged to witness Sophia creating her new self-identity.

Anastasia presented the ambiguity of meaning-making within linguistically symbolised time, adding sensory synaesthesia. A microanalysis revealed how such linguistic rule-based errors are missed in conversation, yet appear in the physical world of the transcript:

\[ Yeah, it was useful to kinda think about, go back a bit and see how it feels now. (Anastasia, p.274–275) \]

**Theme 4: The group process**

Smith (2004) considered a rarer level of phenomenological analysis: theory. This concept merits exploration as PPD theoretically and simultaneously operates at multiple levels.

**Facilitators and ambiguity**

A series of ambiguities appear between the personal and professional aspects, whether to embody, or not, the facilitators:

\[ The first year’s facilitator was more from a humanistically employment... um, intervened quite often... Mediated between people... in the second year it was psychodynamic... would say something about the whole group that would not ever get in between people if there was an argument... (Alexander, p.90–102) \]

**Splits (then and now)**

The response to a ‘clash between two little in-groups’ (Alexander, p.344–345) emerged from the psychodynamic model taught in the second year:

\[ Like the elephant in the room, the group, it was very quiet and we spoke around issues all the way around it... then it was unpacked and that was really... what had been happening in the group. (Sophia, p.276–283) \]

The potential of applying one contextualised PPD group as a global template for professional placements raises concerns. Philosophically, pragmatically and academically one may question ‘epistemological domain conflation’ (Clarkson, 2003, p.168), a category error of attempting to fit complex co-existing realities of experience into a simple monistic truth (i.e. that there is one PPD approach). Yet I offer no plausible alternative.

**Alternative forums for PPD**

A pertinent interview question asked if PPD provided the best context for the development of trainee counselling psychologists. Given that mandating PPD seemingly runs counter to the ethos of the field, the responses were surprising:

\[ ...there is something about being in that formal setting where you are forced to address the dynamics... it’s an important learning... and you don’t get it by being in a teaching group and moving from class to class. (Sophia, p.304–306) \]

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Clinical Psychology Forum 253 – January 2014
The trainees were emphatic regarding the value of PPD, adding:

*It would be lovely to be available in the third year (Alexander, 395–396). I kind of miss seeing this through to the end and everyone graduating together and ending together.*

(Alexander, p.427-428)

In closing, the trainees passed out of their basic training with flying colours. All survived the process and elegantly spoke their truth.

**Conclusion**

The four themes support a ‘move away from a theory of reflexivity into the pedagogy of a living experience allied to science’ (Schön, 1983, in Martin 2010, p.553 – emphasis original). Concluding with the collaborator voices, if life (or PPD) is an experiential process, the experience itself cannot be mandated: ‘you don’t get it by being in a teaching group and moving from class to class’. Yet as the mandated process unfolded it was revealed as meeting its aims, and was emphatically recommended by all the trainees.

**Acknowledgements**

With gratitude to Dr Joanna Semiyen for helpful comments on the draft manuscript and Dr Owen for the blessing and curse of introducing me to personal development. Thanks also to my Surrey University trainee clinical and counselling psychology peers for great discussions.

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Reflections on Joining the SURJ Team

Philip K. Cox

When I applied to the *Surrey University Research Journal (SURJ)* to become part of the editorial team, I had not expected to find myself writing about my experiences. Here, my aim is to reflect on joining the team, and to pass on what I have gained. This is far more than I could have anticipated, and so could benefit other students. For some background, my lecturers had expressed concerns about my writing style. They suggested I visit the Research Development Programme based in Surrey Library, to seek educational support. The support I needed was both personal and professional. Professionally, I needed guidance regarding how to structure my work. Personally, I needed the confidence to write to an academic standard.

The application process to join *SURJ* began with an email seeking editors, copy layout assistants and proof-readers. I thought I could manage the layout or proofreading roles, and quietly learn about academic writing from within the Journal team. The recruitment process involved writing a 500-word piece about a title provided by selection team, and then an exercise around editing and proof-reading. There was also a brief informal discussion. To my surprise and absolute delight, I was offered the opportunity to join the *SURJ* editorial team. The welcome workshop was both informal and informative. Here, we formed a mixed group of postgraduate researchers from diverse backgrounds. By the time the workshop finished I had already grown in confidence and ability.

It was exciting to receive the first paper to copy-edit, which brings us to the heart of my reflections. By editing the work of others, I have become more attuned to editing my own work. Through the process of applying the workshop training and ongoing support, I now see
the strengths and weaknesses of my own work. This feeds back into editing process and
creates a virtuous cycle; the more I give the more I get back. There is a proven reality to this
philosophy. Since joining the team my lecturers' feedback has improved to a level where it is
now a pleasure rather than a stressful chore to submit work. The Journal experience has also
shaped my awareness of the readers' needs in that I am learning how to convey my ideas with
greater clarity, and to specific audiences.

Engagement with my reflections on joining the SURJ team has also shaped awareness
of my own needs. It had not occurred to me that being part of SURJ offers a pathway to other
experiences, and the path is leading to an action plan. The outline of the plan is simple;
within our team of postgraduate researchers and editorial staff I noticed how each of us writes
in a different way. Some of us write using a scientific objective method, some in a more
socio-humanistic subjective approach, and for some their style is somewhere between. From
that observation, beyond the team I noticed how the writers I admire write across academic
disciplines and for non-academic audiences. Some write short stories or poems, and I feel
they express more of themselves in their personal labour of love. So, my straightforward plan
is this; I have enrolled on a creative writing course.

From the reflection about creativity, this plan also suggests some steps to move
towards broadening my self-learning. To put my plan into action I became a reviewer for a
key Journal in my chosen discipline. Additionally, I have two publications forthcoming.
Beyond writing, the conference presentations of my research are now more succinct and
skilfully delivered. My point is not to self-congratulate; it is to say that the benefits of
working with SURJ during my time at Surrey have impacted to expand my academic
development. These steps also supported the type of creative course I chose, which is to say
how I used them as a springboard to direct my choices.
As I look forward to graduation and will have more space to put into practice my plan for a more personalised writing style, the areas of professional and personal growth can be further developed. Professionally, the key Journal in my chosen discipline is seeking assistant editors. Whether we believe in chance, fate or synchronicity, the networking process curiously keeps placing me in the right place at the right times; or perhaps like noticing our writing styles I am leaning to see new opportunities. While this reflective piece was going through the editorial process, and following on from a link made with the co-author of a forthcoming publication, I was invited to present my own research at a conference dedicated to my research topic. I recently designed and delivered it in the form of a workshop. My point is that these developments began with a simple response to SURJ, which gave me confidence to accept offers to collaborate on projects. Being part of SURJ gave me the self-belief.

