Psychological Therapists' Experiences of Goal-Based Practice Within Adult Pluralistic Private Practice: An Interpretative Phenomenological Analysis

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Declaration

I hereby declare that the work submitted in this dissertation is fully the result of my own investigation, except where otherwise stated.

Signature: *Christopher Lloyd*

Date: 24/11/20

"For we mean that man first exists, that is, that man first of all is the being who hurls himself toward a future and who is conscious of imagining himself as being in the future" (Sartre, 1967).

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Anticipated Research Outputs

Lloyd, C., & Antonino, R. (under review). *"It's got to be a gentle balance of pushing and pulling and sitting with"*. Psychological Therapists' Experiences of Relational Goal Working Within Pluralistic Private Practice: An Interpretative Phenomenological Analysis.

Abstract

Background: Outcome monitoring (OM) has been shown to support client progress in psychotherapy (Lutz et al., 2015). For the most part, this has taken place through the nomothetic tradition, which involves the client responding to a global and standardised checklist of psychological functioning (Alves, 2016). The idiographic tradition, however, represents an alternative whereby clients construct and rate progress against their own items, within a standardised questionnaire format (Sales & Alves, 2016). Idiographic measures take one of two forms: problem-focused and goal-focused. Problem-focused measures ask clients to identify the difficulties, issues, or concerns that they want to overcome, and then to rate the extent of these problems. By contrast, goal-focused measures, or goal-based practices (GBP), invite clients to pinpoint the objectives that they would like to strive toward, and then the degree to which they have achieved them (Lloyd et al., 2019). For the latter, emerging evidence supports the validity, reliability and clinical utility of GBP (e.g., Di Malta et al., 2019; Lindhiem et al., 2016; Lloyd et al., 2019; Smith, 1994; Tyron & Winograd, 2011). **Rationale:** Despite the significance that GBP may have for psychotherapy, there is a paucity of qualitative studies exploring how psychological therapists experience working with GBP with their clients. Given that pluralistic therapy (Cooper & McLeod, 2011) represents a specific form of therapy that fosters acceptance of therapeutic diversity, as well as a focus on explicit goal discussion and agreement, it seemed prudent to explore how therapists make sense of GBP within this framework. **Methodology and Results:** Interpretative phenomenological analysis (IPA) was selected for this research. Eight semi-structured interviews were conducted with psychological therapists working with GBP within pluralistic private practice. Three superordinate themes emerged from analysing the transcripts: a) a pathway through the jungle; b) invalidating the therapeutic journey; c) maintaining the client-led story. Results suggested that GBP could aid the therapeutic partnership through the

monitoring of progress, by providing focus and increasing positive affect. However, GBP had the potential to detract from the client's frame of reference, to jeopardise the therapeutic containment of sessions and to increase the client's feeling of failure. The theme of 'maintaining the client-led story' emerged from the results as an antidote to what was experienced as non-humanistic GBP. Relational GBP entailed practitioners preserving time for therapy, reflecting on their own goals and agendas for their clients and maintaining principal focus on the therapeutic relationship; establishing this first and foremost, as a means to support their clients to create meaningful goals, which led to change. **Conclusion & Implications:** GBP can enhance psychotherapeutic work but cannot be separated from the primacy of the therapeutic relationship. Approaches to GBP, which dichotomise positive and negative aspects are likely to overlook therapeutic processes, which are vital to ensure GBP is collaborative and meaningful for the client. Results are discussed with reference to wider literature and the identity, ethos and praxis of Counselling Psychology (CoP).

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Chapter 1. Introduction

1. Overview

This chapter will begin with a reflexive statement, which will cover both pre- and post-literature review reflexivity. This will include exploration of my personal motivation for conducting this research, as well as, biases and assumptions which I have identified.

2. Outline and Rationale

A major tenet of counselling psychology (CoP) is the centrality placed on dialogue between researcher subjectivity and research (Willig & Rogers, 2017). CoP acknowledges the irreducibility of researcher, language, theoretical perspective and personal experience and how these interrelate to co-create phenomena of interest. As such, no researcher can claim impartiality or objectivity of truth, instead, researchers are positioned as co-constructors of knowledge (Gergen, 1985). In an attempt to restrict the influence of such processes, transparency of approach is advocated. This has been termed reflexivity and characterises the process of the researcher acknowledging their presuppositions and personal interests, as they relate to and arise within the generation of new knowledge (Berger, 2015).

This reflexivity section will critically consider my personal motivation for conducting this research, including reflecting on my own personal narrative and approach to the literature, as well as my ontological and epistemological positioning.

3. Pre-Literature Reflexive Scoping

In encountering psychology, I was exposed to social constructionism, which gave a penetratingly critical analysis of theories within mainstream psychology (i.e., overt and reductive medicalisation of mental distress). I continue to be influenced by such critical readings, which seek to challenge taken-for-granted societal structures and understandings (Burr, 2015) but now also desire for a grounded therapeutic approach which is based upon

the notion of an external reality, even if not fully knowable, that works to alleviate mental distress. This position has been termed critical-realism (Bhaskar, 2013).

Many of the writings I had been exposed to, were also critical of cognitive-behavioural-therapy (CBT), which for them, located distress within the person, at the expense of social factors (Bentall, 2004). CBT appeared to rationalise away mental distress and I was wary of working with clients' cognitions or eliciting therapeutic goals, when they were suicidal, had minimal social support and were due for eviction from their home.

As my course progressed, I was alarmed by the early focus CBT placed on goal setting. I saw this as rigid and could not imagine working with a client who was severely distressed, eliciting their goals early on seemed inappropriate and dehumanising. I regarded therapy as a space where it was sufficient for clients to just be and to reflect. On beginning placement, however, using goals seemed to afford clients a thoroughly purposive and person-centered approach that resonated with my own views of the person. Working with goals invoked an image of the client as agentic, as thoroughly conscious and aware – as opposed to a more passive view, which placed them at the mercy of solely unconscious sources.

Encountering Laing (2010) and his conception of people as intelligible struck with me. Although using goals in therapy had been critiqued, particularly if used in a mechanistic fashion, I could see how they could offer an empowering tool for growth. I recognised that my view of CBT and relational therapies had been falsely dualistic – the two could be combined – and using goals in therapy could also be a part of that combination.

In pursuing this project, I wanted a strong link to practice. I began thinking about the demand placed upon therapists to use OM – how this was useful but how its undiscerning use might overlook the subjectivity of the client that was so imperative for CoP. I wondered how both the client and therapist experienced these forms. When I came across goals measures in a book chapter I was persuaded by their potential use as an adjunct to standardised measures.

I read how working with clients in a relational way could be integrated with what I had previously considered more manualised approaches to treatment – yet instead of instructing clients to complete a tick box form, we could have a collaborative discussion about where they wanted to be. Moreover, that this need not be reductive or exclusionary to external life and social events was all the more compelling and resonated with my vision of therapy as a process whereby clients have the right to choose their direction –it was not set by external structures or medical discourses but the person articulating for themselves.

My own experiences of personal therapy also reinforced my ideas about the potential efficacy of GBP. My therapist used an existential frame – and this for the most part was useful - particularly when I wanted space to reflect. There were, however, times when I wanted structure and where I brought a focused issue to session. My therapist, however, continued to spend the session engaged in discussion about my past experiences and meaning making. I would have relished the opportunity to articulate my own therapeutic aims and to begin to work towards those. For me, my therapist was missing an important dimension for therapeutic support.

Indeed, my time through personal therapy also led to further introspection concerning the nexus between my own lived experiences and what aspects of myself might have propelled me towards the study of goals in therapy. My reflections have been iterative and staggered, in this area, but closer examination of my own personal material has enabled me to be curious towards aspects of my own self I might have previously preferred to otherwise push away from. In particular, I recognise that my interest in goal working may stem from a personal tendency to avoid my own negative earlier life experiences and to instead, focus and compensate through attention to the future. In many ways, I recognise that in my earlier life my own choices for living were restricted and, in this respect, being able to set my own goals and directions for my life has offered a hugely supportive and important framework, with

which to build and establish my life. I am mindful that I carry these presuppositions with me, to this project.

4. Post-Literature Reflexivity

I have become acutely aware of my assumption that nomothetic measures are solely reductive, as thus, unable to capture the lived complexity of human experiencing. Consequently, earlier on, I was promoting idiographic measures through a false dichotomy. I wish to state, however, that in comparing nomothetic and idiographic traditions, I am not suggesting one or the other tradition be used in an isolated fashion. Rather, I see both, as integral tools to the therapeutic encounter.

In realising this and out of concern for the potential consequences for my research, I reflected on what aspects of my own personhood might be implicated. Specifically, what aspects of myself were legitimising the idiographic as superior to nomothetic? This involved frank discussion with my research supervisor and peers and through the process of maintaining a reflective diary, whilst writing this literature review.

In particular, I wonder how goals have functioned in my own life, to direct and adjudicate aspects of my living. For example, I recognise that I thrive through goal working in my own life and goals have, at times, perhaps functioned as a form of avoidance to past and painful early life experiences. Specifically, during my earlier life, there were times when I found my experiences reduced and unheard and goals seemed to allow me some compensation for this by allowing focus towards a new possible future, one which would take me away from whatever dilemma I was facing. For the purpose of my research, I can see how my interest in idiographic approaches might, in part, be born out of a desire to ensure the voices of others are promoted.

As I progress with my research, following engagement with the literature, I am aware of two overarching themes. Firstly, overall, I view the use of goals in therapy, as a largely

positive force – I need to be aware that this might not be the experience of all clients or therapists – and to be open for multiple perspectives, beyond dichotomies. Secondly, that I have, in the past, assumed that nomothetic measures operate on a subtractive level. This position has evolved somewhat, especially as my own therapeutic practice has developed further. Indeed, I recognise that my perspective has also helpfully broadened as a result of engagement with empirical research. As such, I believe I have shifted further, from rigid dichotomies, towards a place of valuing both nomothetic and idiographic measures.

5. Search Terms and Year of Publication

The following key words and years were utilised for the search pattern in order to identify relevant literature: Goal*; Therap*; Experience*; Measure*; Idiograph*; Nomo*, 1968-2020.

Chapter 2. Literature Review

6. Overview

This chapter will present a critical literature review (CLR), where the topic of outcome monitoring and goals will be socio-historically contextualised. This will follow with reference to empirical research which has explored goal working in therapeutic practice and will include a critique of existing literature so as to present a rationale for the current study. Finally, I will highlight the gaps in the literature that led me to propose the present study alongside the aims and research question of this thesis.

7. Theoretical Orientation

This review is theoretically grounded within the patient-focused-approach (PFA). First advocated through Howard et al., (1996), the PFA prioritises implementing session-to-session measures of client progress to assess and advance outcome through data-driven feedback (Lutz et al., 2015). Significantly, the PFA has signalled the establishment of research and practice, tailored to the patient voice and their specific therapeutic needs (Alves, 2016). Fundamentally, this tradition is rooted in the belief that clients should have a larger say in what happens to them, with the aims of therapy resting on their own wishes for therapy, sometimes including their individual goals (Kiresuk, 2014).

8. Note on Terminology

Noting the overlapping array of terminology, which is used in the OM literature, these terms will be explicated herein, for the purpose of clarity. Hence, in this review, "outcome monitoring" (OM) refers to the broad historic practice within mental health services to systematically and routinely track client progress, symptomatology and outcomes, over the course of therapeutic intervention, often through the administration of standardised global checklists (Lutz et al., 2015). This entails regular monitoring throughout sessions (e.g., the use of psychometrics on a weekly, or session-by-session basis) to chart progress and is

distinguished from “outcome measurement” which is often used to refer to a singular pre- and -post therapy snap shot of a client’s wellbeing or symptomatology, obtained through outcome measures. For example, assessing a client’s symptoms at the start of therapy and at the end, in order to assess and determine therapeutic outcome.

“Goal based practice” (GBP) signifies one approach within the idiographic tradition, namely, working with idiographic goals therapeutically, regardless of therapeutic tradition and is inclusive of inter- and intrapersonal processes related with working with goals. "Goal based outcome measure" (GBOM) is used to refer to a collection of goal-based measures, which allow clients to qualitatively list and numerically rate their own therapeutic goals and are hence, solely idiographic in nature.

9. Socio-Historical Perspectives on Outcome Monitoring

In the introductory section that follows, a brief orientation to the socio-historic landscape of OM will be provided, with due consideration to how GBP has emerged, in line with recent social policy.

9.1 Outcome Monitoring and the Move to Goals

Over the last 20 years, OM has been employed as a principal means of privileging the client perspective, by gaining outcomes and goal statements directly from the client (Ogles et al., 1996). Accordingly, in counselling, OM has had a considerable bearing on national and international policy decisions (Lutz et al., 2015). Specifically, the session-by-session procedure of using OM has been fundamental to NHS England's Improving Access to Psychological Therapies (IAPT) agenda, which has, in part, been determined by a climate in which service funders increasingly require demonstrable evidence of client improvement before approving funding through an outcome-based payment system (NHS England and NHS Improvement, 2016).

In England, current policy has moved to endorse the use of GBP within the therapeutic setting (Cooper & Law, 2018). Most recently, The Five-Year Forward View for Mental Health paper (2016) outlined directives for embedding evidence-based treatment pathways by 2021. This included a stipulation for measures, with a reliable change index and a statistically normed cut off but also, in combination with individual, patient-owned outcomes, which capture change concerning therapeutic goals (NHS England and NHS Improvement, 2016). These developments are seen as synonymous with CoP philosophy and practice, which places significance on client subjective experiences over an isolated focus on symptomology with disregard to individual meaning making (Orleans & Van Scoyoc, 2009).

9.2 Measuring Mental Health

Mental health, representing a latent construct, presents challenges for monitoring and measurement through its historic reliance on subjective assessment from multiple perspectives (Wolpert et al., 2016). Accordingly, hard outcomes in relation to mental *health* are non-existent and an array of measures has been developed, to capture progress and outcomes in services, which provide mental health intervention (Alves, 2016).

These developments have also coincided with meta-analyses, which suggest that offering clinicians feedback on client progress may support positive improvements in outcome, compared with treatment as usual (Lambert & Shimokawa, 2011). Considerable conjecture exists, nevertheless, as to the relative strengths of the nomothetic versus idiographic approaches, in terms of therapeutic practice. These differences will be contrasted below, namely through two traditions: nomothetic and idiographic.

10. The Great Divide: Nomothetic Versus Idiographic Monitoring

10.1 Norming the Nomothetic

The development and implementation of psychometrically standardised, valid and reliable measures, which have the potential to screen for, and monitor significant clinical

changes in individual psychological functioning, has been a long-term goal of academic and applied psychologies, including CoP (The British Psychological Society, 2008). As such, the BPS places significance on the development and use of psychometric tests in order to support best practice (Douglas et al., 2016).

This has characteristically taken place through problem-focused nomothetic approaches, e.g., PHQ-9 (Patient-Health Questionnaire; Kroenke et al., 2001) and GAD-7 (Generalised Anxiety Disorder; Spitzer et al., 2006). These measures, as well as informing clinical practice, through monitoring the severity of symptomatology (Carlier et al., 2012), also have the potential to provide information, which feeds directly into *service* development (Slade et al., 2006), as well for local and national benchmarking purposes (Cooper & Law, 2018). It is also worth mentioning that there exist wider socio-political factors undergirding their use, such as the substantive demand placed on practitioners and services to report upon detailed and rigorous evidence of their clinical effectiveness, for instance, in NHS England's IAPT programme (Clark, 2011).

According to Sales & Alves (2016), traditionally, OM and measurement has followed a nomothetic approach (from the Greek “nomos” = “law”), whereby pre-selected items mirror existing dimensions that are common to all people (from the general population), in variable degrees. These measures, therefore, tend to be constituted of predefined global statements, which are grounded on data aggregated from large samples (Overington & Ionita, 2012). Consequently, they tend to emphasise problems as opposed to goals; the earlier referring to obstacles or difficulties that clients wish to work through, the latter about what the person is aiming for. Hence, the role of nomothetic assessment is to locate the patient on these global dimensions, by comparing scores from a client with those from the general population, in order to pinpoint the client's distress in relation to clinical thresholds, thus highlighting areas viable for therapeutic intervention (Sales & Alves, 2016). Moreover, owing to the normative

nature of these measures, they generally have demonstrable psychometric evidence of their validity and reliability (Sales & Alves, 2012). Nomothetic measures are therefore useful when a broad-based assessment of client needs or problems is required.

10.2 Critique of Nomothetic OM

Although widespread, the use of standardised measurement and monitoring has been critiqued for minimising client's individual subjective experiences (Dozois et al., 1998; Evans et al., 2010). This certainly might represent challenges for CoP, as nomothetic measures tend to restrict a clients' liberty to express their personal lived experience, being constituted solely of pre-defined response options, which may be either irrelevant to the client or negate individual meaning making (Blount et al., 2002). Nomothetic measures also suffer from issues relating to vague items as well as specific language and cultural assumptions (Crawford et al., 2011; Rodgers, 2017). Specific concerns have been raised as to whether normative measures are capable of capturing all aspects of a client's care – such as coping skills, which become particularly salient when symptoms are not necessarily anticipated to improve (Batty et al., 2013). Fundamentally, nomothetic measures may not be able to capture the subtle variations in the problems, or goals, that are of significance to clients (Sales & Alves, 2016).

10.2.1 Move to the Idiographic.

Responding to the nomothetic paradigm, a form of more personalised OM and measurement tradition that has evolved relatively recently, is based upon the idiographic approach (from the Greek "idios" = "own" or "private") (Alves, 2016). Pertinent examples of idiographic tools include, the Personal Questionnaire (Elliott et al., 2016), PSYCHLOPS (Ashworth et al., 2004), Goal Attainment Scaling (GAS; Kiresuk & Sherman, 1968), or the Goals Form (Cooper, 2015).