As I gain more professional confidence the process of personal development also seems to be taking on a life of its own. The experiences with SURJ have shaped how I feel about myself and what I secretly dream of. That is to say, each area where I have grown still leaves room for further development; I am far from the finished product. For instance, I have started writing a short story and while sharing it or collaborating with a child in our family, I was told off for being too ‘dry’. For my 10 year old relative I think that translates as, ‘ummm, yes you’ve been at university for a while now and learnt a nice academic style - what about creativity and fun’? Funny that it takes a child to remind me that it’s ok to develop writing skills and enjoy the experience.

So, what is the take-home message of these reflections on joining the SURJ team? I’m wondering if other students know what is on offer because no one from my training cohort even read the initial email seeking to recruit for SURJ. The experience of being part of an editorial team has opened my eyes to the benefits of giving and receiving knowledge, and it feels good. Professionally, I can now structure my work. Personally, I feel more confident in
writing and am expanding beyond academia. Doors to pleasurable activities post-university are opening. So, as we end, being part of SURJ is definitely worth your consideration. Also, it is lovely telling my Mum what I am doing and seeing her joy at how my life has developed since simply responding to an email from SURJ.

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Review of Ethics and Psychotherapy: The Debate
Philip Cox & Heather Dale

FROM ANTIQUITY, Hippocrates’ (460–399 BC) dictum First, do no harm became the guiding ethical and underpinning of the helping professions. Yet in our contemporary world, where ethical practices may now face new and unforeseen challenges, a space is required to discuss the ethical dilemmas facing professional helpers of today.

The BPS Psychotherapy Section created such a space to explore what sometimes feels like the unspoken dilemmas of psychotherapy practice. The afternoon workshop, Ethics and Psychotherapy: The Debate, was held at the BPS London office in March. Attendees were invited to participate in a discussion centred on the papers published in the Psychotherapy Section Review, Winter 2015 special issue of Ethics in Psychotherapy. Perhaps 30 people attended from an impressive range of professionals working in health, therapeutic, social, educational, forensic and prison settings. Both trainees and seasoned practitioners attended. Independent practitioners were also present, although sadly, there were only two attendees from outside the London area.

The workshop was led by Terry Birchmore, whose initial talk summarised the main themes of the special Winter issue. Terry covered some key ethical issues such as whether ‘do no harm is a moral debate’ and, how some ‘competing facts, norms and capacities may be irreconcilable’. Whether they are irreconcilable, and if so how, was hotly debated. These points brought the day to life and filled the room with energy that comes with active engagement. Terry went on to suggest that one way forward to the day’s moral debate is to discuss and explore topical issues with others. This meta-comment as to why this workshop is so relevant in today’s climate of austerity, managed care and shifting social mores opened up the debate.

The core thread of the day was the presentation and discussion of a credible clinical vignette regarding a grandfather downloading child pornography. The group divided into two, and then came back to share the various consequences of different actions, or inaction (Eds note: in this context ‘inaction’ refers to the process of not acting immediately, perhaps driven by anxiety, in a situation in which what is happening may be unclear. Taking time to think about possibly conflicting ethical dilemmas and the consequences of a number of courses of action may be important in order to act responsibly and professionally. Thinking about the need to gather further information, and how one goes about this, in order to be clearer about the field of action, will be part of this thinking). Rarely have the authors heard the topic of inaction so openly discussed. Perhaps inaction creates more fear or even shame than poor ethical decision making. In this safe professional setting, such dilemmas opened up a wonderfully focused discussion to unpack our thoughts and feelings around ethics in psychotherapy.

For one of the authors, the value of the day was in wondering what would happen if this was a real life situation and whether in that situation, it would be possible to remain as cognitively and emotionally functional as in a hypothetical debate. For the other author, it was learning how few of the participants clearly understood the legal requirements concerning the duty to report actual or suspected child abuse, and that these sometimes seemed to contradict...
professional policies and guidelines. This in itself poses the question of whether as practitioners we have an ethical duty to make ourselves clearly aware of our legal obligations, if only in order to consider whether these are in conflict with our personal or professional ethics. I think all of us were left with something to reflect on here.

Through the vignette we were artfully shown how some kinds of thinking, such as how the sexual abuse of children, may inadvertently lead professional helpers into a narrow way of thinking. At this point the value of the workshop truly emerged. That such a hot and emotive debate around the ethics of working with child abuse was generated from a vignette speaks to the power of its use. As it was, the debate was non-defensive and remained focused on the topic, which was lovely to experience. Curiously, the rich and sometimes evocative or even provocative comments from group members, perhaps depending on one’s professional or personal stance in relation to the emotive topic, ranged as broadly as our personal and professional backgrounds.

One critique of the workshop is that the focus tended towards a debate centred on the vignettes. This left less time for a debate of the Psychotherapy Section’s special issue on Ethics in Psychotherapy, which is what had been advertised. Those who read the special issue had little time to ask questions. However, this was recognised and a further workshop may be planned. Also, it did not detract from what we did achieve.

At most workshops people rush off at the end or even near the end. Here, there was a post-workshop networking space which many if not all took advantage of. Perhaps summing up the feel of this important and vibrant workshop, long after the end many of us were still networking over drinks and snacks. The BPS office staff had to ask us to leave. This suggests a well-deserved thank you to the Psychotherapy Section for thoughtfully providing a safe day supported by a format that emotionally contained us to debate the hot ethical issues. We hope that for many of us the workshop continued as we reflect on the day.

For November 2016, the Psychotherapy Section has organised what may be the first UK or international conference on the topic of iatrogenia (unintended harm caused by treatment). Rarely discussed within psychotherapy this topic is emerging as an important ethical issue across the helping professions. The Psychotherapy Section is positioning itself at the forefront of an under-reported and challenging ethical debate around the role of ethics in the field of psychotherapy.

Philip Cox (University of Surrey)
Heather Dale (University of Huddersfield)
Exploring unintended harm in psychotherapy

Philip Cox

Webinar hosted by Online events

This talk focuses on the ethical and philosophical imperative 'do no harm' in psychotherapy, also known as unintended harm (iatrogenesis). Around 10% (Lambert, 2010) of the public say they feel harmed by attending psychotherapy. This figure significantly rises for marginalised groups. Between 27%–40% (Williams, Lyons, & Coyle, 1999; Macaskill & Macaskill, 1992) of therapists report experiencing their personal therapy as harmful. The trend of complaints to all professional registration bodies is upwards.

The practice of naming and shaming those who get the delicate balance of good work vs making errors wrong is causing distress, which could drive an open and honest debate underground. This means the very ethical frameworks or codes of ethics meant to protect the public or practitioners from needing to complain, could themselves have an unintended and harmful impact.

Philosophically, we are the good and bad therapist too (Shohet, 2017): a practitioner involved in what is perceived as unintended harm, in many ways harms themself. This talk considers the exploration of unintended harm as a sign of good rather than poor practice. Yet, the topic seems rarely discussed in trainings or openly amongst therapists. Here, we will create a safe space to explore what the public, therapists and complaint trends, seem to be telling us. We will also discuss what to do if you receive a
complaint and how the Psychotherapy & Counselling Union (2016), whose motto is 'Standing up for Therapists', could support you.

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Informed consent: recent legal changes, complaints and dilemmas

Recent legal changes intended to clarify issues around informed consent have resolved some issues, yet also created new dilemmas. This article will briefly comment on the upward trend in formal complaints, highlight the legal changes and the dilemmas they create, and then consider the impact of these issues upon practising therapists. Next, I will consider upcoming legal changes to our professional registration bodies, the experiences of the Psychotherapy and Counselling Union, and how the Psychologists Protection Society (PPS) offers potentially unique support to its members.

Formal Complaints

It may surprise therapists to hear that irrespective of a client’s presenting issue, the therapeutic modality applied or therapy’s context within the Western world, around 10% of people attending therapy report experiencing their therapy as harmful. For therapists reporting on their personal therapy, the figure ranges between 27% to 40%. As feeling harmed can be a subtle and therefore difficult to define subjective experience, our perceptions of it can change over time or contexts. Within or between session distress may be part of the therapeutic encounter and so for purposes of this article, harm must be relatively lasting i.e. this definition excludes transient effects ... [such as in-session anxiety or between session sadness, and] must be directly attributable to ... the quality of the therapeutic experience or intervention”.

Therapists’ Complaints

All the key professional registration bodies report an increase in the number of formal complaints. What may surprise therapists is that across the registration bodies,
the largest group of complainants are typically therapists. For example, Raffles\textsuperscript{5} reports that 71\% of complaints made to the \textit{British Association of Counselling and Psychotherapy} (BACP), are made by people associated with counselling. Similarly, while practitioner psychologists are the seventh largest professional group (of 16) on the \textit{Health Care and Professions Council}\textsuperscript{6} (HCPC) register, they are the second largest group complained about. Around half of complaints are made by professionals. The situation is similar for the \textit{United Kingdom Council for Psychotherapy} (UKCP).\textsuperscript{7}

**Legal changes & informed consent**

In the past, the Bolam test, whereby a professional’s actions were deemed acceptable if other professionals would have acted similarly, has now been superseded by case law. Recently, in \textit{Montgomery v Lanarkshire}\textsuperscript{8}, an NHS patient who was also a health professional won her claim that she should have been presented with the uncertainties and \textit{not} just risks of her treatment. The outcome of this case impacts on what is now considered informed consent. The case has also created new dilemmas for our professional practices.

**Dilemmas**

At last year’s PPS CPD event, Dawn Devereux\textsuperscript{9} gave an interesting talk in support of informed consent. Given the upward trend in complaints and new case law, there seems a question of what informed consent actually looks like. For example, when physicians deliver a painless treatment yet say that it may hurt you, patients can “experience distress, which can tax the coping mechanisms of even well-functioning individuals.”\textsuperscript{10} This presents a dilemma; as therapists, should we be warning our clients that therapy could engender harm? Also, when we add the words, ‘to a significant number of people’, could that increase the risk of harm? It’s a bit like going to the dentist and being told ‘this may hurt’, and then it hurts. When it doesn’t hurt, it’s possible that a client might question the dentist’s expertise. This creates a double-bind for the professional. Also, the idea of harm is introduced into a room just by mentioning it. I suggest this is an important dilemma
facing therapists today, and I believe we need to say more about our best to manage exceptions – our own, and that of our clients.

**Naming & shaming**

Foulkes\(^1\) suggests that what can heal can also harm. In a field that is inherent with risks because we are working in relation-with-others, the therapists who get the delicate balance of doing good work vs. poor work wrong, can become enmeshed in a formal complaint procedure. The current lack of clarity regarding how to inform our clients of the uncertainties and *not* just risks of attending therapy, can itself lead to difficulties. Formal complaints are dealt with by our professional registration bodies. However, they apply a quasi-legal approach, and the new case law has created dilemmas around what constitutes informed consent? When having to face a grey area, and a potential professional ‘name and shame’ process, therapists may turn to others for support.

**Psychotherapy and Counselling Union**

The *Psychotherapy and Counselling Union*,\(^1\) whose motto is ‘Standing up for Therapists’, offers support to members who have received a complaint. In my role as the lead for complaints, it feels sad that in a profession committed to openness, honest and transparency, all of our members who have been involved in a complaints process feel damaged but it. This is irrespective of the professional registration body, which suggests it is a regulatory issue rather than relating to any one professional body.

**Professional Standards Authority**

While beyond the scope of this study, it is worth noting that the *Professional Standards Authority (PSA)*\(^1\), which oversees all the regulatory bodies, has drawn up a Bill to put before Parliament that intends to change the landscape of complaint procedures. Titled, *Right-touch Regulation*, the PSA considers “[t]here is a real need for legislative reform ... [because] The confrontational nature of proceedings and the stress that hearings engender can affect the health and wellbeing of all concerned ... [and] runs
counter to our growing understanding of the situations where things go wrong, and the inter-connections”. Curiously, while the legal process in Montgomery v Lanarkshire has created new dilemmas, the PSA aims to apply the law to resolve such dilemmas.

**Is anxiety driving the complaints process?**

The PSA has recognised that there is no resolution for any stakeholder in the current approach. The underlying fears and anxieties remain unaddressed, because the emphasis is on examining the complaint, and not the interaction in the therapeutic space. The potential is for this to engender increasingly vigorous complaints procedures, which in turn may further fuel the fears and anxieties of health professionals. Fearing being ‘named and shamed’ for getting the delicate therapeutic balance wrong, health professionals may increasingly be inclined to practice in a defensive way.

The lack of clarity around informed consent could unintentionally drive the upward trend of complaints. The uncertainty around the way complaints are treated itself risks further difficulties and conflict, and so may engender more complaints. Unfortunately for our profession, a profession that works to heal relationships and reduce distress, the issues remain unsolved. To address the circular process of anxiety-complaints-anxiety, our profession would appear to require external intervention because we have been unable to resolve the problem ourselves. I suggest this sends a poor signal to the public and perhaps other professionals. (For an alternative process to formal complaints procedures, I highly recommend Robin Shohet’s article).