In contrast to the nomothetic tradition, idiographic monitoring and measurement broadly supports clients to construct and rate progress against their own items, within a

standardised questionnaire format (Sales & Alves, 2016) and typically take one of two forms: problem-focused (sometimes also referred to as ‘target-complaint’) and goal-focused. Problem-focused measures ask clients to identify the difficulties, issues, or concerns that they want to overcome, and then to rate the extent of these problems, e.g., PSYCHLOPS; Ashworth et al., (2004). By contrast, goal-focused measures, or goal-based practices (GBP), invite clients to pinpoint the objectives that they would like to strive toward, and then the degree to which they have achieved them, e.g., GAS; Kiresuk & Sherman, (1968). These can include questionnaire-based forms that comprise open-ended questions in order to support the client’s articulation of desired therapeutic goals, or in a more active collaboration with the therapist through mutual discussion and exploration (see Lloyd et al., 2019 for a full review of available goal-focused measures).

Consequently, idiographic measures permit clients to determine their own therapy foci and allow the client to define the content to be evaluated or scored in therapy; thereby affording attention to the broadest range of value systems and individualised notions of treatment success (Kiresuk, 2014; Jacob et al., 2017). This PFA to OM has the potential to capture therapeutic change that is of most significance to clients with 'outcome' assessed not by recourse to normative scales of functioning but rather by analysis of self-completed scores (Edbrooke-Childs et al., 2015). Moreover, the use of idiographic measures has been promulgated on ethical terms: principally in reference to promoting individual as opposed to normative identity and as a way to empower clients (Kiresuk, 2014).

Of particular pertinence, is the argument that the use of a personalised goals system might mitigate against a culture of ‘tick box’ exercises, which has become synonymous with standardised OM (Badham, 2011; Wolpert et al., 2012). Decisively, in support of the goal-focused idiographic approach, a meta-analysis conducted by Lindhiem et al., (2016) suggested that effect sizes were significantly larger where personalised treatment goals were

implemented rather than when utilising symptom checklists. Their review suggested that psychological intervention was more effective when supporting clients towards their individual goals as opposed to reducing scores on broad measures of symptomatology.

10.2.2 Critique of Idiographic OM. A major challenge of the idiographic tradition, however, is the difficulty in aggregating scores for service evaluation purposes (Alves, 2016). Nomothetic measures may have superior utility over idiographic measures, when aggregating data across groups of clients, and examining change in outcomes, at a service level, as opposed to an individual level (Sales & Alves, 2016). Moreover, research suggests that level of progress is dependent on the ease of goals selected and can be manipulated to show greater progress (Kiresuk, 2014).

In comparing idiographic and nomothetic traditions, I am not attempting to exclude, exalt or prioritise one tradition above the other; rather, I am proposing complementarity. Therefore, I feel they have the potential to be mutually enriching. Following the above review of nomothetic and idiographic monitoring and associated critiques, I will now examine the rise of GBP within psychotherapeutic traditions.

11. Tracing the Rise of Goals within Psychotherapeutic Traditions

11.1 Historical and Current Controversies around Working with Goals

In 1968, the term ‘goal setting’ was formally introduced into the psychological literature (Locke, 1968). Goals can be defined as, “subjectively desirable states of affairs that the individual intends to attain through action” (Kruglanski & Kopetz, 2009). Meanwhile, therapeutic goals are the specific preferred states that an individual desires to achieve through therapy (Michalak & Grosse Holtfort, 2006).

Since their inception in therapeutic discourse, comment Grouzet et al. (2005, p.800), ‘*psychological research on goals has experienced a real renaissance’*. Historically, the study of goals within therapeutic traditions was fiercely contested, being mired by the dominance of

psychoanalytic and subsequent behaviourist traditions, which marginalised the study of goals. Although this has not been the case within the context of coaching psychology, where GBP has long been used as the basis to facilitate behaviour change (Grant & Spence, 2010), within broader psychotherapy, GBP has long been deemed adversative to the therapeutic space, as promoting an individualistic and neoliberal achievement-orientated culture, rather than relational connection to clients' authentic selves and values (Cooper & Law, 2018).

Critiques of GBP emerged largely from within psychotherapeutic traditions. Early psychoanalysts directed attention to instinctual drives that were conceived as immediately unknowable to the client (Freud, 1990). Accordingly, as the desires and wishes of the client were assumed as driven by unconscious forces alone, there could be little value in enquiring into client-specific goals. The advent of the 1950s also bore little scope for the study of motivation and goal pursuits. This, however, was owing to the dominance of the behaviourist movement, as exemplified through reinforcers and punishers of behaviour with disregard to cognition (Locke & Latham, 2002). As motivation and goal pursuit were viewed as lying inherently outside of the person, the behaviourist movement also reduced the study of goals to the non-consequential.

In line with a shift to the cognitivist paradigm, in the 1970s, which most markedly resulted in cognitive therapy (Beck, 1979), there was a growing necessity placed on collaboration with the client. This also paralleled the creation of brief solution-focused therapy – which supported clients to reach their 'preferred futures' (de Shazer, 1991). Arguably, it was through this paradigm that working with goals was sanctioned as legitimate therapeutic interaction.

Having contextualised GBP within earlier historical developments and psychotherapeutic traditions, I will now address the rise of GBP within pluralistic therapies.

11.1.1 Working with Goals in Pluralistic Therapy. Even inside humanistic circles, a historic distaste to GBP has thrived (Rowan, 2008). Consequently, it is understandable that a humanistic framework to GBP has only recently emerged, in particular, with developments in the pluralistic approach (Cooper & McLeod, 2012).

The pluralistic approach as developed by Cooper & McLeod (2012) belongs to a family of therapeutic approaches which support clients in 'actualising' their existence as human beings (Cain et al., 2016). As such, one of the basic tenants is that all individuals have a sense of their intended future, striving variously to construct a personally meaningful existence (Cooper & Law, 2018). The approach does not prioritise any one mode of therapeutic intervention as necessarily more efficacious but is, rather, inclusive of numerous therapeutic interventions, which promote therapist-client collaboration (Cooper & McLeod, 2007). Taken together, the pluralistic approach invites clients to take a fully functioning role in the decision-making process, collaborating on the tasks, goals and methods for therapy. Indeed, the philosophies and practices in which the pluralistic approach are predicated upon are closely intertwined with CoP identity and practice (Douglas et al., 2016).

After reviewing the historical emergence of GBP within the therapeutic milieu, as well as explicating how GBP has been conceptualised within a pluralistic framework, I will explore the potential benefits and hindrances to integrating GBP.

12. Benefits and Challenges of a Goals Based Approach in Therapy

As discussed, many of the therapeutic paradigms branded GBP as antithetical to the therapeutic space (Cooper & Law, 2018). This, however, is a changing picture with empirical research highlighting the potential advantages that GBP might afford. These chiefly range from giving clients a sense of personalisation and agency, to the significance for the practitioner in focusing, monitoring, and tailoring treatment, in addition to, contributing to

professional development (Ionita et al., 2016). Importantly, these advantages are tempered with challenges, and it is necessary that these be adequately discussed.

It is noteworthy, at this stage, that present empirical literature for the adult context, provides largely anecdotal evidence from a clinician perspective for the advantages and disadvantages of GBP. I will explore some of the main benefits and challenges to employing GBP, as highlighted within the literature. Some of the literature presented has been taken from the broad OM literature, in addition to the child and young people (CYP) context, principally due to the scant availability of literature within adult GBP. I wish to note that although the dichotomous division of benefits and challenges presented below, may seem abrupt, it is indeed a representation of the literature, at present.

12.1 Benefits to Implementing a Goals Based Approach for Client and Therapist

12.1.1 Benefits for Therapeutic Process. At a ground level, working with GBP, permits the monitoring of progress, both for the therapist and the client. Clinicians have proposed that, exclusive of goal setting, it can be difficult to monitor progress (Batty et al., 2013). Indicative of these benefits is converging evidence that understanding between clients and therapists on goals of treatment, is linked with positive outcomes, with a mean correlation of 0.34 (Tyron & Winograd, 2011). Moreover, in a recent meta-analysis, GBP corresponded to goal attainment, with a moderate effect size of (d+) of 0.40 and converging evidence that frequency of monitoring was a mediator for these effects (Harkin et al., 2016).

Another distinct benefit to incorporating GBP, which presents a shared theme within the literature, is the possibility of active involvement and engagement of the client, through participation in deliberative goal setting (Austin & Vancouver, 1996). Here then, GBP has the possibility of empowering the client - ensuring that their hopes and expectations form the basis for therapeutic work (Cooper & Law, 2018).

As Holtforth & Grawe (2002) suggested, clients with comparable diagnoses can often hold diverging objectives for therapy. Specifically, clients struggling with depression may want to focus on improving exercise routines or rebuilding interpersonal relationships, whereas clients focused on working through anxiety may prefer to address avoidance behaviours. Importantly, focusing therapeutic work around a client's goals, permits primacy of client autonomy over any theoretical assumptions or diagnosis aligned treatment schedule (Sales & Alves, 2016). There is also indication, that GBP can motivate clients to contribute in discussions regarding their care and is a method by which they can feel comfortable and contained (Law & Wolpert, 2014). Although as briefly noted above, this latter evidence is drawn from the CYP context and may not be transferable to the adult domain.

12.1.2 Benefits Outside Therapeutic Space. Aside from therapeutic process, the use of GBP has been suggested as aiding supervision by providing tangible examples of areas to discuss, on which to base client progress (Law & Jacob, 2015). Evidence has also emerged that a focused GBP can improve communication in a multidisciplinary context, where information from the client perspective may be particularly noteworthy (Emanuel et al., 2014).

12.1.3 Challenges to Implementing a Goals Based Approach for Client and Therapist. Challenges to implementing GBP have been touched upon within the literature; however, the focus of such research has generally been concerning OM broadly (Boswell et al., 2015; Ionita et al., 2016).

For Bevan & Hood (2006), a significant barrier to GBOM, is that the idiographic nature of these measures leaves them susceptible to subjective interpretation. This is potentially problematic when linked to performance targets (Law & Jacob, 2015). Other practical and individual barriers extolled within the literature have tended to focus on difficulties, such as: insufficient IT systems and lack of resources, in addition to inadequate

training to complete GBP. However, such concerns have been criticised as trivial, and have been readily countered by suggestions that all GBP necessitates is pen and paper (Fleming et al., 2016).

12.1.4 Barriers for Therapeutic Process. The literature presents a vague and contrasting picture on the impact of GBP for therapeutic process, from the practitioner perspective (Phelps et al., 1998). Dominant concerns within the literature relate to GBP as potentially deterring communication away from therapeutic interaction and as imposing external or normative expectations for ensuing therapeutic work (Cooper & Law, 2018). Lambert (2005) have also cited concerns, such as possible empathic ruptures in the therapeutic alliance.

13. Critical Appraisal of the Available Literature on Experiences of OM and GBP

As indicated above, available literature suggests that implementing OM in the therapeutic encounter has the potential for therapeutic benefit and hindrance (Ionita et al., 2016). However, a preponderance of this literature is anecdotal and has not drawn upon empirical evidence. Moreover, what seems to emerge from the literature is a distinct lack of exploratory qualitative research, which explores GBP and meaning making within the context of the therapeutic relationship, although it is worth noting that some literature exists in the field of coaching psychology. I will now focus on presenting a critical distillation of the literature, which has examined therapists' experiences of OM, including GBP. The decision to focus on therapist experiences was two-fold. Firstly, recent literature has previously explored clients' experiences of GBP (Di Malta et al., 2019). Secondly, as no literature has, of yet, explored therapists' perspectives, it was deemed important to consider these, so that they might be triangulated with the experiences of clients.

As discussed, the socio-historic negation of GBP within psychotherapeutic traditions has perhaps mired research initiatives. Arguably, this may partially account for the relative

absence of empirical studies exploring therapists' experiences of GBP. Accordingly, in the section that follows, it is necessary to draw upon the OM literature more broadly, including drawing upon published studies of GBP in the coaching psychology field. In doing so, I hope to illustrate the emerging gaps in the literature, which point to the necessity of further investigation.

13.1 Studies on Therapist Experiences of OM

Some qualitative studies have attempted to explore how therapists variously experience OM within clinical practice. The majority of these studies explicate barriers to routine OM (Ionita et al., 2016; Moltu et al., 2016; Unsworth et al., 2012).

Unsworth et al., (2012) adopted a convenience sample of four therapists from a primary care counselling setting, who were experienced in using CORE-OM (CORE Information Management Systems, 2002) and five therapists from an NHS occupational health service, who were inexperienced with using CORE-OM. The CORE-OM, as a nomothetic self-report OM, provides a pan-theoretical 'core' of clients' global distress. Therapists were interviewed in a focus group setting regarding their perceptions of using the CORE-OM with clients. The authors stated that data was analysed using an inductive qualitative approach, however, no further details were provided with respect to the type of analysis. Results suggested that therapists acknowledged four obstacles to their use: initial anxiety and resistance, wariness of technology and fear of judgement. In particular respect to the therapeutic relationship, CORE-OM was considered to both 'ground' and 'integrate' the therapeutic relationship by flagging areas of risk early on, validating the feelings of the clients and enabling the visual inspection of progress, enhancing and focusing therapeutic conversation and triaging sessions through the examination of clinical cut-off scores. Importantly, this study was useful in providing initial insight into the therapist perspective on

OM; however, the focus on a specific measure has somewhat limited the scope of the findings to wider therapeutic practice.

In a larger scale study, which used a consensual qualitative research methodology, Ionita et al., (2016) engaged 25 clinicians regarding their use of OM. Specifically, using open-ended semi-structured interviews they explored clinicians reluctance to engage with OM. Results suggested four areas that related to both the challenges clinicians experienced with OM, such as, technical anxieties, negative responses from others, therapists' personal barriers, in addition to strategies used to overcome these challenges. Although this study is valuable in highlighting common barriers to practice, from a practitioner process perspective, the study is subject to limitations. Principally, despite pursuing open-ended qualitative interviews, the project seemed exclusively geared towards unpicking barriers and facilitators to OM. Possibly, this binary restrictive approach may have minimised the fluidity of the participant response, in as much as little attention was afforded to therapeutic process. Explicitly, there seems little interpretive engagement as to how therapists considered these measures might impact the therapeutic relationship, beyond recognition of OM as potentially generating anxiety or negative responses from clients.

In considering these studies together, it is noteworthy that whilst both attempted to explore therapist experiences of OM, they largely did so in a manner, which negated the miniature of therapist experiences. For example, they seemed to limit or pre-specify their argument to listing obstacles but failed to look in more interpretive depth, at how these might variously impact on the therapist's subjective experience of OM or the wider therapeutic relationship.

In the same year, Moltu et al., (2016) conducted focus groups with 32 practitioners and 18 clients in order to explore how OM might be beneficial for therapeutic process. They were seeking to gain an understanding of what aspects of OM patients and clinicians reported

as helpful and acceptable to them. Distinctly, unlike the studies discussed above, Moltu et al., (2016) combined both phenomenological and hermeneutic epistemologies (Laverty, 2003), which permitted an open exploratory and experiential focus in addition to engagement with participants' own interpretation of their experiences (Gadamer, 1975). Through thematic analysis (Braun & Clarke, 2006), it emerged that clinicians seemed to favour OM as a means to support collaborative processes in the therapeutic alliance. This appeared to be allowed through supporting intimate conversations about trust between therapist and client as well as allowing both to monitor progress towards therapeutic goals. In addition, there was a sense that practitioners saw OM as facilitative of important conversations about client agency, ownership, and activity. Therapists also suggested that OM might be helpful in providing information on client's affective states, supporting the empowerment of the client and enabling monitoring of risk and symptomatology.

One prominent limitation posed by Moltu et al., (2016), seems to relate to the participants' therapeutic orientation. The authors did not distinguish between the therapeutic orientations of participants, which arguably would have been useful in order to contextualise the data. Specifically, some practitioners in the study held a psychodynamic affiliation, while others worked within a cognitive-behavioural or emotion-focused tradition. Conceivably, these participants may have related to OM differently as a result of diverged therapeutic orientation and indeed this is suggested within the literature (Corrie & Callanan, 2001). The study, therefore, should have made this explicit. Countering this critique, however, is the interpretive and phenomenologically oriented epistemology of the study, which allowed for a focus toward the lived experiences, as opposed to a focus on theoretical language. This integrative stance, therefore, supported the authors to explore patterns of commonalities regardless of differing therapeutic backgrounds.

In sum, through examining earlier empirical literature relating to therapists' experiences of OM, it seems apparent that there exist few, if any, findings that have drawn on therapists' experiences of GBP.

13.2 Studies on Therapists Experiences of Idiographic Measures

There is an absence of literature exploring therapist experiences of GBOM and GBP and hence for this reason, it is necessary to draw more widely on literature which discusses therapists' experiences of idiographic, problem-focused measures. A principal study was conducted by Kelly et al., (2012) who adopted a social constructionist lens in order to explore how therapists and clients discursively constructed the use of PSYCHLOPS, an idiographic problem-focused measure, also referred to as a target complaint measure, (Psychological Outcome Profiles – Ashworth et al., 2004) within the context of CBT for psychosis. Interestingly, this was the first study to examine how discourses of power and control shaped understandings of OM. The construction of discourses for PSYCHLOPS revealed the nuanced repertoires involved, specifically, power, empowerment, 'being heard', engagement, chaos and containment, which led to therapists constructing PSYCHLOPS as an instrument redirecting the inequality of power in favour of the client (Kelly et al., 2012). As one of the few studies which has explored therapist perceptions of idiographic measures, this study is foundational, in particular with recognition of the often value laden nature of OM and measurement. Nevertheless, epistemologically, I feel that by adopting a social constructionist framework the authors have perhaps restricted their focus. A focus on discourse seems to perhaps disregard lived experience and wider sense making as an embodied process.