**Personal reflection**

For transparency, it is important to state my personal position and own my personal assumptions about these issues, and where these assumptions come from. I consider that I myself, and “[w]e are the bad therapists too. If there is someone who says he [she or they] has never done bad therapy (whatever that is), then this is someone who is likely to be doing bad therapy (whatever that is)” While I feel it is appropriate to be concerned about
what our profession delivers to the public, I am also concerned at the lack of caring for therapists caught in ethical dilemmas. By extension, the professional bodies may not be fully caring for clients. In my personal position being a client who has received some questionable as well as great therapy, I have come to appreciate that caring for therapists caught in ethical dilemmas also extends care to clients.

As a therapist who believes in the work we do, I am troubled by the implications and dilemmas regarding the issues above. In recent research, therapist’s form many registration bodies reported ethical quandary: not sharing errors is unethical, yet sharing errors can feel very uncomfortable and can be humiliating; particularly when publicly shamed. I feel empathy for those who have years, even decades of good practice, yet whose reputations can be damaged by a single complaint. Other professions manage complaints in far more constructive ways. I suggest we need to assure practitioners that it is alright to disclose their errors. Only by feeling free to disclose our errors are we then free to own up to them and reflect upon them. The airline industry and the House of Commons Public Administration Select Committee (NHS) have produced supportive frameworks to reduce and learn from errors. Both interventions are relevant to therapy practitioners because they introduce a ‘no blame culture and open process’. The intention is to minimise reputational damage to the individual or an organisation, so that mistakes can provide an opportunity to learn.

Psychologists Protection Society

I was honoured to be invited by the PPS to write this article. I believe in the work we collectively do and fully support the aims to PPS, which is run for therapists, by therapists. As the PCU lead on complaints, I believe that when most therapists receive a formal complaint they would like to openly and transparently respond. Most, in such circumstances, also think of how to support the client. Yet the first response letter is often written under pressure and at a time when the recipient is feeling confusion and anxiety.
Early disclosures can harm a therapist’s defence. It is for this reason that I suggest it is vital to seek support before initially responding. Few insurance companies offer this first support; the PPS does.

My parting thought is to say that at this year’s PPS AGM and CPD event, Heather Dale will be giving a talk titled: The hidden virtue: Towards a new understanding of humility in counselling and psychotherapy. The title captured my imagination because this article and therapy in general could benefit from being supported with greater humility. As I view the above issues through my own narrow lens, you may look through a different lens - and I believe that, with humility, we can open a dialogue. It seems that the anxieties within the therapy space are paralleled by the processes outside of the therapy room. I suggest that, with humility, we can work together to support all the stakeholders in our chosen profession.

References


First do no harm:

A thematic analysis of therapists’ perceptions of unintended harm

Abstract

Aim: Underpinned by Merton’s theory of unintended consequences, this study focuses on the ethical imperative ‘do no harm’ in therapy. The topic of unintended harm (iatrogenesis) is rarely discussed in counselling and psychology. Clients are increasingly complaining to the professions regulators that they experienced their therapy as harmful. One response has been the introduction of new codes of ethics. Method: Through semi-structured interviews, 10 counsellors/psychotherapists and 10 counselling psychologists (10 female, 10 male) from various modalities, were asked about their day-to-day experiences of ‘do no harm’ when delivering therapy. The data was analysed through Thematic Analysis. Results: Two themes, ‘Preparation for practice’ and ‘Praxis and ethical issues’, were transcended by the overarching theme of Professionalism. Therapists stated they work in a contradictory field that protects the public, yet may shame therapists who get the delicate balance of making errors vs. not making errors wrong. Concern was voiced regarding the manualisation of therapy, and whether therapists are professionals with therapeutic knowledge from which to draw intuitively, or technicians whose expertise follows adhered to rules and regulations. Transcending all comments was the key tension: ‘Is therapy an art or a science”? Discussion: The potential colonisation of therapy via top-down pressures giving rise to the notion that there is only one way to practise, or be psychologically healthy, was considered a particular risk to the health of therapy. Awareness of unintended harm is considered to signal good and ethically-grounded practice, rather than poor clinical practice. Implications are explored for training, practice and the future.

Keywords: “do no harm,” iatrogenesis, codes of ethics, Thematic Analysis, “latent” & “manifest,” professionals vs. technicians
Psychotherapists and psychologists aim to offer treatments and interventions that reduce negative affect and improve their client’s wellbeing. Yet sessions are not entirely free from harmful effects. The study of and talk about unintended harm (iatrogenesis) happens within medicine (Illich, 1995; Makary & Daniel, 2016), but it has received less attention within psychology and psychotherapy (Lambert, 2013; Parry, Crawford, & Duggan, 2016). Increasing numbers of complaints to registration bodies and recent changes to codes of ethics within key professional bodies would indicate that iatrogenesis is indeed an issue. Yet to date the topic, which is complex and whose full implications require time and effort to clarify, has yet to become embedded as a standard part of psychology training.

For clarity, the terms applied herein are: ‘therapists’ to represent those who self-identify as psychotherapists or counsellors; ‘psychologists’ to represent counselling psychologists; and ‘practitioners’ to represent jointly counsellors, psychotherapists and counselling psychologists. This study is concerned with practices that may occur routinely when psychotherapy is being delivered within an ethics code, and excludes gross misconduct. The rationale is that the former can occur within ethical guidelines, while the latter are considered as malpractice by all mainstream ethical codes. As Bond (2015) notes, an essential aspect of ethics is to safeguard clients from harm that may have occurred from attending therapy. For transparency, this study considers that awareness and management of unintended harm is considered to signal good and ethically-grounded practice, rather than poor clinical practice (Linden, 2013).

**Conceptual definition of Iatrogenesis**

Harm is a particularly difficult concept to define because its meaning can change across contexts, between people and for a person over time. In this study, harm is defined as “a negative effect [that] must be relatively lasting, which excludes from consideration transient effects ... [such as in-session anxiety or between-session sadness, and] must be
directly attributable to, or a function of, the character or quality of the therapeutic experience or intervention” (Strupp, Hadley, & Gomes-Schwartz, 1977, pp. 91-92).

**Theoretical and epistemological grounding**

This study is grounded in a contextualist epistemology. The contextualist position assumes that human actions perform a function, are dynamic, and that human perception of reality is incomplete and can never be fully known. Contextualism emphasises how “the interrelationships between an event and its context ... do not arise out of a social vacuum and cannot remain abstract or irrelevant to the phenomena that gave rise to it” (Jaeger & Rosnow, 1988, p. 66 & p. 71). Therefore, the context is understood not as something separate from the phenomena being studied but as an intrinsic part of it.

As Counselling Psychology seems to have no clear theory of the phenomenon of iatrogenesis, I draw on Merton’s (1936) social psychological theory of the unanticipated consequences of purposive social action. Merton’s (1936) theory explains the problem when unintended consequences arise from actions expected to engender beneficial change. Merton (1936) considers the difficultly involved with the development of his theory is due to, “the diversity of contexts in which social action occurs” (p. 894). This study’s contextualist epistemology narrows this difficulty to a point where unintended harm can be studied when two people enter the social context of the consultation room.

Merton’s (1936) theory groups unintended consequences into three types: an unexpected benefit such as a positive therapeutic outcome; an unexpected ‘drawback’ defined as an unintended consequence; and a perverse result, which is here termed paradoxical, to what was intended. This paper draws particularly upon Merton’s (1936) notion of drawbacks and paradoxical outcomes. Merton (2016) also considers that unless the meanings of unintended consequences are explored, their impact may remain unrecognised and so unconsciously function to mask their underlying meaning. Merton’s (2016) theory states that the latent function of therapeutic beliefs is not common
knowledge, and so may be inaccessible to clients, and therapists themselves. Thus, the process of unintended harm is arguably perpetuated by the very people whose intentionality is towards well-being; the practitioners.

**Literature review**

The mapping of the psychological literature regarding iatrogenesis is in its infancy (O’Hara et al., 2011). Based upon a comprehensive review of the literature, Cox (2012a) reported that irrespective of presenting issue, therapeutic modality, research methodology or context within the Western world, around 10% of the public report experiencing their psychotherapy as harmful (Linden, 2013; Scott & Young, 2016). For practitioners reporting on their personal therapy, the figure ranges between 27% to 40% (Williams, Coyle, & Lyons, 1999; Macaskill & Macaskill, 1992, respectively).

**Complaints**

All the key professional registration bodies report an increase in the number of complaints. The most recent available figures for the British Association of Counselling and Psychotherapy (BACP), reported that 71% of complaints are made by people associated with counselling (Raffles, 2015), and most complaints are made by women (Khele, Symons, & Wheeler, 2008). O’Dowd’s (2017) recent analysis of BACP (2016) data confirms that complaints levels continue to rise. Also, a disproportionate number of complaints (48%) are made against accredited counsellors, who are also typically male (Khele et al., 2008). Following multiple concerns in the public domain regarding harmful practices and failed regulatory procedures, the number of complaints against United Kingdom Council for Psychotherapy (UKCP) members 2014-15, rose by 48% (UKCP, 2015). However, UKCP recently changed its data collection methods, which may account for the significant increase.

The Health and Care Professions Council (HCPC), which registers practitioner psychologists, recorded an increase in complaints from: 2010-11, .35 of the total
membership, which in 2014-15 rose to .66 of the total membership (330,887 members with 2,170 complaints). Some complaints do not relate directly to harmful acts towards a client, for instance administrative issues such as poor record keeping. Complaints against practitioner psychologists are rising at double the rate of new practitioner psychologist registrants (HCPC, 2015a). As only one registered counselling psychologist has been removed from the register (HCPC, 2015b), counselling psychologists may be in a position to make a valuable contribution to this topic.

**Choice of method**

This study sought a ‘big Q’ inductive method (Kidder & Fine, 1987) to apply a ‘bottom up’ analysis. Braun and Clarke (2013) credit Merton (1975) with naming Thematic Analysis (TA) as an identifiable approach with its own method. Braun and Clarke’s (2006) method of TA affords a robust and systematic framework for coding qualitative data, which in turn supports the use of the coding to identify patterns across a dataset in relation to this study’s research question.

**Choice of participants**

Careful consideration was given to which group of participants had the knowledge to adequately answer the research question. Counselling psychologists were selected because they are trained to be reflective scientist-practitioners, skilled “to investigate the human predicament as it unfolds within and outside the consulting room” (BPS, 2015, p. 16). To broaden the participant base, recruitment was extended across disciplines and registration bodies, to include therapists. As practitioners, the participants were assumed to have negotiated the experience of unintended harm during clinical practice, and be psychologically minded to reflect upon client-practitioner interactions (Coltart, 1988). Further, they were assumed to be able to report ethical issues or dilemmas. Therefore, the participants in this study were considered well-positioned to provide retrospective accounts of their perceptions of unintended harm when delivering therapy.
Justification for the research

There appears to be little known about the experience of iatrogenesis within therapy sessions. Less is known about iatrogenesis within therapy sessions from the practitioner’s qualitative perspective (Flor, 2016; O’Hara et al., 2011). Iatrogenesis remains an under-researched and under-reported topic with “lots of conjecture but few good empirical studies” (O’Hara et al., 2011, para. 1). To fill a gap in the literature, the research question explores: What are therapists’ perceptions of unintended harm within their practice? The aim is the increase the awareness and management of unintended harm, with the objective of enhancing ethically-grounded practice.

Methods

Design. This study applied an inductive qualitative discovery design and employed in-depth semi-structured interviews, either face-to-face or using Skype. Interviews were transcribed using Poland’s (1995) guidance to ensure maximum quality and rigour. This format is ideal in qualitative research because it allows participants “to think, speak and be heard” (Reid, Flowers, & Larkin, 2005, p. 22). This also allowed the participants to follow areas of interest to them within the concept of ‘do no harm’. The interviews were analysed using Thematic Analysis (TA: Braun & Clarke, 2006), which afforded a pathway to consider the experiences of two professional groups and different genders (female vs. male). Self-identified genders were applied to avoid unintentionally promoting emic constructs (culture specific) or etic constructs (universal factors that hold across cultures) (Berry, 1969). This is relevant because the semantically reported extracts offer a descriptive insight into each speaker’s world. The subsequent interpretations of latent meanings uncover the obscured patterns within each data item (transcript), and holistically link the insights from individual extracts across the data set.

Participants. This study recruited 20 practitioners to purposively fill four groups;
10 therapists and 10 (counselling) psychologists; 10 female practitioners and 10 male practitioners. These two groups were differentiated by their training and the professional training bodies with whom they can register. Within each group of 10 all self-identified in cisgender terms of 5 females and 5 males. The therapist-psychologist group comprised 2 counsellors with 3 psychotherapists, and 5 psychologists. The participants varied by ethnicity, age, qualifications and years in practice (Table 1).

Table 1

*Participant Groups by Gender, Age, and Training*

<table>
<thead>
<tr>
<th>Participant Group</th>
<th>Mean</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychologists (n=10)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td>44.72</td>
<td>10.83</td>
</tr>
<tr>
<td>Years in practice</td>
<td>10.39</td>
<td>7.26</td>
</tr>
<tr>
<td>Therapists (n=10)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td>54.94</td>
<td>6.27</td>
</tr>
<tr>
<td>Years in practice</td>
<td>13.11</td>
<td>6.97</td>
</tr>
<tr>
<td>Females (n=10)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td>48.95</td>
<td>10.97</td>
</tr>
<tr>
<td>Years in practice</td>
<td>9.50</td>
<td>6.51</td>
</tr>
<tr>
<td>Males (n=10)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td>51.67</td>
<td>9.87</td>
</tr>
<tr>
<td>Years in practice</td>
<td>14.00</td>
<td>7.26</td>
</tr>
</tbody>
</table>

All shared one key factor; practising a mainstream psychological therapy recognised by their professional registration body. Therefore, the sample was considered homogenous. The sample was selected to broaden potential analytical themes beyond one type of training, interpretation of iatrogenesis in modality specific terms such as transference or negative thinking and membership of a particular registration body.