A similar study utilised a survey design to capture qualitative responses to therapists' appraisal of PSYCHLOPS (Ashworth et al., 2005). Content analysis from four therapists suggested concerns relating to: feasibility (simplicity of use and relevance), validity (PSYCHLOPS' capacity to capture clients' difficulties) and utility of PSYCHLOPS in the

therapeutic encounter. Through the findings it emerged that clinicians observed the process of clients conceiving problems in their own words, as of significant benefit to the client. However, such measures were seen to expose clients to demands beyond ticking boxes, such as problems of expression. Despite the usefulness of the study for providing a snapshot of clinician's views, some limitations can be highlighted nonetheless. Firstly, the survey design elicited responses through a fixed response framework, which potentially controlled the scope of participant response. It is arguable whether these fixed questions restricted the ability of the respondent to openly reply, thereby minimising the breadth of data generated. Accordingly, it is uncertain whether the data more likely reflects the assumptions of researchers, rather than the experiences of therapists.

Another study (Sales et al., 2007) which also utilised a survey collection method, with a mixed-methods design, explored 25 psychotherapists' perspectives on the use of the Simplified Personal Questionnaire, a problem-focused (target compliant) idiographic measure, consisting of approximately 10 client-generated problems to work on in therapy (PQ; Elliot, Mack & Shapiro, 1999) and the Helpful Aspects of Therapy form, a post-session open-ended self-report instrument that asks about patient perceptions of key change processes in therapy (HAT; Llewelyn 1988), in routine clinical practice. Results suggested that therapists reported such measures as generally useful and were open to using these measures, with 91% reporting willingness to use these measures. Qualitative data was reportedly analysed with content analysis, with results suggesting that therapists experienced these idiographic measures as helping to monitor and enhance individual and family treatment response through attunement to the client; as being useful in adjusting therapy in vivo. Moreover, participants reported that these measures often provided therapists with a structured perspective of clients' complaints and difficulties that they were wishing to overcome. Disadvantages, however, were felt to relate to the time needed to complete these

measures, alongside the risk of information overload and excessive focus weighted towards the client's perspective, in isolation. Whilst this study is unique in providing initial qualitative data regarding therapists' experiences of idiographic problem-focused and process measures, which are used in the psychotherapeutic context, and thus is one of the few studies to report this, the study also lack detailed methodological transparency and rigour regarding how the qualitative analytic process was carried out, as well as any epistemological assumptions of the researchers.

In sum, present qualitative research drawn from psychology and the mental health field largely seems to fall into two domains; that focused towards therapists' experiences of specific OM from a nomothetic perspective (Ionita et al., 2016; Moltu et al., 2016; Unsworth et al., 2012) and that which explores therapists' experiences of idiographic, problem-focused and process measures (Ashworth et al., 2005; Kelly et al., 2012; Sales et al., 2007). The latter is most relevant to GBP as it allows clients to identify the difficulties, issues, or concerns that they want to overcome, and then to rate the extent of these problems, often as therapy progresses, however, in the absence of direct empirical evidence, there is little scope to lay claim to therapist experiences of GBOM.

13.3 Studies on GBP in the Coaching Relationship

Although not often directly associated with alleviating mental health challenges, or indeed set within a psychotherapeutic context, the field of coaching psychology has long championed GBP through its respective practice (Grant & Spence, 2010). Hence, due to the relative absence of qualitative studies exploring GBP in the psychotherapeutic or mental health literature, it seems prudent to make use of the available qualitative literature from the coaching psychology field.

In an available qualitative study by Weinberg et al (2001), 14 sport coaches were interviewed regarding their current coaching position and perceptions of the process of goal

setting. Through a content analysis (Patton, 1990), results revealed that coaches often employed goal working extensively in their coaching practice. Additionally, coaches tended to favour shorter term goals which were not written down but emphasised the importance of collaboratively setting goals with their clients. Moreover, the findings illuminated some helpful and unhelpful goal processes that coaches reported as deterring a positive coaching relationship, which included: the length of time needed to set goals and associated practical implications, such as difficulties with subjective measurement of goals. This qualitative study is particularly helpful in that it has illuminated core processes and perceptions that coaches report when engaging with goal working. Moreover, that the study provided in-depth and transparent information regarding the analytic process and how themes emerged, adds to the credibility of the findings. Nevertheless, the context of the study being coaching, perhaps limits the ability to assume similar processes and experiences will take place within a psychotherapeutic context.

13.4 Studies on GBOM and Pluralistic Practice

Having reviewed literature related to OM and problem-focused idiographic measures, as well as studies of GBP drawn from the coaching psychology literature, it seems necessary to review additional literature, which focuses on GBP, both within private practice and within the pluralistic context. This is because the pluralistic context, as discussed, is one where GBP is frequently and explicitly utilised.

A singular study by Oddli et al., (2014), which explored GBP in private therapeutic practice, noted that explicit goal agreement was not a component of psychotherapeutic work for experienced, high-alliance psychotherapists. In their study, audio recordings taken from the initial three sessions of therapy, from nine experienced therapists were subject to a modified constructivist grounded theory analysis (Charmaz, 2017). Results revealed that therapists often held a nuanced and complex understanding of GBP, which did not recourse

to linear presentations of goals. This study was particularly commendable in that it drew upon in vivo therapy sessions to make sense of therapists' strategies for goal working, however, it is suggested that it remains important to seek the phenomenology of their experiences in further depth.

Additionally, recent work undertaken by Di Malta et al., (2019) examined clients' experiences of goal negotiation in the context of pluralistic therapy. In their qualitative study, 22 participants who had experienced up to 24 sessions of pluralistic therapy were interviewed individually to explore their experiences of goal setting within the early stages of pluralistic therapy. Questions were partially exploratory in nature, for example: "Was the goals form helpful or unhelpful in identifying your goals for therapy?" "Was being asked about your goals a helpful part of the therapeutic process?"; "How have your goals on these forms changed over time, if at all?". A thematic analysis was conducted incorporating reflective principles borrowed from the phenomenological tradition, such as maintaining a reflexive journal in order to bracket personal experiences and assumptions (Hill et al., 2005). This transparent reflective position arguably lends credibility to the findings. The authors also defined their analytic approach as focused towards the semantic or explicit level rather than at a latent interpretative level, thereby assuming a unidirectional linkage between language, meaning and experience (Boyatzis, 1998; Widdicombe & Wooffitt, 1995). The authors stated that this decision was made in order to "put the client's voice first" (Di Malta et al., 2019, p.8), however, it is suggested that this minimised latent meanings from emerging (Braun & Clarke, 2006).

Data was broken down into: helpful aspects of GBP, challenging aspects of GBP as well as what made GBP more effective. Helpful aspects identified related to GBP as facilitating common ground, as an enabling force, facilitating greater awareness of one's problems, as relieving pressure and making progress more manageable. Challenges,

meanwhile, related to clients' initial experiences of uncertainty in the therapeutic encounter, with GBP sometimes generating an oscillating affect for the client, linked to their perceived achievement or lack of achievement with goals. This seemed especially marked when GBP was mechanistic in delivery. Participants also discussed feeling stuck and demotivated around creating goals, with GBP potentially generating feelings of incongruence between lived experience and goal-related activities.

As the first study to have explored client experiences of GBP, results present a strong basis to advance GBP knowledge and practice. The merits of this study lie in its ontologically and epistemologically transparent approach, which lends rigor to the credibility of the findings. Although the study was concerned with the use of the Goals Form, a GBOM (Cooper, 2015), the inductive nature of the methodology allowed general therapeutic practice to be explored.

A large critique of this study, however, is that whilst claiming an exploratory approach, a plethora of questions presented were leading in nature. This implication of this semi-closed questioning is potentially problematic, as it limits any potential nuances in the participant's response, for example, specifying GBP as either helpful or unhelpful. As Di Malta et al., (2019) acknowledge: when a client is feeling well, they may tend to report positive experiences of GBP. This may have worked to distort the results of this study, as those clients reporting GBP as 'helpful' may have felt more positive about their recovery journey. In essence, these results, at least partially, might reflect the mental wellbeing of the client at the time, as opposed to their views of GBP.

Arguably, although this study presents a good basis for understanding the client's perspective, it is conceivably important to also seek the therapist's perspective, so that these can be converged with the client voice. I suggest that this would permit the enhancement of GBP practice. I will now summarise the rationale for this exploration.

14. Critical Literature Review Summary and Proposal of a Research Question

Historically, the majority of OM has been captured exclusively through nomothetic means, with pre-specified items (Alves, 2016). This affords the advantage of comparing clients' current difficulties against clinical and non-clinical populations. Nomothetic measurement and monitoring, however, risks negating the lived experiences and agentic desires of the client (Cooper & Law, 2018). These critiques are particularly significant within the context of CoP, which places a directive on prioritising individual subjective experiences (Orleans & Van Scoyoc, 2009).

The idiographic approach permits clients to form, for themselves, their therapy foci; thus, accommodating the widest potential variety of value systems and understandings of treatment 'success' (Jacob et al., 2017). Their use is supported by a growing body of literature, which indicates that embedding GBP may benefit therapeutic engagement for two reasons: firstly, setting goals and reaching agreement may support therapeutic collaboration, secondly, working with the client to elicit and monitor goals may be fundamentally therapeutic in and of itself (Cooper & Law, 2018; Tryon & Winograd, 2011). In support of GBP, a meta-analysis of personalised treatment goals indicated psychotherapeutic intervention to be more efficacious in supporting clients with individualised goals, than lessening scores on broad-based measures of psychopathological symptomatology (Lindhiem et al., 2016). Importantly, this seems to suggest that employing GBP does not necessitate the exclusion of either nomothetic or idiographic traditions, but rather, that each has their own role, which might be reciprocally enhancing.

The implementation of GBP, however, is not unproblematic. Goal-focused idiographic measures, whilst affording distinct advantages, also prevent clients' scores from being easily interpretable: in degree, nature or difficulty. These potential difficulties have conceivable impacts, not only for aggregating scores and comparing improvements in client

functioning on a service level but also in terms of professional communication and identity or service funding directives (Sales & Alves, 2016). As Cooper & Law (2018) purport, they are potentially subject to manipulation: for example, clinicians are more readily able to influence goals towards softer treatment goals, in order to evidence larger client progress effects.

It has been suggested that the theoretical positioning of clinicians can influence the employment of OM. Specifically, those clinicians adopting a CBT frame may consider the assessment of symptomatology as fundamental to their work, while, those working psychodynamically may consider the process of goal setting as antithetical to the therapeutic space (Cooper & Law, 2018). Expectedly, those who view measures as productive for clinical practice have been shown to be likely to engage with OM, regardless of whether drawn from the nomothetic or idiographic tradition (Corrie & Callanan, 2001). Pluralistic therapy, however, represents a marked opportunity to cut across these differences through its situatedness with humanistic underpinnings, allegiance to CoP identity and philosophy and explicit acknowledgement of the role of GBP (Cooper & McLeod, 2012). I feel therefore, that it makes sense to explore the views of therapists who practice from, or are aligned with, this approach.

I feel it is noteworthy that therapist experiences of particular GBOM have been largely negated. Even in theoretical and clinical areas, which thoroughly endorse GBP, such as pluralistic therapy, there is little empirical evidence to draw from. Research suggests that clinicians can often hold robust opinions and concerns about OM and their implementation in therapy (Hatfield & Ogles, 2004; Unsworth et al. 2012). It is, therefore, perhaps not unexpected that engaging OM within therapeutic services has been connected with multifarious challenges and complexities (Ionita et al., 2016).

Current research has concentrated on client and therapist perceptions of OM almost entirely from a nomothetic perspective (Sales & Alves, 2012). Presently available research

has tended to use focus group methodologies in order to pool attitudes towards specific measures themselves (Moltu et al., 2016) or to focus solely on specific measures without examining therapists' experiences in a fluid and non-reductive manner. In addition, there are no qualitative studies, which have attempted to gain insight into the lived experience of therapists using GBP through qualitative interviews, within a psychotherapeutic context. There is a limited pool of qualitative data from the coaching psychology literature (Weinberg et al., 2014) regarding goal processes, however, it is difficult to assume the applicability of the coaching context to the psychotherapeutic sphere.

As McLeod & Mackrill (2018) purport, the absence of qualitative research into GBP, within the context of the therapeutic relationship, resembles a critical gap in the psychotherapeutic evidence-base. Arguably, whilst it is certainly fruitful to consider clients experiences of working with goals and to triangulate this with therapist experiences, this has already been the topic of recent research attention (Di Malta et al., 2019).

Prior research has also often used varied contexts, which limit the homogeneity of the results and prevent in-depth focus on therapist experiences. In acknowledgement that there may exist fundamental qualitative differences in GBP across differing service contexts and client groups, and in order to provide sufficient focus, this research will, therefore, explore GBP in the context of pluralistic private practice (PPP), with adults. The private practice context seemed apt for the present study owing to the increasing numbers of psychotherapeutic practitioners working with this setting (Brown, 2018). Moreover, the private practice context was also considered beneficial as this was felt to limit the influence of service context and policy upon the participants responses; specifically, where particular service contexts may dictate, or impose a particular way of GBP.

With the present qualitative study, looking at psychological therapists' experiences of using GBP in the context of PPP with adults, a less directive and more exploratory overall

research question seemed crucial within the context of such a minimally researched field: How do psychological therapists experience working with GBP within the context of pluralistic private practice with adults?

I hope to answer this question through three main objectives. Firstly, to generate empirically grounded knowledge from the lived experience of psychological therapists, as to the impact of GBP on therapeutic process. Thereby, filling the present substantive gap in the literature, which hitherto has neglected to focus on therapists lived experience of GBP.

Secondly, to facilitate an understanding of applied working practices surrounding the use of GBP more broadly. Which aspects of using GBP are helpful or problematic from a practitioner process perspective? As explicated literature has predominantly grouped findings into supportive and hindering factors to GBP, I aim to take a more exploratory approach to my investigation, however, remaining open to explore these areas if they arise.

Finally, to gain an understanding of how psychological therapists feel GBP could be improved or modified. The ultimate expectation is that this research will support an understanding of how therapists make sense of, and experience, working with GBP, in their respective therapeutic practice. This knowledge would thereby translate to advance practice, by understanding from clinicians themselves, their experiences of GBP.

Chapter 3. Methodology

15. Overview

In this chapter, I will present interpretative phenomenological analysis (IPA), my chosen methodology for the current study (Smith et al., 2009). This will include an examination of its underlying philosophical and theoretical roots, so as to demonstrate how these fit with the aims of the present study. The rationale for selecting IPA over other qualitative methodologies will be presented and situated within a wider framework which, critically, appraises the merits of traditional quantitative methodologies versus qualitative explorations and resultant meaning-making. This will include a reflection on my ontology, that is, what I consider the world to be constituted of, and my epistemology, my view of what can be known from the world and how new knowledge is formed (Willig & Stainton-Rogers, 2017), as well as to how these positions have evolved over time. Additionally, contained within this chapter, analytic reflections connected with the process of data collection and interpretation of findings will be presented alongside details of validity and credibility checks. To conclude, pragmatic considerations such as the recruitment process, participant demographics, data collection and analysis as well as ethical considerations will be examined.

15.1 Considering a Qualitative Methodology

The decision to align this study within a qualitative framework was partially guided by my review of the literature, which seemed to indicate the need for exploratory, non-directive research that focused on experience and meaning-making around GBP. Therefore, mirroring Brower's (1949, p.1) remark that: *"Statistical methods… promote atomistic, categorical thinking, and over- or under-determination of meaning",* I felt that a quantitative approach would likely offer too reductive a lens, owing to its focus on identifying cause and effect variables and delineating outcome variables. Moreover, a large proportion of previous research has adopted a quantitative approach, in that it has sought to identify and determine

the effects of idiographic monitoring, or indeed GBP, upon the client's presentation, or the wider therapeutic relationship. For example, previous quantitative research has explored how GBP is associated with treatment outcome (Lindhiem et al., 2016; Tyron & Winograd, 2011). Accordingly, I considered that a qualitative approach would likely complement such existing quantitative literature by capturing understandings and meaning-makings relating to GBP, that might not otherwise be available through a solely quantitative approach. Within this study, this entailed seeking experiences and meanings directly from therapists employing GBP in their therapeutic practice. Hence, the utility of qualitative studies is such that the knowledge and understanding they develop, can later be complemented with hypothesis generation and testing by the hypothetico-deductive paradigm (Willig & Rogers, 2017). In this sense, both a quantitative and qualitative approach represent symbiosis, rather than, discord.

Furthermore, my critique of the literature led me to identify a preponderance of research which examined how OM was experienced as either benefit or hindrance. Whilst this research undoubtedly offered an important perspective that I sensed could readily support clinical practice, I felt it necessary that my research not be limited by this binary approach to OM. Instead, I felt it important that the lived experiences of psychological therapists working with GBP in their private therapeutic practice emerge freely. Additionally, due to the limited availability of research exploring this topic, a qualitative approach also seemed a good fit (Smith et al., 2009). Moreover, I felt that such an approach was more appropriately situated within a qualitative framework, at this stage, as opposed to a hypothetico-deductive methodology, in which hypotheses are generated and tested due to the paucity of qualitative data available (Popper, 2005).