Practitioners with experience of private practice and registered with BABCP, BACP, BPS, HCPC or UKCP were recruited. To evidence competency, professional practice experience for at least 5+ years was required. Participants subject to a past or current formal complaint were excluded.
<table>
<thead>
<tr>
<th>Participant</th>
<th>Gender</th>
<th>Age</th>
<th>Years in practice</th>
<th>Psychologist</th>
<th>Therapist</th>
</tr>
</thead>
<tbody>
<tr>
<td>P1: Pam</td>
<td>F</td>
<td>28</td>
<td>5</td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>P2: Alan</td>
<td>M</td>
<td>54</td>
<td>10</td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>P3: Sean</td>
<td>M</td>
<td>52</td>
<td>18</td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>P4: Pat</td>
<td>F</td>
<td>51</td>
<td>5</td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>P5: Amy</td>
<td>F</td>
<td>51</td>
<td>18</td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>P6: Mary</td>
<td>F</td>
<td>52</td>
<td>5</td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>P7: Alex</td>
<td>M</td>
<td>28</td>
<td>5</td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>P8: Dale</td>
<td>M</td>
<td>53</td>
<td>10</td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>P9: Gale</td>
<td>F</td>
<td>51</td>
<td>5</td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>P10: Rani</td>
<td>F</td>
<td>52</td>
<td>12</td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>P11: Jamal</td>
<td>M</td>
<td>56</td>
<td>20</td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>P12: Jane</td>
<td>F</td>
<td>48</td>
<td>20</td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>P13: Elan</td>
<td>M</td>
<td>72</td>
<td>25</td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>P14: Ayo</td>
<td>M</td>
<td>34</td>
<td>5</td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>P15: Maya</td>
<td>F</td>
<td>57</td>
<td>18</td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>P16: Toren</td>
<td>M</td>
<td>47</td>
<td>8</td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>P17: Maya</td>
<td>F</td>
<td>42</td>
<td>5</td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>P18: Zoe</td>
<td>F</td>
<td>57</td>
<td>5</td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>P19: Luis</td>
<td>M</td>
<td>53</td>
<td>20</td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>P20: Anil</td>
<td>M</td>
<td>58</td>
<td>20</td>
<td>Y</td>
<td></td>
</tr>
</tbody>
</table>

Total Participants: 10
**Procedure.** The recruitment method followed a multi-stage snowball sampling technique to locate participants for this sensitive topic (Silverman, 2013). Information was provided one week prior to interview. A consent form was signed pre-interview and support information given post-interview. The interview schedule was piloted. Recruitment seeding followed, Stage 1: the researcher emailed two practitioners, one a counselling psychologist and the second a psychotherapist, both from within his professional network. They were selected because they had expressed an interest in the research topic and so were invited to participate. Stage 2: each participant was asked to provide the names of two other practitioners from any therapeutic orientation who might be interested in participating. The recruiter asked the recruited person to opt-in through emailing the researcher. Stage 3: the method was applied until the recruitment quota was fulfilled. A research diary was kept, which informed the data analysis and write-up.

**Ethics.** Favourable ethical approval was given by the University of Surrey’s Faculty Ethics Committee. BPS professional conduct and research ethics were followed throughout (BPS, 2014a; BPS, 2014b). The participants all have pseudonyms.

**Reflexivity.** As a reflexive researcher, I acknowledge ‘centring’ myself in the research (Etherington, 2007). In terms of axiology, I acknowledge that I bring our own beliefs, morals, biases and experiences of therapy (as a professional and client), to the research. For transparency, I hold the ontological assumption (Ponterotto, 2005) that *Being-with-others* is a natural state (Heidegger, 1962). This relational stance underpins my worldview. My personal relationship to and motivation for the research developed across years as a client, then as a practitioner and more recently as a researcher. For decades, psychotherapy has conducted research to increase the 80% statistic of clients who report benefits from attending psychotherapy (APA: American Psychological Association, 2012). While much research has been conducted around the common factors of therapy (Lambert, 2013), the statistic has remained broadly static. This study seeks to explore the remaining
20%, because if this can be reduced, the 80% would thereby be increased. The design of this study is a new and creative approach to explore an old question.

I suggest the position we assume in relation to the topic, codes of ethics, complaint procedures and praxis, reflects an attempt to try to heal something in ourselves (Shohet, 2017); in myself. For transparency, I consider that “[w]e are the bad therapists too. If there is someone who says he [she or they] has never done bad therapy (whatever that is), then this is someone who is likely to be doing bad therapy (whatever that is)” (Shohet, 2017, p. 70). While my personal assumptions about the topic now come from the position of transference and counter-transference, to increase its relevance to all stakeholders, this study seeks to explore iatrogenesis without allegiance to any one theoretical perspective.

Data analysis

The data was analysed using Thematic Analysis (TA; Braun & Clarke, 2006) because the method is considered theoretically flexible, and so comes without a set of *a priori* theoretical assumptions (Vossler & Möller, 2015). TA also has a clearly described analytic process (Braun & Clarke, 2006), which has been further developed recently (Clarke, Braun, & Hayfield, 2015).

Results

The interviews were analysed using TA in light of the research question: *What are therapists’ perceptions of unintended harm within their practice?* From this analysis two key themes were identified: ‘Preparation for practice’ and ‘Praxis and ethical issues’. These were transcended by the overarching theme of Professionalism. Finally, transcending each of these themes was the notion of tensions. The resultant tensions will be explored in the discussion. Extracts from the interview transcripts are used to illustrate the themes, which increasingly develop from the broader descriptive ‘manifest’ level, to a deeper and interpretive ‘latent’ level of analysis (Merton, 2016).
Theme 1: Preparation for practice

At the manifest level (Merton, 1972), the participants described the key role of preparation for practice in terms of two subthemes: Training regarding ‘do no harm’ and supervision (training to practice). Curiously, the participants seemed to find this more factual information relatively easy to relate during the early stage of the interview process.

Training re ‘do no harm’. Central to the notion of preparation for practice is the role of training. The participants all talked about the lack of training regarding unintended harm and the specific concept of ‘do no harm’. Although this study explores UK based practitioners many of the participants originate from beyond the shores of the UK. Adrian, wondered if the lack of training to ‘do no harm’ is a UK or international phenomenon:

   to what extent this is [unintended harm] part of the core curriculum across our countries, all countries. (Adrian, counselling psychologist).

Pat, who is British born and trained exclusively in Britain as a counsellor and then as a counselling psychologist, explained:

   In 12 years of training in the fields of psychology and counselling, I have yet to have any training around it [do no harm] and in a sense that’s some kind of unintended harm. (Pat, counselling psychologist).

The topic seems an international training issue, evidenced by its absence or limited reference to it in key psychology training texts (Parry et al., 2016). This gap could impact upon the debate around, “both safeguarding the public and protecting the reputation of the profession” from unintended harm (BACP, 2017).

Supervision (training to practice). A further issue discussed by all the participants was the use of supervision, which the participants expected to facilitate their transition from trainee to newly qualified practitioner. However, many of the narratives speak of
difficulties where support was expected, yet was experienced as absent. John described an occasion when he struggled with a formative experience that happened at the training institution:

in group supervision, I brought a client with erotic transference and I got torn apart and everyone found it quite difficult ... there needs to be a really clear lead, and that can come for the Director of the course to say “Mistakes need to be normalised”, and it needs to be a very clear message at all different levels that it’s a learning profession and people have got to bring mistakes; and they get protected. (John, counselling psychologist).

Although bruised emotionally, John did not attack his training course. Instead, he expressed a constructive problem solving perspective. Mary’s perspective voices a broader concern, which begins to drill down into an issue that most participants shared:

I have a bit of an issue with our profession because I think it’s incredibly shame based … and this is the problem with do no harm, even in supervision … you think, well, how are you ever going to talk about where you’ve said the wrong thing at the wrong time, you know? (Mary, counselling psychologist).

Shame serves to highlight the tension between descriptive and interpretive research (Willig, 2013). The tension translates into the balance between initially presenting broad singular descriptive extracts that stay close to each participant’s account, with this study’s gradual shift towards the deeper interpretive subjective level that is discovered when we actively look across the data items, and knit the extracts together. This perspectival shift engages with the “nuance, subtly and interpretative depth” of iatrogenesis (Braun & Clarke, 2014, p. 1).
Theme 2: Praxis and ethical issues

As the analysis shifts towards latent meanings (Merton, 1972), the participants described the role of Praxis and ethical issues in terms of two subthemes: Practitioners’ concerns with codes of ethics, and Who do the codes serve?

**Practitioners’ concerns with codes of ethics.** While the codes define boundaries, the horizon between some acceptable-unacceptable practices or behaviours may curiously be less visible:

I think there’s massive subtle effects … across most of the areas of difference and diversity there’s a lot of shutting down of gender, of sexuality, disability, reliance of diagnosis over relationship, referral to client resistance where its normally therapist resistance in the room and … it’s all within the code of ethics. (Pam, counselling psychologist).

While Pam (above) illustrates the tensions of difference and diversity, Pat (below) offers a parallel example and fine-grained illustration of the tensions when working with competing codes of ethics, and how they impact upon the concept of ‘do no harm’. Pat’s extract diverges from all the other participants, yet develops another aspect of risk management; the tension between incompatible professional obligations:

I don’t just have the ethics, the code from the HCPC, I’ve also got my organisational policies and guidance, and I’ve got legal requirements, and I think sometimes they can all combine and can clash. (Pat, counselling psychologist).

The tensions of diverse perspectives and ethical clashes, which in different forms have become increasingly prevalent across the extracts, turns to anger. The anger seems to sit at the point where professional identity and shame overlap.
Who do the codes serve? Many participants questioned working in a field that publicly protects one identifiable group rather than the whole; the clients rather than the professional members. Luis was vocal:

I have an issue with the idea that a code of ethics is there primarily to protect clients … we need to protect clients and in the process of protecting clients we need to protect practitioners. Because a practitioner who causes harm in many ways is harming themselves. (Luis, counselling psychologist).

Under the surface the practitioners in this study question the function and application of ethical codes. With over 20 years of practice experience, Jane echoed the participants’ concerns about seeking support due to the fear of feeling shamed, and how the process differs between regulatory bodies:

BACP only publish if the complaint has been upheld … Well if you look at HCPC which is the psychologists’ governing body you’ll see that not only do they publish the names of people who have had complaints upheld against them but they publish the names of people who are about to have complaints heard. (Jane, Humanistic counsellor).

The naming and shaming of practitioners by the regulators cut across the data set. The practitioners were angry and concerned that this impaired the delivery of therapy on a day-to-day basis. They often questioned, who do the codes serve?

Overarching theme: Professionalism

Participants described the key role of professionalism through: ‘Normative conceptions of health’ and the ‘Shame of openly owning errors’. The thread of professionalism highlighted strong feelings, and insightful contributions.

Normative conceptions of health. Several participants questioned what they called
IAPT’s increasing medicalisation of practice thorough public health care policy: counselling is very much based on the medical model. (Dale, CBT counsellor).

At the manifest level, Dale’s words disclose his practice-based conceptualisation of psychological distress as seen through the lens of IAPT’s medical model. The model sits at the heart of the ever-developing discourse around how macro public health programmes should treat distressed individuals. Hidden behind Dale’s words is the issue of how the discourse serves to “perform an ideological [latent] function ... in the medicalisation of everyday life” (Strawbridge, 2016, p. 28), which reduces distress to the micro level individual rather than the interpersonal meso social level.

Luis links the medicalisation of psychotherapy to public policy and praxis, and questions who this serves:

I am worried when manualised therapy becomes the only thing that is on offer by the practitioner because it is the only thing they know … there is no possibility of engaging in a different approach ... a colonisation [of therapy], this idea that there is one way to be psychologically healthy. (Luis, counselling psychologist).

Reflexively, I interpreted my tension as the signal of an undercurrent across some of the narratives of “normative conceptions of proper functioning [or] well-being” (Sharpe & Faden, 1998, p. 119-120). The tension leaves me wondering where we, and I, as practitioners are situated on the continuum of normal-to-abnormal well-being.

**Shame of openly owning errors.** Buried in Sean’s narrative sits the shame of openly owning errors so that in the interests of all, we can learn from them: it would be good to be open about it ... not just in private, to be open as a profession (Sean, counselling psychologist).
Gail related angrily that while in the work staff room, and as part of the snowball recruitment procedure, with her lecturer-therapist colleagues:

no one wanted to take part, and the reaction was very, “Oh, oh no I don’t harm anyone, no I don’t.” It’s very defensive. (Gail, counsellor).

Pat offered one interpretation for the lecturer-therapists’ manifest concern regarding defensiveness, which masked a latent message that wove throughout the narratives:

We might talk about ethics, but we don’t talk about the nitty gritty as much ... you know, it’s an uncomfortable topic. (Pat, counselling psychologist).