15.2 Reflexivity on Ontology and Epistemology

My choice of qualitative approach, although guided by my critique of the literature, has also been intertwined with my evolving ontology and epistemology. My journey to both of these positions is best understood as an iterative progression, rather than as static, discrete dimensions. To me, the latter resembles more of a positivistic epistemology, such as the assumption and privileging of psychological science as objective, generalisable and value-free, with the need for quantification of variables and experimental design (Breen & Darlaston-Jones, 2010). While I feel that a quantitative approach can sometimes be useful, I believe qualitative approaches have equal value. Thus, the choice of approach should typically flow out of the research question or focus of investigation. In the section that follows, I will consider how my ontology and epistemology have developed and how this has influenced my approach to the present study. I feel such a reflective positioning of myself and my beliefs in this thesis is essential, as it allows readers to understand my view of the world, what I understand as knowledge and how this might impact the present thesis.

During my undergraduate training in psychology, I was fortunate enough to be exposed to critical social constructionist theories (e.g., Burr, 2015). These theories were radical and led me to question the fundamental foundations of psychological science. This early environment fostered within me a critical appreciation of psychological knowledge as partially reflecting the embedded attitudes and socio-cultural context of the researcher rather than independent knowledge alone. I keenly involved myself in this area and published a paper situated in the field of relativistic social constructionism (Lloyd & Finn, 2017). During this point, I felt a pull to social constructionism and related relativist ontologies (Foucault, 1971). I was attracted to the notion that language might be actively constructive rather than merely reflective of reality (Burr, 2015).

Over time, as this early social constructionist undergirding intersected with my clinical work with human distress and suffering, I became aware that a relativist ontology

(Parker, 2013) – that is, a view of the world as not made up of 'truths' but rather as entirely subjective and hence dependent on interpretation and context – could not fully capture a view of the world to which I subscribed. Furthermore, my previous experiences of working in dementia care and as a research assistant on a quantitative study showed me how a relative and discursive view of the world could not easily be matched up with my understandings of mental distress. Specifically, I could see clearly how those struggling with their mental health often had experienced very tangible difficulties in life. I therefore came to recognise the integral role language and discourse play out in experiences of mental distress but, importantly, affect and negative experience remain as primary drivers of distress. To think about mental distress only in terms of discourse would be missing an important link and potentially denying the lived experiences of those with mental distress. Conversely, in my role as a research assistant, my experiences of quantifying the social and developmental trajectories of children were unsatisfactory. I missed the richness of exploring an individual's experience first-hand and hypothesising about how their discursive structures might be used to restrict, contain or open up different ways of living or understanding phenomena. For example, it did not seem sufficient to understand their experiences through questionnaires and psychometrics in isolation, as this did not wholly capture their lived experience. Rather, I felt I was missing out on a deeper and more idiographic understanding of the whole person, that perhaps could not be apprehended through quantification of variables alone.

During my developing therapeutic practice, and in relation to GBP, I could see that clients' goals were not just fulfilling discursive functions, but instead tapped into real-life events. That is to say, clients often sought therapeutic support to move beyond or come to terms with real periods of distress. Granted, adopting a critical position, I understood that the very notion of GBP, at least in part, could be seen as reflective of an underlying neoliberal socio-political discourse, associated with individual striving and success (Cooper & Law,

2018). In these terms, I felt acutely aware that GBP might be colluding with the broader political aims for psychological therapy, such as that provided by NHS services, where the goal was not solely the amelioration of mental distress but also to enable return to employment and hence support fiscal development (Clark et al., 2018). Over time, however, I was able to look beyond this and consider whether these goals were just socio-political actors or if they could be of benefit for my clients. Given this, I now feel that two aspects of my experience aligned with intellectual knowledge, rather than being opposed. Principally, I was able to hold onto my appreciation of both positivistic and relativistic understandings of the world as reflective of a spectrum, rather than as discrete, fixed positions.

Accordingly, I currently embrace critical-realism (Collier, 1994) as an ontology and phenomenology (Giorgi & Giorgi, 2003) as an epistemology. I consider these positions to represent an equilibrium that understands lived experience as an independent reality, yet does not discard the socio-political tensions and repertoires which will always be present in our narratives. Therefore, as a critical realist, I believe in a material world outside of individual consciousness, which is only intelligible through examination of the individual accounts of those experiencing phenomena (Giorgi, 2006). Phenomenology provides the nearest epistemological fit for me as it allows me to seek the accounts of those experiencing phenomena in their own words and terms (Pietersma, 2000).

15.3 Origins and Characteristics of IPA

IPA was developed in 1996 and represents one qualitative approach within the social sciences (Willig & Stainton-Rogers, 2017). Unlike some other methodologies, such as ground theory (GT; Glaser and Straus, 1967) or discourse analysis (DA; Potter & Wetherell, 1987), which have roots within sociology and critical literary theory, IPA was initially created in the field of health psychology (Smith, 2010). Since its inception, IPA has grown in popularity,

particularly with CoP. This rise has been attributed to its ability to bridge psychological and social dimensions (Eatough & Smith, 2017; Smith et al., 2009; Smith, 2017).

As an exploratory method, IPA seeks to *"... capture the experiential and qualitative and […] still dialogue with mainstream psychology"* (Smith et al. 2009, p. 4). Furthermore, the use of IPA allows for the in-depth exploration of how individuals understand their worlds (Pietkiewicz & Smith, 2014). Eatough & Smith (2017) described IPA as embedded within phenomenology, idiography, and hermeneutics.

IPA is phenomenological in that the particular meaning an experience carries for participants becomes the emphasis of exploration (Giorgi & Giorgi, 2003). Consistent with a focus on idiography, IPA discards a nomothetic position, favouring instead the examination of individual experiences (Lyons & Coyle, 2016; Shinebourne, 2011).

The hermeneutic position of IPA leads to an appreciation of the distinctly interpretative nature of research. Importantly, individuals are required to utilise language to necessarily interpret and communicate their experiences. This account is then subject to a subsequent interpretation by the researcher. This twofold progression of interpretation is referred to as the 'double hermeneutic' (Eatough & Smith, 2017).

15.4 Rationale for IPA

Given my epistemological position, IPA (Smith, 2017) seemed the most appropriate methodology for exploring how psychological therapists' made sense of and experienced working with GBP in their pluralistic private therapy practice. Furthermore, as demonstrated in my critique of the literature, there is presently a paucity of qualitative research exploring GBP in therapeutic practice. Accordingly, it made particular sense, to me, to utilise IPA considering its utility with exploring under-examined phenomena (Smith, 2017). Additionally, as much of the available literature has often employed closed or leading questions, I felt it important that IPA be used to permit participants' accounts to emerge

freely in their own terms. With much of the previous research neglecting to use an exploratory, non-directive lens, it seemed prudent to use IPA to explore how participants themselves made sense of their experiences.

In addition, I was attracted by the depth of analysis IPA could afford me by permitting a focus on individual accounts and meaning making but also allowing some theorising of socio-political contexts to emerge (Smith, 2010). Furthermore, I anticipated the need for an analysis which would go beyond the semantic and would also explore how latent and underlying ideas, assumptions, psychological processes, conceptualisations and ideologies might shape participants' accounts (Smith et al., 2009). In many ways, this seemed to do justice to my previous immersion in social constructionism whilst retaining an important focus on the immediacy of phenomenology and experience.

Finally, as a trainee CoP, I was drawn to the explicit acknowledgement IPA analysts give to the influence of the researcher and their clear welcoming of the often-co-constructed nature of research (McLeod, 2011). As Larkin et al., (2006) remark, IPA is the exploration of lived experience coupled with a subjective and reflective process of interpretation. Any interpretations are therefore exercised cautiously and with an explicit cognisance of the study's context. These principles are aligned with my relational style and experiences of therapeutic work. As I seek to produce research that is authentic and open to my participants' accounts but also transparent regarding my interpretations, I felt IPA lent the necessary rigour and appeal for such a task.

15.5 IPA Versus Alternative Qualitative Approaches

The decision to adopt IPA for the present enquiry did not emerge in a linear fashion nor did it negate the process of considering other qualitative approaches and lenses. In particular, as I immersed myself in the literature relating to IPA, I was struck by its assumption of a unidirectional relation between discourse and cognitive-affective experience

(Willig, 2013). In other words, that language singularly taps onto experience. As a consequence of my previous experience with radical social constructionism (Burr, 2015), I took time to reflect on whether IPA was indeed congruent with my positioning (Lloyd & Finn, 2017).

I considered using DA (Potter & Wetherell, 1987) given my previous experience with this methodology. However, since discourse analysts generally argue against linearity between discourse and 'real'-world actions (which is antithetical to IPA) and instead regard language as constructive of, instead of reflective of, reality (Burr, 2015), I felt the method was not suited. I feel that my ontology and epistemology are no longer aligned with a relativist form of DA, as I accept a fundamental reality that exists outside language. Furthermore, although DA might have afforded consideration of issues of power, as these are constructed through discursive repertoires, a DA approach alone may generally be deemed to offer insufficient consideration to phenomenological experience, being concerned more with language and talk (Willig, 2013). I also considered that DA might shift the study away from an exploratory focus if excessive attention was placed on language and power.

A second consideration was GT (Glaser & Straus, 1967). As in IPA, grounded theorists seek to capture an individual's worldview through the identification of themes. The aim of GT, however, is understanding wider social processes so that theoretical models can be created (Starks & Brown-Trinidad, 2007). As it was not my aim to create a theory around therapist experiences, IPA remained preferable due to its focus on the individual's inner psychological landscape. This resonated with the aims of my research, that is, exploring how clinicians themselves make sense of GBP.

A final consideration was thematic analysis (TA; Braun & Clarke, 2006), which is a broad qualitative method that has the benefit of theoretical versatility depending upon the

researcher's ontological and epistemological alignment. IPA was favourable, however, due to its explicit alignment with phenomenology.

15.6 Design

15.6.1 Data Collection Procedure. Data collection involved a participant recruitment poster being sent to a pluralistic therapy clinic in London (Appendix A). The recruitment procedure was agreed with the clinic director prior to data collection, with initial recruitment from this site acting as a catalyst for later recruitment, known as snowballing sampling. Potential participants were invited to email me for study information and to ask questions (Appendix B). Potential participants were given the opportunity for face-to-face or Skype interviews. All participants opted for Skype interviews, for which informed consent was collected via receipt of electronic signature (Appendix C). Participants were told that following interviews, to render the data anonymous, they would be assigned a pseudonym, with transcribed data subject to immediate anonymisation. Given that the interviews were conducted via Skype, participants were briefed on particularities relating to data security with such online platforms (Deakin & Wakefield, 2014).

15.6.2 Participants. In line with IPA's sampling guidelines (Smith et al., 2009), eight qualified psychological therapists, with a minimum of six months' experience of working within private practice, with a pluralistic approach, were invited to participate (see Table 1). To provide satisfactory homogeneity, as required by IPA (Smith, 2011), participants were additionally required to have regular experience of engaging with client's goals in the therapeutic relationship and to be working with adult clients (aged 18 years old and above). For this study, all participants reported employing GBP fluidly in their practice, specifically, goals were generated through verbal dialogue and discussion with their clients, without recourse to particular goal measures. This included therapists generating goals in collaborative discussion with their clients at the beginning of therapy and reviewing these

periodically throughout sessions, as felt mutually helpful or necessary. For example, by qualitatively asking their clients explicitly, during assessment, as well as, during the course of therapy and at therapy termination, what their goals are for therapy, as well as, their progress towards these stated goals.

Additionally, all participants were required to hold some training in pluralistic practice (Cooper & McLeod, 2012), either as a core qualification route (which emphasised pluralism as a framework of practice) or through continuing professional development. Pluralistic practice was defined as two-fold: firstly, as a general attitude of acceptance towards the diversity of the therapeutic field as a whole, and secondly, as a specific form of practice, which draws on methods from a range of sources, depending on client preferences and therapist skill and is characterised by explicit dialogue and negotiation over the goals, tasks and methods of therapy (Cooper & Law, 2018). Participant identification as holding a pluralistic ‘perspective’, ‘viewpoint’ or ‘sensibility’ (belief that clients may benefit from differing therapeutic methods, at different time periods) was insufficient for inclusion. To ensure participants met these requirements, demographic information was collected from each participant prior to interview which broadly explored ethos of practice and training background. Those who did not meet these inclusion criteria were not eligible for participation in the study.

Table 1. Participants' Demographic Information (Pseudonyms Used to Maintain Anonymity)

Interview	1	2	3	4	5	6	7	8
Pseudonym	Rico	Tom	Annelie	Tobias	Amber	Maura	Pippa	Alessandra
Gender	Male	Male	Female	Male	Female	Female	Female	Female
Age	61	41	36	46	40	34	48	52
Professional Identity	Counsellor	Counselling psychologist	Counsellor	Counselling psychologist	Counsellor	Counselling psychologist	Counsellor	Counselling psychologist
Years Qualified	11 years	7 years	2 years	24 years	10 years	3 years	12 years	1 year
Therapeutic Orientation	Pluralistic	Pluralistic	Pluralistic	Pluralistic	Pluralistic	Pluralistic	Pluralistic	Pluralistic
Qualification Route	MSc Counselling	Professional Doctorate	Postgraduate Diploma	Independent Route	Master of Science Counselling	Professional Doctorate	Clinical Diploma	Professional Doctorate

15.6.3 Interviews. The aim of the research was to inductively explore how psychological therapists experienced and made sense of working with GBP with adult clients, within the context of pluralistic private practice. Given my critique of the earlier literature, it was anticipated that the use of semi-structured interviews with accompanying open-ended questions and probes would permit the creation of rich data which authentically captured the experiences of practitioners (Smith et al., 2009). Semi-structured interviews were chosen over focus groups to promote a deeper exploration of participants' experiences that might not otherwise have emerged (Guest et al., 2017). Furthermore, semi-structured interviews were chosen over structured interviews as these were seen as more closely aligned with the phenomenological nature of IPA (Smith, 2010). Specifically, it was felt that semi-structured interviews would allow participants' own experiences and meaning-making to take precedent during interviews, with the schedule being used as a loose scaffold, to guide, rather than

dictate conversation. Structured interviews would likely interfere with the emergence of participants' own organic material as it would assume the presence of a necessary reality (i.e. assuming goals are experienced in certain ways), rather than seeking these openly from participants in their own terms (Willig & Rogers, 2017). Accordingly, semi-structured interviews were felt to be in more accord with my own epistemological position.

The interview schedule (Appendix D) arose directly from the critical distillation of available literature and supported an interview duration of approximately one hour. Consistent with principles of qualitative research, the schedule was used as a guide to researcher-participant dialogue rather than for formulaic use. Accordingly, I included focused themes to aid exploration with questions and additional prompts to guide, which were broader in nature, than those seen in structured interviews, where all questions are asked in sequential order. The latter are commonly used with positivistic studies, where it is believed researchers can access experience and 'truth' without relational interference (that is, the process of researcher and participant co-constructing experience and meaning, as is assumed inevitable within this study; Willig & Rogers, 2017).

15.6.4 Analysis. My analytic procedure was guided by Smith et al., (2009). Firstly, verbatim transcription of data was completed. Following this, repeated reading and re-reading of all transcripts and listening to audiotapes was completed, to forge familiarity with the data and enable recollection of tone of language, humour and body posture.

Subsequently, initial notes and connections were written on the right-hand margins of the transcripts. These notes were descriptive (the content of participants' speech), linguistic (specific language used, such as metaphors and notes on possible function) and conceptual (more interrogative depth used to comment on possible underlying meanings). During this process, separate notes were kept in a reflexive journal for developing thoughts and ideas and to bracket personal assumptions (Smith et al., 2009). This immersion in the data allowed for

comments on language, associations and descriptive labels (see Appendix E for exemplar of notes and comments) which usefully resembled a form of Gadamerian dialogue; that is, the interrelation of my pre-understandings and newly formed understandings from immersion in the data (Smith et al., 2009).

Abstract notes and psychological concepts were then noted in the left-hand margin. This resembled an analytic shift from working with the transcript alone, to working with emerging themes, in addition, to my notes. While noting/commenting was looser and more open in the right-hand margin, the aim of the emergent themes was to capture understanding at a more abstract level. However, to stay close to the participants' accounts, their language was preserved as much as possible (Appendix E).

Theme clustering was completed in a separate document and involved seeking areas of convergence, in addition to, divergence in participants' narratives (Smith et al., 2009). Emerging themes were ordered chronologically and used to tell a story of the participant's experience. Colour codes were used to highlight and group overlapping themes. Smith et al., (2009, p.96) equate this stage to using an imaginary *'magnet'* to cluster and pool similar themes. This was undertaken to achieve a sufficiently coherent level of analysis, which authentically captured participants' accounts. During this phase, several tools advocated by Smith et al., (2009) for moving to a more sophisticated analysis were employed: abstraction (similarly emerging themes grouped and subsumed under new higher level label to generate superordinate themes), subsumption (emergent theme acquires superordinate status), polarisation (difference and contradiction between themes were identified instead of similarity alone), numeration (examining relative importance of particular themes dependent on indication of numerical frequency across a transcript) and finally function (looking for ways in which participants' rhetoric may position them in the interview). This stage culminated in the production of a table of superordinate and subordinate themes with quotes

and line numbers for each interview. This iterative, interpretive sequence was completed for each interview individually, to ensure idiographic depth, with time spent making reflective notes, before proceeding onto subsequent transcripts (Eatough & Smith, 2017) (See Appendix F, for exemplar). This stage of written reflection aided with bracketing my interpretations from previous interviews, which helped to ensure assumptions or interpretations from previous participants were not carried over onto subsequent transcripts.

The concluding stage involved a cross-case comparison whereby themes were compared across interviews to synthesise a master table with superordinate and subordinate themes and exemplar quotes capturing the essence of each theme (Appendix G) (Smith, 2004). This involved placing each participant's table side by side on an A3 page and visually inspecting the data, looking for commonality but also contradiction and divergence.

15.7 Analytic Reflections

Inevitably, the analysis presented in this thesis represents a culmination of my analytic interpretations which are considered inseparable from my personal and professional context. This is acknowledged most clearly with the principle of the double hermeneutic (Smith et al., 2009). Thus, the very act of interpreting the data rendered the emerging themes and final analysis as unavoidably 'cluttered' with my assumptions. Accordingly, I found that maintaining a reflexive journal throughout allowed me to acknowledge and synthesise my thoughts as well as to understand how my own personal and professional background impinged on the analysis. Below, I offer reflections on the process of data collection as well as analysis and interpretation.

15.7.1 Collecting the Data. I was aware of how my previous research experience may influence my approach to data collection. For example, I have carried out more than 50 standardised interviews for a large scale social and developmental psychology study. During these interviews, data collection was rigid and adhered to a numerical coding format for

responses. For this research, however, I wanted to create a schedule that had structure but that did not prevent deeper exploration of the participants' experiences. As such, I tried to maintain an open and non-leading dialogue with my participants (for example by asking: "*what have been your experiences of using goals in your practice?*"). When conducting the interviews, however, I felt that some participants responded to my questions with vagueness, and there was a sense that the openness I strived for sometimes did not provide enough context for participants to make sense of my questions. I therefore found myself relying on prompts to extract experience and meaning. This process was illuminating, as by explaining the meaning of my questions to participants, I became aware of my own underlying or hidden assumptions. While I felt that I had previously bracketed these, I could see how they were re-emerging to influence the process and how, in many ways, this is an unavoidable aspect of such research. To give one example, at one point, I found myself steering a participant interview subtly towards negative aspects of GBP, as if a part of me assumed that these would exist.

15.7.2 Interpreting the Data. I felt overwhelmed when initially encountering the data, partially due to its quantity, but also as a result of my need to prove that I was 'good enough'. The latter concern was a reflection on process, which I was able to make sense of with my supervisor.

During the initial process, I found it useful to fully emerge myself in each interview, often re-reading from the end of the interview to the beginning to prevent a false feeling of familiarity with the data. During interpretation, I felt compelled to produce an analytic interpretation that had 'sophistication' and was not reducible to a binary approach. Indeed, I had critiqued authors of previous studies for predominantly focusing on helpful or unhelpful factors and so, I felt, partially losing out on a richer representation. This was something I did not want for my research. Reflective discussions with my supervisor were helpful here, as I

was able to explore and acknowledge my need to 'prove myself' and how this was propelling me towards a perhaps disorientating level of analytic complexity. After a long period immersed in my data, I found it useful to pause and spend time in other areas of my life, and thus decided to temporarily disengage from the analytic process. I felt this gave me a fresh perspective upon returning to the data and allowed me to more closely attend to what I felt my participants were expressing.

Working with a tentative analysis at this stage and still feeling overwhelmed, I decided to polarise my data, to strip it of unhelpful complexity so as to illuminate core themes present across transcripts. During this process, I found the metaphor of an imaginary magnet (Smith et al., 2009) supportive in containing my analytic approach. This was a profoundly helpful stage which permitted a more condensed or birds' eye view of what I felt was emerging from the accounts. Furthermore, by stripping down to the 'bare bones', I felt at liberty to add elegance and richness back in. I likened this stage to a seasoning of themes, where I could attend to elements of contradiction across participant accounts. Overall, when finalising my analysis with my supervisor, I found two processes helpful. Firstly, acknowledging and stepping back from my need to include all interesting data in the analysis, a feat which I quickly realised would not be possible. This liberating experience gave me confidence in my analysis. Secondly, I kept in mind my tendency to compensate at times through over-intellectualisation. Thus, I chose to produce an analysis of quality which was also grounded and not unnecessarily complex.

15.8 Assessing Validity and Quality

To ensure research quality, Yardley's (2008, p.235-251) quality checklist for qualitative research was followed. Initially, "sensitivity to context" combined sensitivity to and cognisance of the existing research base, which included ensuring that all data analysis was substantiated and grounded in the participants' own words. Secondly, "commitment and

rigour" was met by carefully attending to participants discourse during interviews, giving space for participants experiences and meanings to surface inductively. In concurrence with Yin's (1989) proposal, a paper trail was collated during the analysis to support on-going reflection and discussion**.** This helpfully included utilising a reflective journal to bracket my assumptions and prevent excessive interference in the interpretative stage. This reflective note taking also aided subsequent supervisory meetings and credibility checks, where my own prevailing assumptions and biases with emerging interpretations were discussed and bracketed. Throughout the analytic process, this entailed roughly three hours of reflexive discussions with my supervisor where we discussed both my participants shared experiences and my own subsequent interpretation of these. This process was also supported by research discussions with peers, whereby we presented our analytic process and results to each other, using Socratic questioning (Carey & Mullan, 2004) to locate hidden meanings or assumptions. To improve the "transparency and coherence" of the study, the step by step procedures which were utilised for the data analysis of this project have been outlined in depth, earlier in this chapter. Finally, criteria for "impact and importance" were attained by my commitment to addressing an important gap in the literature, and by carefully considering and drawing out the potential clinical consequences for GBP in psychotherapeutic practice, from the therapist perspective.

15.9 Ethical Considerations

Below, I set out how I attempted to ensure that high ethical standards were maintained throughout the entire research process.

15.9.1 Ethical Standards.This study was aligned with the British Psychological Society's Code of Human Research Ethics (2014) as well as the UK Data Protection Act 2018 (Carey, 2018). As such, no data was collected until full university ethical clearance was obtained (Appendix H).

15.9.2 Participant Consent. Potential participants were invited to make contact via email, at which point they were provided with further study details together with consent documents (Appendix C). This included a clear reminder of their right to withdraw from the study, including any data collected, up to two weeks post-interview, without penalty (BPS, 2014; 2018). Prior to interview, full-written consent was obtained electronically (Appendix C).

15.9.3 Confidentiality and Data Protection. All participants were assured of the confidential nature of the research and were briefed prior to interview, with the opportunity to ask questions. This included providing all participants with transparent information about anonymity, the purpose of the research and potential for future academic dissemination. Participants were told that following interviews, to render the data anonymous, they would be assigned a pseudonym, with transcribed data subject to immediate anonymisation (BPS, 2014; 2018). Given that the interviews were conducted via Skype, participants were briefed on particularities relating to data security with such online platforms (Deakin & Wakefield, 2014).

During recruitment, participants were reminded that data would not be shared with the clinic in which they worked and as such, total confidentiality would be maintained (BPS, 2014; 2018). Participants were briefed that their transcribed data would be retained on an encrypted device for a period of up to five years following interviews, before being destroyed (BPS, 2014; 2018). This period was determined to support possible academic publication and/or attendance at related conferences, where the data could still be utilised.

15.9.4 Monitoring Distress. Signs of potential distress were monitored throughout data collection. A distress protocol (Appendix I) was developed for this study should signs of participant distress manifest. Despite being a psychotherapeutic practitioner, and thus feeling comfortable managing distress should it arise, I familiarised myself with this protocol.

Participants were additionally provided with details of relevant support agencies during debrief (BPS, 2014; BPS, 2018).

15.9.5 Debrief. Following interviews, all participants were given the opportunity to ask further questions and to give feedback on their experiences of the interview. All participants received a full written debrief following the interview (Appendix J) which acknowledged their participation, provided further information about the study aims and context, provided contact information for relevant support agencies (should distress arise) and sought their support with remaining recruitment (snowball sampling).

Chapter 4. Analysis

16. Overview

In this chapter, I offer an in-depth, iterative analysis of eight interview transcripts. I acknowledge that these findings derive entirely from my perspective and interpretation of the data. While the present version represents my final iteration, many collaborative and fruitful discussions took place with my supervisor around how best to structure the analysis and organise the themes in a realistic, authentic way, doing justice to the participants' experiences. I also recognise, however, that this constitutes just one of the many possible ways in which the data could have been interpreted. Additionally, while I have strived to condense and capture the qualitative uniqueness of themes, some overlap will inevitably remain amongst subordinate themes, due to the narrative style of such an analysis.

16.1 Reflections on Meta-structure of Themes

Three superordinate themes and nine subthemes emerged from the analysis (see Table 2). The quotes provided were selected to effectively capture a theme's core. Through the process of analysis, a sequential structure emerged that captured a dialectic present within the individual interviews on an idiographic level, but also across the data set as a whole. As such, a developmental process emerged from participants' accounts whereby participants initially seemed to make sense of GBP through a dichotomy. Accordingly, superordinate themes one and two point to the potential positive and negative aspects of goal working. However, as participants reflected on their developmental journeys as pluralistic psychotherapeutic practitioners, the focus shifted to the relationship between therapist and client. As such, theme three is an attempt to capture both ends of this polarisation and the integration of the two by exploring how therapists made sense of goal integration through relationship.

Table 2. Superordinate Themes and Subthemes, with Exemplar Abridged Quotes		
Superordinate Themes	**Subthemes**	**Key Quotes**
A Pathway Through the Jungle	Assessing Progress	"…look down over the jungle that we've been travelling through to assess how far we've come" (Tom; 17/521-573).
	A Grounding Focus	"it grounds the work and keeps things real" (Rico; 30-31/873-883).
	Enabling Positive Affect	"I think to me it's, I would like to think mainly, it energises hope and creates a sense of hope in clients… (Tobias; 13/405-411).
Invalidating the Therapeutic Journey	Forcing Rigid Goals	"And you have to not force people into boxes" (Annelie; 26/801-808).
	(Not) Sitting with Distress	"…We want to move you out of the despair to somewhere else and cheer you up, but we struggle to hear the struggle" (Pippa; 13/386-397).
	Promoting Client Failure	"A client can feel like they're failing if they're not achieving their goals" (Amber; 370-379).
Maintaining the Client Led Story	Preserving Space for Therapy	"It's not about getting from A to B it might be just getting comfier at A [laughs]" (Amber; 28/868-875).
	Bracketing the Therapist Agenda	"The important thing is to know it's you who's clinging on" (Alessandra; 26-27/819-826).
	Finding Meaningful Goals Through Relationship	"Goal achievement, happens within the context of a therapeutic relationship" (Amber; 35-36/1104-1116).

17. Superordinate Theme One: A Pathway Through the Jungle

All of the participants made sense of goal working as facilitating the therapeutic task; that is, as representing a *"journey"* for both client and therapist which could navigate and mark progress, as well as to change direction.

Hence, goal working was understood variously by participants through the metaphor of a *"journey", "jungle"* or *"voyage",* with accompanying checkpoints used to monitor or alter direction. These references seemed to lead to a combined recognition, from participants, that goal working could function as a map of the therapeutic task; that it necessarily permitted both therapist and client to chart their route and journey through therapy at the beginning but also, to pause and to check upon the journey travelled throughout, at times changing direction if needed.

This facilitation centred around progress monitoring which, in turn, enabled grounding within the therapeutic frame for both client and therapist. For many, this culminated in increased self-efficacy and positive affect within the therapeutic partnership. These aspects pointed to a positive representation of goals as they guide therapeutic progress.

17.1 Subtheme One: Assessing Progress

All eight participants experienced goal working as enabling monitoring of therapeutic progress. This subtheme captures participants' experiences as they make sense of ways in which goal working supports progress monitoring and navigation within the therapeutic relationship.

Tom remarks:

> *"…it's the bit where after cutting our way through the jungle, it's the bit where we climb up a tree... together [laughs] and look down over the jungle that we've been travelling through to assess how far we've come" (Tom; 17/521-573).*

Tom describes goals using the metaphor of a jungle. Goals enabled a view over the entire jungle as a result of climbing *"up a tree".* Tom sees goals as facilitating a *"look down"* from the tree *"over the jungle",* implying a greater view or vantage point from such a position, possibly over the course of therapy. Meanwhile, the idea of a *"jungle"* seems to acknowledge the potentially arduous therapeutic journey, one filled with different paths and directions, as well as dangers. I wondered whether his use of

"we", serves as a gentle reminder of the collaborative nature of GBP, in that client and therapist journey together.

Tobias experiences goals in a similar manner:

> *".. Kind of a sea voyage where you have these, kind of marker buoys. And I think that's where goals are quite useful is just kind of marking out a sense of where it is that you're going to and how to navigate that..." (Tobias; 7/194-201).*

Tobias likens the therapeutic journey to a sea voyage. His metaphor of the sea suggests the vastness and potential endlessness of the therapeutic journey, one in which many directions are possible. I wondered whether Tobias's metaphor carried a similar emphasis of meaning to Tom's notion of the *"jungle",* in that both might signify a vast landscape [actual therapy] in which multiple routes can be traversed, to reach the same destination [the goal]. Tobias' remark of the presence of the *"marker buoys"* meanwhile, as part of GBP, suggests easier navigation to the direction of therapy. As he seems to imply, goals may enable a sense of *"where it is you're going".* The combination of a sea voyage and navigation stirs within me an image of a compass, one in which goals enable a felt direction and destination.

Rico and Maura have similar experiences of goal working:

> *"...We'll use it as a kind of a marking of the journey that they've gone through you know erm, so.. 'we came in 6 weeks ago, you said that you were er, er felt terribly upset and isolated everyday you know and now you say, not at all'" (Rico; 6/138-147).*

> *"I would say it has to do with monitoring progress mainly, where we come back to goals on a regular basis even when they are in long term therapy and I would assess together where we're at on this goal, or how we can get closer to that goal, what we can do to work on that goal" (Maura; 4/110-118).*

Goals serve an important function for Rico. As well as allowing for a *"marking of the journey"* in which progress is continually monitored, they also enable reflection at the end of

the journey: *"that they've gone through".* It is perhaps at this point that client and therapist can look back together on the journey travelled so far. His language: "*we came in 6 weeks ago"* suggests his perception of the utility of GBP in reviewing progress with clients, almost as if a checkpoint had been reached, serving as a gentle reminder for clients to reflect and appreciate the progress made. Later on, however, Rico departs from his use of *"we",* to use *"they"* instead. I wondered whether this partly mirrored Rico's interpretation of GBP, that they allow a collaborative marking of the journey, but also allow for client independence, responsibility and ownership of the goal. In these terms, his switch to use of *"they"* may serve to individuate the goal.

Similarly, Maura likens the *"regular"* use of goals as a tool to assess progress or to make changes in the journey's direction. GBP seems to allow her to review progress and consider change. Maura's reference to long term therapy seems to indicate the use of goals to assess progress but also to survey the journey ahead: *"or how we can get closer to that goal".*

17.2 Subtheme Two: A Grounding Focus

Eight participants seemed to express an experience of GBP as grounding the therapeutic work in the immediacy of the therapeutic encounter, as it unfolded within the therapeutic dyad.

Rico remarks:

> *"it grounds the work and keeps things real and it makes that counselling bubble that you kind of get caught up in, it makes that something which is much more everyday life…" (Rico; 30-31/873-883).*

Rico's use of the word *"ground"* positions goals as concretising the therapeutic task; they tap into the *"everyday life"* of the client. It seems to come in contrast to his reference to the *"counselling bubble",* which implies an almost non-pragmatic focus. Specifically, I interpreted his use of *"bubble"* to implicate counselling as sometimes removed from real-world action or consequence; floating high in the sky, away from

the ground, or, in these terms, the life of the client. Additionally, his use of the phrase *"get caught up"* appears to imply a drift in the therapeutic frame, whereby the therapeutic work could move away from *"everyday life"* and hence, possibly, what matters. For Rico then, it seems to matter to him that counselling retains a focus towards *"real"* life. His phrase *"everyday life"* underscores the grounded nature of GBP and to me, conjures notions of emphasis towards the daily miniature of the client's experience. For him, GBP seems to helpfully enable this.

Alessandra discusses her experiences:

> *"I see it as giving some focus for the client to the work and introducing the idea about thinking about what they might want, or what they might need. It sort of looks like a little imagery about sometimes if someone is in a real fog of distress, that maybe the goal is like a little lighthouse. For some people" (Alessandra; 12/372-380).*

The potential focusing nature of goals work feels palpable in Alessandra's quote. In part, her metaphor of the lighthouse, seems to parallel with Tom and Tobias, who also remarked of the metaphor of the jungle and ocean. Here, Alessandra seems to position goals as beneficial for her clients as they can introduce an *"idea"* or suggestion of possible change, that their current experience could be different. As she illustrates vividly in her metaphor of a lighthouse, goals can be understood as a beacon of light amidst the *"fog"* of mental distress. Her use of *"fog"* arguably illustrates the potentially confusing and disorientating effects of mental distress, as if the beam of light from the lighthouse, illuminates a pathway away from experiences of distress.