The ‘uncomfortable topic’ encapsulates the tension between do no harm, shame at making errors, and the potential benefits of a healthy discussion of iatrogenesis to signal good and ethically-grounded practice (Linden, 2013).

**Discussion**

Through the thematic analysis of therapists’ perceptions of unintended harm within their day-to-day therapeutic practice, the aim of this study is to increase the awareness and management of unintended harm, with the objective of enhancing ethically-grounded practice. From the analysis two themes were identified: ‘Preparation for practice’ and ‘Praxis and ethical issues’. These were transcended by the notion of Professionalism. The results suggest these professionals are concerned about attempts to manage or minimise the risk of harm. To manage potential risks, all but one of the participants directly or indirectly expressed that the regulation of therapeutic practices needs to be more balanced. For the regulators and practitioners alike, part of the professionalism of psychotherapy is achieving the balance between working with errors vs. not making errors. Transcending each theme was the notion of tensions: through the themes the narratives enable us to discuss and challenge the notion of what it means to be a professional.
While Parry et al. (2016) suggest that it is now time to move on from the discussion of iatrogenic practices within psychotherapy, there seems a need to gain a deeper understanding of the issues described by the participants. For instance, Parry et al. (2016) consider the absence or sporadic mention of unintended effects in standard textbooks on psychological therapies represents professional complacency (e.g. Brown & Lent, 2016; Douglas, Woolfe, Strawbridge, Kasket, & Galbraith, 2016). Castonguay, Boswell, Castantino, Goldfried & Hill (2010) recommend trainees be made aware of the topic, and examine it. For all stakeholders, this topic is a gap that holds the potential to impact upon practices and shape the debate around, “both safeguarding the public and protecting the reputation of the profession” from unintended harm (BACP, 2017).

**Tension**

Each participant-practitioner related their unique narrative regarding the topic. As a group, they are aware of their perceptions relating to the perceived polarised options they face in the day-to-day struggle to manage the perceived right way to practise, versus a perceived wrong way to practise. A key tension is that the group seemed aggrieved at being publicly held to account for their choices in a field that all acknowledged is inherent with risks. In short, they say the more scared they become, the less creative they are. These participants, in a profession where the codes of ethics value openness and honesty, say they are fearful. This exemplifies Merton’s (1936) theory of drawbacks because ethical codes are meant to make therapy safer. This exemplifies also Merton’s (1936) theory of paradoxical outcomes, because the codes seem to be creating the opposite of their intended function. These tensions are subsumed within a bigger tension, which transcends the whole narrative; the tension that pulls between whether psychotherapy is an art or a science.

**The notion of psychotherapy as an art or a science?**

The notion of art vs. science explains how, by attempting to avoid harm, people lose the creativity in their training discipline and their practice. Ultimately, this does harm to
the client because the therapists say they cannot fulfil their potential to be the best practitioners they can be to serve the client well. This finds reflection in the notion of professionals vs. technicians (Friedson, 1994). It finds reflection in the struggle that has been going on within medicine in terms of defensive practice. Also, it finds reflection in the discussions around psychotherapy regarding the systematising of practices that impact the hidden theme of professionals vs. technicians as practitioners.

**Professionals or technicians: implications for ‘do no harm’**

This study’s overarching theme speaks to the unintentional undermining of professionalism by the professional bodies. Freidson (1994) argues that through “hierarchical forms of control, professional elites exercise considerable influence over the technical, administrative and cultural authority previously held by professionals” (p. 9). This names the tensions: the codes of ethics are stated to protect the public, to limit harm. However, they are also applied inadvertently to shame members who commit human practice errors, which inhibits their artistry. The BPS’s (2017) timely Declaration on equality, diversity and inclusion, advocates, “for the importance of equality, diversity and inclusion and being accountable for improving practice and communicating psychological knowledge ... to our membership and other stakeholders” (point 2). This declaration underpins the aims and objectives of this study.

**Professionals or technicians: the impact of ‘do no harm’**

Based upon the extracts, I suggest the rapid impact of systematised therapy is akin to a colonisation of the field. Here colonisation means the propagation of the idea there is only one way to practise, or to be healthy. Gergen (2007) proposes the greater the harm the higher the stakes, which shapes the discourse to control professional resources. As increasing levels of perceived harm are reported through complaints procedures, it is becoming apparent that the technician elite inclined to use the codes of ethics to manage the harm. The parallel is if professionals themselves are being harmed within the field
itself, the potential to harm clients must also increase. Professionals may, as a result, practise ever more defensively until many become technicians by default.

**Recommendations**

We need to train practitioners that it is alright to disclose their errors. Only feeling free to disclose our errors are we then free to make them and reflect upon them. Without specific training or workshops, some practitioners could continue harming their clients and may not even recognise that they are doing harm. Additionally, the word ‘harm’ itself might mean different things to different people, which underlines why transparency from training onwards is so crucial (Castonguay et al., 2010). A second core finding is the need for training institutions, practice settings and workshop providers to create a safe place to explore the complex issue of iatrogenesis. A safe place is defined as a context where curiosity and not shame is experienced when practitioners share their experiences, ideas and propose solutions.

**Limitations**

There are some methodological limitations to consider. As the participants were recruited via snowball sampling a potential bias was introduced. Also, in this practitioner-centric study, the participants were interested in the study topic and so may have come with a priori beliefs. My own epistemology shaped how I experienced and so presented the data to my co-authors and readers. Further, harm is a subjective experience. It is unique to an individual within their environment and may be experienced on many intersecting levels (Crenshaw, 1989).

**Conclusion**

The topic of iatrogenesis and ‘do no harm’ is complex. In their day-to-day practice of psychotherapy, the practitioners would like to see a way to engage with their professional registration bodies without fearing a punitive response. The practice of
shaming those who make errors is causing distress, which could drive an open and honest debate around iatrogenesis underground. This means the very codes of ethics meant to protect the public or practitioners together with facilitating being able to complain, could themselves have an unintended and harmful impact. The field of therapy needs to talk about the tensions of competing viewpoints.

Also, the topic needs to be introduced into training programmes to acculturate practitioners to accept that causing unintended harm, and seeking support, are normalised. The field’s shift towards manualised therapy to control for harm or variability is de-professionalising psychotherapy, and increasingly turning well-intentioned practitioners into technicians. To counter this shift, we need to celebrate our differences and variability. So, to thrive in the face of the current socio-political pressures we could reach out to join with other mental health disciplines and voice the paradox; the way to reduce harm is to talk unashamedly and more openly about harm. Counselling psychology’s competency to ‘strive to do no harm’ offers a pathway to open the debate and dialogue in the service of all.

References


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