Tobias shares his experiences:

> *"…it helps clients to be more aware of what they want, and what they want in their lives, and what they want in therapy. In that sense, it focuses the therapeutic work. I think it's a really nice way of not wasting time in therapy" (Tobias 22-23/690-696).*

Tobias seems to perceive that goals allow his clients awareness of areas of possible change, perhaps as a means to think through areas of focus or change. His phrase *"what they want"* clarifies Tobias's belief in the empowering effects of GBP, placing the client as the expert in their lives. I wondered whether his remark of: *"what they want, and what they want in their lives, and what they want in therapy"* signified a level of division, for Tobias, in terms of the client's psychological makeup, indicating, a separation between; their general wishes, their wishes in their daily life and their wishes in therapy, as if all three might refer to separate entities. This seems to parallel Rico's previous language change to *"they're",* in that it honours the autonomy and individuality of the client. Goals also focus sessions, which he feels is helpful and perhaps necessary: *"nice way of not wasting time".* His reference to *"wasting time"* alludes to the utility of GBP for prioritising areas of therapeutic change. Through such a positioning, the absence of GBP, at least for Tobias, might lend itself to therapeutic drift. This seems to connect with Tom's reference to GBP as mirroring *"everyday life".* Maura's shares her experiences:

> *"And not just in the NHS, but also in private practice. A lot of the time now clients come and say they don't want to be in therapy forever. They want to have something to take out with them and they want to have clear objectives" …With one of my clients, he really wanted to focus on goals" (Maura; 3/69-80).*

Tobias' previous suggestion that GBP, might focus sessions, and thereby prevent *"wasting time",* seems to align with Maura's experience here. Accordingly, goals can be understood as a tool for providing *"clear objectives",* thereby focusing the therapeutic task. Maura draws comparison between NHS work and her private practice, to suggest a client's wish for time-limited therapy, even in private practice. Her use of *"now"* perhaps indicates her awareness of a change in the private therapeutic climate towards focus on outcomes and focused work. For Maura, the focusing nature that

goals permit, seems to align with her clients' interests: *"they don't want to be in therapy forever".* I interpreted her use of *"forever"* as implying her belief in the potential aimless direction of therapy, without GBP. Thus, she seems to make sense of GBP as a means to focus session, in accord with the wishes of her clients: *"he really wanted to focus on goals".*

17.3 Subtheme Three: Enabling Positive Affect

For five of the participants, the combined effect of having a tool to monitor direction and progress, as well as, a grounding focus for sessions, aided belief in the potency of the therapeutic relationship for instigating valued change. Explicitly, as the journey progressed and clients and therapists monitored progress collaboratively and continued to focus their sessions, a renewed sense of hope and self-efficacy regarding tangible change emerged. This increased self-efficacy was felt to by a product of GBP, as Tom remarks:

> *"…and I think that that conversation about goals is a great opportunity for them to really experience how much progress they've made to feel satisfaction in that, pride in that, maybe relief, all sorts of emotions" (Tom; 18/19-567-577).*

Tom seems to recognise GBP as a possible tool to embed client self-efficacy. Working with goals permits an acknowledgement of the progress made. This contributes to increased feelings of pride and perhaps self-worth for his clients, as they *"really experience how much progress they've made".* This perhaps indicates the possibility that clients and therapists may somehow discount or ignore their achievements if such an *"opportunity"* [GBP] is not utilised. GBP might, therefore, allow recognition of therapeutic progress as well as resultant feelings of achievement.

Rico shares his experience:

> *"When the client can see that they are making progress on something that they haven't been able to make any progress on up until they went to counselling, it then helps them believe in counselling, it helps them believe you know, this is*

> *something different and it's actually moving me forward in my life" (Rico; 17/477-489).*

Rico appears to perceive GBP as allowing the client to witness *"progress".* This supports an increased belief in the value of the therapeutic task itself to promote change. His wording, *"this is something different",* arguably implies Rico's belief in his clients' possible surprise or even disbelief at change, as if they had had low expectations about change. Working with goals quickly permitted Rico's clients to realise change was possible: *"it's actually moving me forward in my life"*. I interpreted, his use of *"moving me forward"* as indicating a level of tangible change for his clients, that contributed to feelings of positive affect. In this extract, Rico does not seem to make sense of increased self-efficacy as solely emerging from achievement of a goal alone, as in goal attainment, as his use of emphasis on present tense process possibly indicates: *"making progress"* rather than achieved or made progress. Specifically, Rico does not appear to see goal attainment and positive affect as mutually exclusive. Rather, he positions the process of goal setting and monitoring as conducive to supporting belief in the potency of the therapeutic frame, as well as, the generation of positive affect.

Tobias describes his position:

> "I think to me it's, I would like to think mainly, it energises hope and creates a sense of hope in clients… (Tobias; 13/405-411).

Tobias seems to make sense of GBP as providing hope for clients, as he explicitly refers to GBP as energising hope. His use of *"in clients"* implies a level of internalisation of hope within the client, as if to suggest GBP fosters an internal quality or psychological structure, in this case, hope, for clients. For me, the concept of hope provides a striking parallel and overlap to experiences of increased self-efficacy. Goals seem to enable the

experiencing of positive affect, which seems connected with belief in the possibility of change.

18. Superordinate Theme Two: Invalidating the Therapeutic Journey

All participants described characteristics of goal working which they felt could cause harm to the therapeutic alliance; functioning unhelpfully, to draw both client and therapist away from the therapeutic journey or path.

18.1 Subtheme One: Forcing Rigid Goals

Four of the participants felt that working with goals in a *"rigid"* or *"strident"* way often diverged therapy away from the client's wants and needs, experiencing early or premature goal setting as detrimental to the therapeutic task. Premature goal setting was felt to *"distort"* or *"impose an agenda"* on the client's material.

Tom seems to feel this palpably:

> *"I can think of folk who come in… in a very distressed state for example, or perhaps not, not distressed, a perhaps almost subdued mute state, where they are really struggling to express anything and in those sorts of scenarios it just it feels so clunky and... erm, non-humanistic to ask that person: 'could you please give me a specific measurable achievable realistic and time-bound goal?' [laughs] obviously you wouldn't use those, those words, but my experience has been that most people in that situation really struggled to articulate" (Tom; 8/245-258).*

Tom highlights the perils of goal work with clients who are distressed or *"subdued",* suggesting the potentially *"non-humanistic"* and forced side of goals. His employment of *"non-humanistic"* seems a strong term, which perhaps emphasises his belief in the potentially invalidating or non-client led approach, that goal working might afford. He utilises humour, arguably demonstrating his felt belief in the absurdity of using goals in a rigid manner, such as the proposed model. I interpreted that Tom felt goals could be demanding for an actively distressed client, through his use of sarcastic humour and his

example of what might reflect an overbearing intervention: *"could you please give me a specific measurable achievable realistic and time-bound goal?' [laughs]"*. Tom's laughter perhaps points to his belief in the futility of goal working during acute periods of client distress. As Tom suggests, working with goals in this way would not only be forced and rigid but would also potentially seem meaningless for such clients.

Maura also shares:

> *"If the therapist comes up with the goals form or with the goals work, it's kind of infringing on the client's space and putting a positive frame for them, which they haven't welcomed and they aren't really ready to work with" (Maura; 12/369-374).*

As Maura suggests, if the therapist *"comes up with"* the goals work, there is a risk of *"infringing"* the client's frame of reference. Her use of *"infringing"* here, perhaps suggests a belief that clients may feel violated, hijacked or disregarded by such goal use. In particular, her phrase *"comes up with"* denotes a potentially non-client led encounter in which goals are transposed onto a passive client. The phrase *"positive frame"* perhaps describes a promotion of idealised or artificial state of being or living, which is not necessarily welcomed or desired by the client themselves. I interpreted her comment: *"haven't welcomed and they aren't really ready to work with*" as stressing the potential negative therapeutic ramifications of goal work, as if the client may stall or seize up.

Annelie similarly reflects:

> *"and you have to not force people into boxes or to – to give that to you early because that's distorting what they're wanting..." (Annelie; 26/801-808).*

Annelie seems to equate forcing goals to *"distorting"* a necessary client reality, which has marked overlap with Maura's experience of goals as potentially *"infringing*" the client's narrative. The suggestion that goals may *"force people into boxes"* provides a salient illustration of imposed goal working, perhaps one which views the perils of goal working as

having the potential to contribute to standardised approaches to therapy, that discount the individual, through *"forcing"* a reality for them. For Annelie, it seems she feels that goals, which are not client-generated, or are generated prematurely, can distort a client's therapeutic needs and wants. Again, her use of *"distortion"* seems to underline a belief in the potential for goals, if used forcefully, to interfere with or misrepresent the client's goals or wishes. Tom reflects on the consequences of imposed goal working:

> *"...to impose a structured and explicit erm discussion about goals…erm and I'm not sure if it'd be helpful and moreover I think if you, if I did it, erm and I think it, it wouldn't be on... I think the other person might reasonably look across at me and say 'have you not been listening? Do you really need me to spell this out for you?'" (Tom; 10/294-302).*

Tom provides a clear example of non-relational goal working which serves to *"impose"* structure, leading to bewilderment and disconnection in the therapeutic relationship. His word to *"impose"* evokes notions of forced, procedural working, that again, parallels the experiences of Annelie and Maura. The bewilderment that Tom feels this would create for his client is emphasised through his imagined client response: *"Do you really need me to spell this out for you?".* Such relational rupture would be underscored by Tom's sense that the therapist was not *"listening"* and thus not attending to the client's needs.

Interpreting further, I wondered what Tom would possibly feel here, as a therapist, responding to this hypothetical interaction from his client. Indeed, from the imagined tonality and emphasis he positions in the client's rhetorical response, I discerned a level of surprise and frustration from the client. I wondered what this might trigger for Tom. In these terms, the language of: *"do you really need",* perhaps implies the sense of failure or inadequacy that Tom might feel in hearing this from a client. On an emotional level, I wondered whether Tom might feel some level of shame here, if he were to hear this from a potential client and what sense this might provoke in him, such as potential failure as a therapist. From Tom's

comments, I interpreted a deep discomfort, at feeling he has not connected, or has glossed over his client's needs through *"impose[d] structure[d]".* Moreover, on a functional level, his vivid illustration of micro-conversation between client and therapist perhaps, for Tom, functions to emphasise, his commitment to and, awareness of, his priorities for his practice; specifically of listening and tuning into his client.

18.2 Subtheme Two: (Not) Sitting with Distress

Four of the participants seemed to feel that goals introduced a tension into the therapeutic relationship which endangered the therapeutic containment of their sessions. This occurred when too much focus was given to the destination, resulting in therapists not *"sitting with"* their client's distress in the therapeutic encounter.

Pippa reflects:

> *"Goals can be as useful as they can, but they can also be damaging if we don't understand how… I see this with new therapists. I'm 12 years in but when I'm supervising new therapists... We want to move you out of the despair to somewhere else and cheer you up, but we struggle to hear the struggle and to really hear that because it's too distressing. So, we're trying to kind of move you out" (Pippa; 13/386-397).*

Pippa seems to believe it is common for therapists to move clients on from their distress. Her repetition of *"to move out"* can be seen to place emphasis on therapy as a task which is to be achieved, almost as if therapy is rolled out and delivered to the client as a commodity, without reference to being with the client through the process of their *"struggle".* For Pippa, such a position is *"damaging"* and seems to be a process she witnesses within *"new therapists".* I wondered whether her explicit highlighting of her 12 years of clinical experience perhaps served to draw a line between her and other *"new therapists",* seemingly making her different: *"...I'm 12 years in but when I'm supervising new therapists".* In essence, I wondered whether her remark functioned as a defence of her

own therapeutic conduct. Her use of *"struggle"* perhaps evidences Pippa's humanistic appreciation of her client's distress, as normative and comprehensible, considering their life experiences, which represents a contrast to terms such as, disorder or disease. I interpreted her comments as potentially implying a level of avoidance by therapists, who struggle to contain their client's difficulties and hence focus on the destination rather than listening authentically to distress. For me, what emerges here is the therapist's sense of anxiety, which points to an aversion of the client's distress. Thus, goals might be understood as a tool to defend against discomfort arising from listening to a client's *"struggle"* or distress. Meanwhile, Pippa's comment here goes someway to humanising the therapeutic encounter, by recognising the shared humanity between therapy and client, in that therapists too, as well as clients, can *"struggle".*

Tom says:

> *"I think in those days goals were.. I would probably erm.. when I did eventually use them early in my career, I probably would have over focused on them I would have over fixated on them erm because I was so concerned about helping this person, so concerned about making this therapeutic work successful erm … with experience I guess, I've learned that erm I hate this expression but to 'trust the process'" (Tom; 14/15-437-457).*

Pippa's warning about not sitting with a client's problems and instead focusing on the destination seems to align with Tom's reflections on his *"overuse"* of goals earlier in his career. He links their overuse to anxiety regarding his competence, suggesting he previously attempted to mask his anxiety by overcompensating and *"fixating"* on goals. As Tom continues, he reflects on the potential consequences of this by indicating that he is more attuned with and trusting of the *"process"* now. His use of *"trust the process"* coupled with *"I hate this expression"* made me curious as to whether some level of shame may lie beneath his comment.

Moreover, his use of *"when I did eventually"* seems to allude to an initial resistance in his therapeutic career, where perhaps goals might not have represented the same meaning for him as they currently do. Additionally, I interpreted an ironic mismatch between his desire for *"helping this person"* and a feeling of over fixation, as if through *"concern"* for his clients *"early in his career",* he ironically ended up fixating on the goals.

Maura says:

> *"…I think goals at times can be a little bit… misused in the sense that they can be an artificial structure where we talk about them because we're used to talking about them and maybe it comes in the way of the actual process of doing the therapy and we're just talking about the meta-therapeutic skeleton of the therapy as opposed to doing the therapy" (Maura; 5/145-154).*

Maura seems to caution against goal enmeshment; she highlights a potential *"misuse*" of goals, which can sometimes be employed routinely. Her phrase: *"where we talk about them because we're used to talking about them*" arguably implies a level of resigned awareness of the use of goals as part of therapist etiquette, rather than because they are efficacious. Meanwhile, her use of *"we"* seems to imply recognition of her own part in using goals in an almost blanket approach, because they are part of the therapist toolkit, rather than necessarily because they might be therapeutically helpful for clients. Accordingly, Maura seems to perceive goals as a framework or *"skeleton"* for therapy, but their blanket use risks detracting from the therapy.

18.3 Subtheme Three: Promoting Client Failure

Whilst five of the participants felt goal working carried the potential to aid positive affect in the therapeutic partnership, a polarity emerged whereby seven therapists reported that GBP risked aiding a climate of failure through the introduction of goals.

As Amber and Alessandra comment:

> *"I also think it can be really difficult because I think a client can feel like they're failing if they're not achieving their goals..." (Amber; 370-379).*

> *"It feels like for some people it could be there is a goal if you don't achieve the goal then you've failed…" (Alessandra; 21/653-657).*

Both Amber and Alessandra seem to perceive that working with goals carries the potential for instilling a sense of failure in their clients. Accordingly, their remarks position goal attainment, or lack of, as integral for later psychological functioning in their clients. As such, Amber and Alessandra seem wary that the potential non-achievement of goals by their clients could lead to feelings of failure. Alessandra's remark that: *"if you don't achieve the goal then you've failed"* implies clients' internalisation of goals. Thus, the task of therapy could become goal attainment, rather than emotional processing, and therapy's success, or general living, becomes synonymous with achievement or, rather, non-achievement of the goal.

Alessandra reflects further:

> *"…especially if they had a goal that reasonably would be unobtainable for them at the moment, which then would feed into their depression. Do you see what I mean? Becomes a negative spiral" (Alessandra; 16/494-499).*

Alessandra describes a sense of unease in working with client goals which are felt to be *"unobtainable".* From her remark, it seems for her, the *"unobtainable"* goal can detrimentally reinforce a client's difficulties. Her suggestion of a *"negative spiral"* implies a cascading or self-fulfilling effect whereby failing to achieve unrealistic goals feeds into the client's negative view of themselves, maintaining their depression.

Tobias and Tom share their perspective:

> *"It can be hard if you're not getting towards... There was a client who's been saying to me actually, it was you know, where they seem to measure it kind of fluctuates up and down and you expect that, but with the goals measure that's*

> *like really important and you want to progress on that, and if you're not, then that feels more personal and that feels actually more demoralising than getting worse on the symptom tracker" (Tobias; 15/450-460).*

Similarly, concern over potential client failure emerges as prominent for Tom:

> *"… they set people up to fail, you know, so if somebody comes in and they set a goal and you're, you're working way towards it and erm it creates, it can within some people, create the sense that if they're not achieving that goal that they're failing" (Tom; 32/1009-1015).*

Tobias seems to perceive goals as carrying a risk of creating a feeling of failure for his clients, particularly if they take on a personalised or localised meaning. He describes his clients' difficulty when they do not see progress towards their goals. He compares goal work to the standardised outcome monitoring (*"the symptom tracker"*), placing goals as "*more important"* to the client, owing to their personal nature, in that they are tailored to each client. Tobias sees the non-achievement of goals as more *"demoralising"* than non-achievement of psychometric change. Conceivably, Tobias feels that the idiographic nature of GBP means they carry more meaning if the client fails to achieve them.

Meanwhile, Tom suggests goals *"set people up to fail".* His language is initially explicit, suggesting it is inevitable that goals create failure if not achieved. The language at the end of the quote becomes more tentative, however, as he suggests goals can create a sense of failure *"within some people"*. This suggests variability and nuance in the meaning goals hold for clients and therapists, and how this might feed into their self-efficacy.

Alessandra offers further reflection:

> *"It could be that the person doesn't want to address whatever it is that's causing them the most distress for whatever those reasons are. Unconsciously they are avoiding that goal and it could be that they're just too vulnerable, or too frightened to achieve that goal. It could be that their self-esteem or their*

> *feelings of self-worth, or their feelings of self are so battered or broken, or not available to them that they can't focus on the goal" (Alessandra; 9/266-277).*

Alessandra discusses her perceptions of clients' possible emotional processes connected with goal working, where the client: *"doesn't want to address whatever it is that's causing them the most distress".* She seems to locate the client as responsible for avoidance of goal working, suggesting negative psychological processes such as low self-esteem and related anxiety as barriers to goal working. However, questions arose for me about Alessandra's role in contributing to this cycle and I wondered whether there was a level of projection at play here. For example, there seems a level of absence of her own positioning as a practitioner alongside her client. I interpreted that Alessandra could be describing her own feelings of anxiety about what goal failure may induce in the client and what this says about her as a practitioner, rather than as merely reflecting the anxiety of her client.

19. Superordinate Theme Three: Maintaining the Client-Led Story

In the prior superordinate themes, participants positioned goal working as helpful for the therapeutic relationship but also as potentially harmful and leading to a dehumanisation of the therapeutic encounter. Reflecting on these experiences together seemed to permit participants a means of negotiation that allowed for the integration of a relational goal working. Hence, whilst participants previously discussed the benefits of goal working (superordinate theme one), many were aware of a simultaneous dialectic in the therapeutic relationship if goals were not held tentatively or integrated relationally, with respect for the client's narrative (superordinate theme two). Non-relational ways of goal working were felt to be characterised by overly rigid goals, avoidance of distress and fear of creating a sense of failure. This final theme explores therapist experiences of integrating goals into a relational therapeutic frame.

19.1 Subtheme One: Preserving Space for Therapy

Five of the participants made sense of goal working as one part of the therapeutic story. Effective goal working, however, should not negate the main task of therapy; hence a "*gentle balance"* (Pippa; 19/588-592), was necessary for understanding the client in the process of their distress whilst simultaneously supporting them move towards a new and valued direction. In these terms, therapists seemed wary of a dichotomised approach to goal working, where goals were either set or not set, but rather understood therapeutic goal working as combining emotional containment for clients with a focus on end destination.

Pippa reflects on balancing goal work alongside *"sitting with"* the immediacy of clients' distress:

> *"It's got to be a gentle balance of pushing and pulling and sitting with. As I said, they can be as destructive as they can be helpful if you don't get the balance and the timing" (Pippa; 19/588-592).*

Pippa sees goal working as one part of the toolkit of the therapist. Her phrase: *"a gentle balance of pushing and pulling and sitting with",* for me, conjures the idea of a set of scales and suggests Pippa adopts a flexible outlook in her therapeutic practice. Pippa understands the importance of *"pushing and pulling",* using this idea to make sense of and employ a goal framework in her practice while recognising the importance of *"sitting with".* Her suggestion of *"sitting with"* arguably represents her work with clients, where the task might not be to look for what can be changed but rather to simply acknowledge the client's distress. Pippa seems to indicate the potential for therapeutic rupture if this balance is not met through her use of *"destructive".*

Rico shares a similar perspective:

> *"If someone has just suffered a loss, they just lost someone in their lives right, then sometimes they just need to, you know tell the story of that person and to*

> *try and you know so, sometimes I'll hold back on asking them about goals, because they just need to get it off their chest right" (Rico; 28/797-804).*

Here, Rico seems tempered in his approach to using goals stating that sometimes he will *"hold back"* from goals to allow clients to express their difficulties in their own terms. Rico is highlighting the necessity of the therapist allowing for some level of client emotional processing, so as to persevere space for therapy. I interpreted this notion of holding back as fuelled by a desire to contain and validate his clients in their distress, perhaps through emotional attunement with their needs, in the here and now of the unfolding therapeutic encounter. His language of *"tell the story"* perhaps reveals his belief in the necessity of allowing space within therapy, so as to honour the client's narrative or story. His example of the need to not set a goal with a client experiencing bereavement underscores his belief in the value of allowing clients time to process. Meanwhile, his suggestion to *"hold back"* from a goal, rather than dispensing of them entirely, seems to acknowledge a possible tension that a therapist may hold.

Rico's strategy of pausing from goal work rather than dispensing with it entirely is further highlighted below:

> *"So sometimes I just, I just let that story run for, you know for a whole session and we might not then ever get to a goal initially right erm and then the next session we'll have to say "ok now that you've kind of got that off your chest, in relation to that story, what direction do you want to go?" (Rico; 29/817-824).*

Rico seems to allow his clients time to process but also seems to recognise a need to establish direction with his clients. From this interpretative vantage, Rico is giving his clients autonomy, allowing them to be authors of their journey. Accordingly, I feel Rico adopts a tentative frame, perhaps being mindful of an eventual guided therapeutic frame for his client but also aware of the need to allow clients to navigate their journey through this frame. Of

note to me from this account is the desire to show empathy and support to the client while also supporting them with interventions to move them on from their distress.

Annelie reflects on her experiences of balancing therapy with end destination:

> *"I don't think it's [using focused therapeutic goals] a sin or something to do it that way but I think usefully it might be good to focus on the process, the direction of the counselling with intentionality of the client, 'I want to go this way, I want to, to work on this as opposed to, this is where I want to be at the end of this'" (Annelie; 43/1350-1357).*

Although Annelie does not position a goal-focused frame as *"sinful"* and hence fatal for the therapeutic encounter, she does express a preference for a focus on the immediacy of the encounter, as opposed to end destination. Her use of the word *"sin"* conjures moralistic dimensions, perhaps revealing the strength of her belief in the negative implications of such goal working. Additionally, I considered whether this remark may function as an almost defensive act of Annelie, whereby she expresses, explicitly, the appropriateness and suitability of working with goals. Indeed, perhaps her choice of the word *"sin"* may also connect with the prejudice she perceives other practitioners might have in relation to this type of therapeutic activity.

Meanwhile, I interpreted her use of the word *"process"* as indicating the immediate work of therapy unfolding between client and therapist. Her remarks point to a desire to give her clients a sense of ownership for their therapeutic journey, which includes a sharing of responsibility, based upon the intentions of the clients. For Annelie, the *"process"* of therapy and the journey itself, rather than end goal, are what matter and in these terms, we might understand the significance Annelie positions on preserving space for the process of therapy.

Similarly, Amber reflects on her experiences of situating goals within the wider frame of the therapeutic journey:

> *"...I think I say, I go to great lengths to explain that, but it's not about getting from A to B it might be just getting comfier at A [laughs]" (Amber; 28/868-875).*

Amber places importance on normalising the therapeutic journey with her clients, one that is not necessarily marked with the need to change, but rather, to experience the process of therapy. She will explicitly explain to her clients that therapy is not exclusively about moving towards a new or valued direction [the goal] but rather may encompass a level of acceptance in present circumstances, emotions and being. I interpreted her remark as allowing clients a choice of movement away from current circumstances [goals] on the one hand or supporting the client to process and accept present circumstances on the other. Although therapeutic acceptance could be understood as a goal in itself, Amber contrasts being with the client through their distress, sometimes helping them to *"get comfier",* with moving them towards a different experience.

Maura holds a similar appreciation of the value and integration of goals work in relation to the grander narrative of therapy:

> *"Goals are important for the process, but maybe not with the meaning that we ascribe to them a lot in our modern society of achieving a clear target. It's more about sensing client's direction as well as being with them in the present moment" (Maura; 18/563-569).*

Maura acknowledges the importance of goals, while least partially refuting their operationalisation in therapy as *"a clear target"*. Maura's sense of goal working seems to draw on the relational components that underpin the task of therapy, which is somewhat antithetical to a solely achievement orientated frame. Accordingly, she positions goals as valuable for *"sensing direction"* but also for enabling being *"with"* clients in the *"present moment".* Of note is a feeling that goals can be used as a gentle framework without being the sole focus in themselves. Simultaneously, there is a partial reflection on the socio-political.

Specifically, I interpreted Maura's statement as critiquing the influence of a modern, goal-orientated zeitgeist in therapy and potentially society at large, as functioning to shield her clients from social expectations, rules and norms. Instead, she desires a different experience for her client, one in which the primacy of the therapeutic space is maintained.

19.2 Subtheme Two: Bracketing the Therapist Agenda

Four participants reflected on how their agenda and role in goal setting was felt to permeate the relationship formed with their clients. For participants, adopting a reflexive position provided insight into how their own goals and wishes were sometimes projected onto those of their clients. Hence, it was felt a questioning position of self was useful in detangling therapist goals from those of their clients, supporting therapists to step back and allow the client to determine their own direction.

Pippa reflects:

> *"Then there's our goals, our agendas, and our goals and I say that in a way that owns that. When you're working with somebody who's very depressed and demotivated then our goals may be to liven up the client and maybe to get them to explore coping strategies, maybe to get them to explore creative pursuits as expressions for themselves. Well, I think us therapists also come, whether we own them or not we come with our goals but as well" (Pippa; 3/83-94).*

Pippa highlights the presence of a therapist *"agenda"* within the therapeutic dyad. She provides an example of goals that therapists may hold when working with client depression. Her comment "*whether we own them or not"* highlights the potentially covert characteristics of a therapist agenda as well as her belief that such agendas are present regardless of whether they are acknowledged by the therapist. Her use of *"our goals"* perhaps points to Pippa's belief in the collaborating and co-constructed nature inherent in goals work, as client and therapist journey together, but that also carries at times, negative ramifications for therapy. Pippa sees value in

"owning" her wishes for her clients, suggesting the presence of an interwoven warning here, firstly to herself and secondly to other therapists, to become aware of their own agenda: *"whether we own them or not".* For Pippa, perhaps this awareness functions to deter the imposition of her agenda onto the client.

Alessandra also feels it is important for therapists to own their goals for their clients:

> *"…and try not impose your, that's something I have in mind as a practitioner is, people come in and I have goals for them in my mind, I have…Again, going back to what I said before, which will be wishes or desires for them and trying not to impose them on to the client. So, to me, that's really important as well" (Alessandra; 717-725).*

Alessandra's use of *"impose"* suggests enforcing a narrative or language onto the client, which seems to mirror earlier therapists cautions of goals as potentially detracting from therapy. Her language appears unequivocal in acknowledging the existence of therapist goals for their clients, almost as if this points to an inescapable reality for therapist. For Alessandra, however, a way forward seems to be located in acknowledging or holding in *"mind"* therapist goals, so as to prevent goal imposition. I wondered whether Alessandra might be referring to a reflective process on the part of the practitioner whereby, the therapist's own goals, for their clients, are explicitly acknowledged and thus moved from a subconscious level to a conscious one, in order to prevent a felt imposition onto the client.

Maura says:

> *"So, going alongside them aligned with their direction and helping them reach or go where they want to go as opposed to having our own goals and assumptions. Really respecting their direction, not what plans we have for them" (Maura; 18-19/569-575).*

Maura places strong value in being *"alongside"* the client. Her comments seem to imply empathic guidance and humility, rather than assuming what is best for the client or the direction that they should take. By saying *"not what plans we have for them"*, she is

acknowledging the reality and existence, of therapists' wishes for their clients. I recall feeling a level of frustration in her tone as Maura said the above words. This frustration was possibly directed at envisaging a clinical relationship with clients, which serves to restrict their direction, but instead places the therapist's directives as paramount. In contrast, for Maura, much like Pippa and Alessandra, it seems such a way of therapeutic working is not consistent with her professional identity and practice.

Alessandra adds to her experiences:

> *"The important thing is to know it's you who's clinging on to there [laughs]. I think it's important to know that distinction for yourself. For me, it's like, "Okay, what's happening here today, with this, who's using this?" Are we using it more than the client, do you need it more than the client today?" (Alessandra; 26-27/819-826).*

Alessandra believes that acknowledging and taking authorship of who wants the goal is an important component of goal working. Her use of the words *"clinging on"* suggests a level of anxiety underneath goal processes that necessitates adherence to a goal. I wondered whether this anxiety might be connected to her sense of clinical competence. Reflecting on participants' earlier experiences of goal working as enabling a journey through a jungle may provide an important clue here, possibly due to the direction and focus that goals were felt to provide (superordinate theme one). Her laughter possibly indicates her discomfort that she as a therapist has goals and plans for her clients, on top of their own, and that these may function to placate her own anxiety at times. I wondered whether this discomfort might revolve around her realisation of the almost indispensable nature of the therapist agenda; although it might be bracketed, it will still be present. As she goes on to suggest, however, a useful strategy for untangling and bracketing the wishes of her clients from her own is located in critical and continual self-questioning on the part of the therapist: *"Okay, what's*

happening here today, with this, who's using this? Are we using it more than the client, do you need it more than the client today?"

Pippa reflects:

> *"I think they're important but again they have to be held loosely otherwise we can end up either bullying clients or getting overly frustrated because they're not hitting the goals that we might want them to" (Pippa; 31-32/984-989).*

Pippa perceives that the answer to disentangling the goals and wishes of therapist and client is connected with how the goals are framed and held. She acknowledges that therapists hold goals and states that this can lead to bullying of clients or therapist frustration. Her reference to *"bullying clients"* seems to underscore her belief in the potential potent function of goals as harassing or taking clients away from their own therapeutic path. It is interesting that she uses, the word, *"bullying",* which I understood as intimately imbued with connotations of power imbalance. For Pippa it seems that holding the goal *"loosely"* might function as a possible solution or point of integration, against the imposition of therapist goals onto the client and hence, as one means, to bracket the therapist agenda.

19.3 Subtheme Three: Finding Meaningful Goals Through Relationship

Seven of the participants experienced the need to build a relationship before initiating goal setting and therapeutic direction with their clients. Goals were, therefore, felt to be complex and multi-layered, and working with them appropriately required emphasis on the therapeutic relationship. Accordingly, authentic and meaningful client goal setting was a long-term process that evolved within the context of that relationship.

Amber remarks:

> *"So, the first thing that springs to mind, is that goals, goal consensus, goal achievement, happens within the context of a therapeutic relationship. So, to my mind, without that, nothing happens anyway. So that they're not separate to the*

> *relationship, they're part of the relationship. That a client's not, if they don't engage with me, then they're not going to engage with their goal, their therapeutic goal. So, something about paying really close attention to the therapeutic relationship" (Amber; 35-36/1104-1116).*

Amber provides a clear understanding of how goal work can be understood as being intimately interwoven within the therapeutic frame. Her repetition of *"goals, goal consensus, goal achievement"* serves to emphasise the breadth and all-encompassing nature of goal working, that for Amber, remains always connected with the therapeutic relationship. For Amber, goal working cannot happen within a therapeutic void but rather is predicated upon *"the context of a therapeutic relationship".* In these terms, she seems to position the therapeutic relationship as primary, as if without this, subsequent goal work will be futile. I interpreted this as implying the inseparable nature of the therapeutic relationship from the interventions – and goals – built within this.

Tom, meanwhile, shares his experience:

> *"I remember one woman... I asked her if she had a particular issue that she was struggling with...she said she wanted to "feel less meh". That was it [laughs]…She was able to articulate that goal in a way that if we'd written it down or just used words erm I think it probably would have left out half, the half quality and meaning, but because it was it was erm, it was multi-dimensional I suppose erm, then I, I knew perfectly well what she meant and we knew then later on when she got to the point where she was feeling less meh, actually and we could bring the work to an end" (Tom; 11/324-346).*

Tom seems to see an empathic therapeutic relationship as permitting an understanding of client goals, which have not been immediately articulated. He discusses an example of clinical work where a client was not able to articulate a specific goal but instead wanted to "*feel less meh".* I conjectured that *"meh"* might indicate a feeling of general malaise or

distress, as if the client, in that moment could not vocalise the core of their distress, however, they were able to state a desire to move beyond their current feelings.

It seems plausible that Tom's laughter, which was gentle in tone, points to his amusement with the client's articulation of their therapeutic wants, suggesting he connected with her felt reality. Tom seems to use this example to illustrate the complex and *"multi-dimensional"* nature of goals work as having the potential to transcend verbal language. It struck me that despite the lack of perceived verbal clarity regarding the goal, Tom felt able to understand it: *"I knew perfectly well what she meant".* He appeared to be able to stay close to the client's organic material as her language resonated with him. Here then, goals are positioned as complex and embodied in both the client's behaviour and the therapeutic relationship. Perhaps for Tom, the therapeutic relationship offers a window to discern goal complexity when ambiguity is present. Tom used this understanding of his client, formed through relationship, to grasp his client's goals and *"bring the work to an end".* I interpreted this process as Tom acting as a container of an abstract material *["feeling meh"],* almost as an interface or processor for material otherwise difficult for the client to translate.

Annelie says:

> *"It's [goal working] about having a strong empathetic relationship with the client where they feel comfortable and accepted and able to talk about what matters most to them and to feel like the counsellor is responding to that and taking on board what, what they want, so they feel, um, empowered to achieve that because they've got someone supporting them through that..." (Annelie; 38/1196-1205).*

For Annelie, goal working does not happen in a vacuum but rather is intimately connected to the depth of the therapeutic relationship. Her use of, *"strong empathetic relationship…"* conjures up emotions connected with compassion, genuineness and authenticity. By emphasising this relationship as the vehicle for change, Annelie states that

without this relational framework, clients may not be authentic in disclosing what *"matters most to them".* Accordingly, Annelie places principal importance on perceiving and listening to the needs of her clients, as if the therapeutic relationship, offers her a tool through which to bring to the fore, and to magnify, the clients true authentic wants or goals.

Tobias offers his reflections:

> *"And I think the challenge is to find goals but I think also the challenge is finding goal that are meaningful to clients. Um, you know, and if you do goal work very early [coughs]... I think goals…setting goals takes a lot of work, and I think if you just ask them what your goals are, then I don't think you get anything particularly rich" (Tobias; 16/481-490).*

Tobias describes the challenge of finding *"meaningful"* goals and cautions against procedural goal working, which he believes produces superficial goals. I interpreted his reference to *"… I think if you just ask them…"* as implying the need for collaboration in the therapeutic relationship as a principal tool to set meaningful goals with clients. For Tobias, it seems that goal working requires more than asking questions of clients, rather it requires active collaboration in the therapeutic relationship. Indeed, his use of the word *"rich"* suggests a paralleled sense of goal poverty, in terms of a lack of depth and authenticity, if goal setting begins *"very early".* Thus, we can infer that Tobias sees premature goal working, without a relationship, lending itself to a deficiency or lack in goal processes. I wondered also whether Tobias' remark spoke of his disillusionment in his client's ability to be aware of and articulate their own goals from the beginning of therapy. I interpreted that, although on one hand this may seem disempowering for clients, on the other, it could be seen as an empathetic act of understanding, that they might not readily have the instruments and clarity to express their deepest wants and desires, from the beginning of the therapeutic venture.

Amber discusses her experiences:

> *"...I think that that [goals] takes a long time to emerge, so that actually, in clients having the confidence to articulate their own goal. It can be quite far into the work. Um, I think goals are multi-layered" (Amber; 14/422-434).*

Mirroring Tobias, Amber seems aware of the time needed to collaboratively set and work with client goals, which take *"a long time to emerge".* Perhaps for Amber, as well as for Annelie and Tobias, goals should not be rushed but should emerge through relationship. Amber's use of *"confidence"* suggests a level of client meekness over sharing their desires, in particular early on in therapeutic work, with the implication being that the therapeutic relationship can be a way to establish client confidence and trust and goals may flow naturally out of a cultivated therapeutic relationship. Her comments suggest a correlation between client goal articulation and the therapeutic relationship, as the therapeutic relationship offers clients support to articulate their *"own"* confident goals.

In the above extracts of this subtheme, many participants spoke of the therapeutic relationship as the cornerstone of goal work and as intimately interwoven with the client's therapeutic wants. In contrast, Amber speaks of different dynamic:

> *"I think that my experience with clients is that even when we're trying to be as collaborative as we could, can and set goals, I'm, I'm conscious that we have the power and I'm conscious that quite often clients want to please us. So, I'm really aware of that when I'm talking about goals, that I'm really, I'm really aware that, that they might be trying to please me" (Amber; 39-40/1230-1251).*

Adding to her earlier comments about the importance of building a therapeutic relationship through which goal working progresses, Amber now offers a critical reflection on meta-therapeutic processes relating to goals work. Drawing on her clinical experience, she draws attention to the inherent power dynamics of the therapeutic alliance: *"I'm conscious that we have the power".* This seems to partly mirror Pippa's (Pippa; 31-32/984-989) earlier acknowledgement of goals as potentially contributing to a *"bullying"* of clients, if the

therapist is not mindful of their own agenda for their clients. Here, Amber, seems to suggest that, regardless of collaboration in the therapeutic relationship, a level of power differential remains. For her, this power differential can impact goal working in ways that push clients to *"please their therapists".* Thus, she offers a caution against an almost naïve assumption that building a therapeutic relationship alone will allow for open and authentic goal working.

Chapter 5. Discussion

20. Overview

In this chapter, the findings from the IPA analysis will be discussed and contextualised within the existing psychological literature. The presentation of this chapter will follow a similar thematic framework to that presented in the previous analysis chapter, so as to aid understanding and logical flow. In order to aid deeper psychological theorising, however, some sections will be punctuated with additional links to theoretical concepts. In maintaining a reflective frame throughout, in being conscious of how my own personal and professional material is inseparable from the results which have emerged within this thesis, I will endeavor to add reflections, observations and interpretations of my own material too.

21. A Pathway Through the Jungle

In order to make sense of how participants variously experienced working with GBP in their pluralistic private practice, it seemed significant to explore how goals were felt to impact on both the immediacy of the therapeutic frame, as well as the journey travelled across therapy, between therapist and client. As has been suggested within the current literature, GBP has the potential to allow individualised progress monitoring, which can contribute to renewed belief in the wider therapeutic frame, as well as, client potential to change (Di Malta et al., 2019; Lloyd et al., 2019).

21.1 Progress Monitoring

A large body of literature has shown that goal tracking and monitoring of therapeutic progress supports psychological functioning (Cooper & Law, 2018). All of the participants referred to GBP as allowing a monitoring of therapeutic progress. In particular, goals were likened to *"buoys"* or therapeutic markers, which enabled guiding, tracking and monitoring of the therapeutic journey through what was reported as a *"jungle".* In turn, this progress monitoring was felt to permit navigation through the process of therapy. These results

appeared consistent with existing literature, which has explored how goals can be used as tools to monitor therapeutic progress (Lloyd et al., 2019). Lloyd et al., (2019) in their systematic review of idiographic goal measures for psychotherapy suggested that the idiographic nature of goals work holds particular value as it allows clients and therapists to review personally salient goals and use these as a benchmark to track therapeutic progress. Furthermore, feedback on goal progress (i.e., goal tracking) has also shown a positive relationship with goal attainment, with a recent meta-analysis determining an effect size (d+) of 0.40 (Harkin et al., 2016). This is further supported with data from a more recent meta-analytic finding, that providing clients with regular feedback about their progress in psychotherapy, may aid therapeutic outcome (Tryon et al., 2018). Similarly, in a recent qualitative study of client experiences, Di Malta et al., (2019) reported goals as useful in guiding and reinforcing client progress, which seems to strongly triangulate with the therapist's experiences in the present study. Taken together, the data from the present study seems in line with earlier research, that GBP can hold a beneficial impact for progress monitoring.

Bracketing and reflective discussions in supervision, were very significant when attempting to withhold overflow of my own attitude to this theme. Reflecting on my own process here during data analysis, I recall feeling initially resistant about including this area as a core theme, partly due to what I perceived to be its over simplicity. Having reflected on the frequency of which this theme emerged across participant transcripts, however, and its fit within the narrative of the results, I felt it significant to include it.

21.2 Focus

For eight of the participants, GBP was felt to enrich the journey of therapy through provision of a focus, both to the frame and process of the work. These experiences of focusing were variously termed by participants but seemed to cluster around experiences of

GBP as concretising the therapeutic task through reference to everyday life. Whereas, the previous subtheme referred more to navigating the journey as a whole through a tracking of direction and progress; this subtheme referred more to expressions of GBP that gave rise to feelings of grounding in the immediacy of the therapeutic frame.

Within the psychological research field, goal working has long been linked to enhanced outcomes through directing an individual's attention to the identified goal (Locke et al., 1981). Furthermore, the utility of tracking progress in therapy in order to facilitate more focused interventions has been well documented, at least within the context of routine outcome monitoring and therapy with children and young people (Lambert, 2005; Wolpert et al., 2012). Within the psychotherapeutic context, and particularly within the context of adult therapeutic practice, however, these processes have received scant empirical attention until recently (Michalak & Grosse Holtfort, 2006). The experiences of participants in this subtheme seemed closely aligned with the research hypothesis of Smith (1994), that GBP can support clients to establish more realistic, and focused therapeutic expectations. Additionally, Di Malta et al., (2019), reported findings that goals are understood as as a form of *"common ground"*, which can in turn, be used as a point of reference in the therapeutic dialogue, to support connection to the clients experience of distress. The results of these studies, in particular, seemed closely aligned to the experiences of participants in the present study, however, they diverge from the present study in that they have largely been conducted from the perspective of clients. The present study, therefore, strengthens previous findings, by lending support from the practitioner perspective, that GBP can indeed support renewed focus.

It was of note to me, that although the context of participants therapeutic practice within my study was private pluralistic practice, assumedly with the option for longer term therapy, should both client and therapist feel appropriate, that focusing sessions was

promoted as such a strong positive characteristic of goal working. In these terms, my results suggest that even outside of NHS or other time limited settings, psychotherapeutic practitioners are likely to feel the benefits of focused therapy sessions.

21.3 Positive Affect and Self-Efficacy

Five of the participants discussed that flowing from the progress monitoring and grounding focus that GBP was felt to provide, permitted the emergence of positive affect, coupled with renewed belief in the potency of the therapeutic partnership, to instigate change. This data is consistent with existing literature, from the perspective of clients, which highlights that GBP may increase feelings of empowerment, hope and self-worth by positioning clients as agentic, intelligible beings, with the potential to determine and enact change upon their worlds (Di Malta et al., 2019; Mackrill, 2010). The present study, therefore, lends further support to this from the perspective of psychotherapeutic practitioners.

Within the present study, following a period of tracking therapeutic progress, which flowed into increased focus in the therapeutic sessions, many participants seemed to witness renewed vitality in the therapeutic partnership; both of their own and their clients. Rico, who spoke of working with clients in his private practice, felt a sense of realisation emerge for his clients: that they had the resources in their lives to make change.

Several additional authors have emphasised the importance of GBP in enhancing client and therapist motivation to participate in therapy and to fully engage in the therapy process (Ryan et al., 2011). Indeed, meta-analytic research suggests that collaborative goal consensus facilitates improved psychotherapeutic outcomes for clients (Tryon et al., 2018). Furthermore, in quantitative research of goal intensity, psychological presentation and therapeutic outcome; patients who were found to be more optimistic about attaining valued goals, showed lower levels of psychopathology and more positive session outcomes

(Michalak et al., 2004). Apt to the present study, Goldman et al., (2013) reported that when therapists collaborate with their clients in setting therapy goals and defining the course of treatment, clients were more likely to agree with and have increased efficacy in the therapeutic process. The results of such studies seem particularly synonymous with the experiences of participants in the present study, namely that, GBP has the potential to lend to increased positive affect and belief in the value of the therapeutic frame. The current study, therefore, extends these previous findings to the domain of private pluralistic practice.

21.4 Hope Theory Perspective

In the late 1950s to the 1960s, early research focused on the concept of hope within the context of positive expectations for goal attainment (Menninger, 1959; Stotland, 1969). In these terms, hope or expectancy was deemed to refer to the client becoming hopeful and believing in the potential of therapy to prompt positive change (Sprenke & Blow, 2004). Numerous scholars have since espoused views, that clients' hope in their lives and therapists' ability to embolden hope, function as foundational common factors that contribute to change (e.g., Frank & Frank, 1991; Hanna, 2002; Seligman et al., 2006; Snyder, 2000; Snyder et al., 2000; Wampold, 2007). As such, goals were positioned as the anchors of hope theory (Cheavens et al., 2006; Snyder et al., 1997).

Psychologically, within the current study, the combination of setting and tracking goals, as well using these to focus the sessions seemed to culminate in a renewed sense of positive affect and self-efficacy for participants. This perhaps, can be understood through the lens of Hope Theory (Snyder, 2000). Snyder (2002) asserted "*hope is a positive motivational state that is based on an interactively derived sense of successful agency (goal directed energy) and pathways (planning to meet goals)"* (Snyder, 2002, p.287). Thus, hope theory was formed around a trilogy of factors: goals, pathways and agency; with goals positioned at the core of Hope Theory, in that they are theorised to create the possibilities of change and to

fuel the motivation to enact that change (Coduti & Schoen, 2014). Within the psychotherapeutic context, goals might be situated then, as central in providing individuals with a sense of agency and hope for their future. Indeed, research exploring the underlying common factors which are deemed causal in processes of therapeutic change, have reported hope and expectancy to account for 15% of change in the therapeutic process (Miller et al., 1997).

This notion of hope and agency seems to emerge for the participants in the present study and is consistently mirrored within the psychotherapeutic literature. Goal-oriented processes, for example, may engender positive expectations and hope about goal attainment (Locke & Latham, 2002). Tobias, for instance, remarks: *"I think to me it's, I would like to think mainly, it energises hope and creates a sense of hope in clients..." (Tobias; 13/405-411).* Five participants advocated GBP, at least in part, due to the empowerment and agency that they felt it offered their clients. Further literature which explored the function of hope and links with GBP has suggested therapists' hope in their clients after the first and last sessions was significantly related to client outcomes (Coppock et al., 2010).

22. Invalidating the Therapeutic Journey

Despite experiencing benefits gained through GBP, which was largely consistent with previous hypothesising (Cooper & Law, 2018), many of the participants spoke of GBP as carrying unwanted or dehumanising effects, with the potential to lead to therapeutic rupture. Existing literature has mostly so far documented examples which almost exclusively rely on anecdotal, or clinical conjecture (Cooper & Law, 2018), in order to illustrate potential perils of GBP. Data from the current study, therefore, provides empirical data, which maps experiences and situations, where GBP is felt to lead to an invalidation of the client and the wider therapeutic task. Furthermore, as no qualitative studies have explored GBP processes

within the context of pluralistic private practice from the practitioner perspective, these findings are original in their application to adult therapeutic working.

22.1 Imposing Goals

A large body of humanistic psychology literature, which places primacy on a 'non-directive' stance, and the fostering of empathy, congruence and collaboration (Rogers, 1961), has warned of the dangers of directing the client into ways or frames of reference that they themselves have not welcomed. Erickson (1980), in particular, criticised against imposing therapist's theories on clients. He instead advocated what he called utilisation: ''*Exploring a patient's individuality to ascertain what life learnings, experiences, and mental skills are available to deal with the problem. . . [and] then utilising these uniquely personal internal responses to achieve therapeutic goals''* (Erickson & Rossi, 1979, p.1). Furthermore, within the context of psychotherapy, GBP has been critiqued within the literature for encouraging a mechanistic approach to psychotherapy; and for emphasising clients' *"extrinsic"* desires—to achieve and *"do"*—rather than enabling a more salutogenic state of *"being"* (Rowan, 2008). Consistent with this literature, many of the participants spoke variously of how they felt GBP, if used rigidly, and hence as prematurely, could endanger the client's own frame of reference. Maura, Tom and Annelie all cautioned against this way of working with GBP, as they felt it risked forcing *"clients into boxes"*, possibly leading to a distortion of a client's therapeutic wants and needs.

Within the psychotherapeutic literature, a range of barriers of GBP have been posited. Most commonly, it has been discussed that GBP may carry the risk of being counter-therapeutic, as clients may not be able to identity and articulate their *"real"* goals (Cooper & Law, 2018). This was experienced by Tobias *(Tobias; 16/481-490)*, who alluded to his disillusionment in his client's ability to be aware of and articulate their own goals from the beginning of therapy. It seemed for him, that although this may seem disempowering for

clients, on the other, it could be seen as an empathetic act of understanding that they might not have the instruments and clarity to express their deepest wants and desires immediately.

Indicative research suggests personalised client goals, which by their very nature are not imposed onto clients and adhere to their frames of reference, generally increase the effectiveness of therapy (Lindhiem et al., 2016; Sheldon & Elliot, 1998). This perhaps suggests that their inverse (non-client led/personalised goals), risks reducing the likelihood of positive therapeutic outcome. As Maura aptly remarked: *"If the therapist comes up with the goals form or with the goals work, it's kind of infringing on the client's space and putting a positive frame for them, which they haven't welcomed and they aren't really ready to work with" (Maura; 12/369-374).* The findings of the present study lend support to past research and anecdotal commentaries (Cooper & Law, 2018), which highlight the dangers of imposed goal use. As such, the risk here is that such goal use could be experienced as disempowering for clients, which appears at odds with humanistic ethos and praxis. Indeed, there is also a level of concordance between therapists' experiences of GBP in this study, as risking an unhelpful goal imposition onto the client and qualitative research from the client perspective, which also similarly cautions against styles of GBP which might feel irrelevant to the client or as incongruent with their own lived experiences and sense making (Di Malta et al., 2019).

22.2 (Not) Sitting with Distress

The literature presents a vague and contrasting picture on the impact of GBP for therapeutic process, from the practitioner perspective (Phelps et al., 1998). Dominant concerns within the literature relate to GBP as potentially deterring communication away from therapeutic interaction and as imposing external or normative expectations for ensuing therapeutic work (Cooper & Law, 2018).

My participants variously spoke of their concerns when GBP resulted in too much focus towards end destination, resulting in therapists not *"sitting with"* their client's distress

in the immediacy and process of the therapeutic encounter. In exploring their sense making, some of the participants felt a collective sense of therapist anxiety or avoidance of client distress might underlie the tendency to use GBP in strident ways, as Pippa remarked: *"...we want to move you out of the despair to somewhere else and cheer you up, but we struggle to hear the struggle and to really hear that because it's too distressing. So, we're trying to kind of move you out" (Pippa; 13/386-397).* Such a result appears consistent with the literature concerning phenomenological critiques of GBP. In particular, theorists have warned of the dangers when therapists introduce active interventions as a means of reducing the anxiety they feel about their responsibility to reduce clients' distress. As Shainberg (1983) remarks, therapists may: *"drown their empathy or appreciation of the patient's struggle"* (p.164).

Shainberg (1983) has also discussed an additional danger, which seemed to tap onto the experiences of my participants, that being more active in the therapeutic dyad seems to function to allow therapists to distract themselves from uncomfortable feelings evoked by clients. In this sense, therapist's overreliance on goals seemed to perhaps carry a defensive function. Within the literature this is commonly attributed to early career therapists as, Tom also felt: *"I think in those days goals were.. I would probably erm.. when I did eventually use them early in my career, I probably would have over focused on them I would have over fixated on them" (14/15-437-457),* but is also discussed more broadly as a defensive function for therapists. Accordingly, the experiences of participants in my study, seem closely aligned to and provide empirical evidence for Shainberg's (1983) conjecture that therapists may attempt to cope by adopting an actively helpful role, without progress being made.

22.3 Psychodynamic Perspectives on Goal Processes in the Therapeutic Relationship

I also held in mind theoretical concepts drawn from psychodynamic theory and practice when interpreting and reflecting upon the potential defensive function of participants reactions towards GBP, including any possible impact for the therapeutic relationship.

Specifically, in the case of Pippa, who remarked: *"I see this with new therapists. I'm 12 years in but when I'm supervising new therapists.. We want to move you out of the despair to somewhere else and cheer you up" (Pippa; 13/386-397).* In this instance, I interpreted that her remark may carry a defensive function, as if she was projecting her own anxiety (a defensive mechanism) around goal use onto *"new therapists"*, to make a statement and distance herself explicitly from this way of goal working (e.g., using goals in order to move a client out of their distressing feelings, as the distress itself, might evoke uncomfortable feelings for the therapist). Within the literature, projection is described as the process of attributing one's own unacceptable internal thoughts or behaviour onto someone else and indeed I interpreted that this process might be present here (Waska, 1999) but I also considered whether this might function as part of a micro-process between therapist and client through their transferential response. Transference is defined as how the patient or client relates in vivo (often from early object relations) to their object (therapist), whilst the countertransference process refers to the phenomenon whereby the therapist reacts, often emotionally but including all reactive responses, to the patient and their transference (Lemma, 2015).

In Tom's case, for example, I considered that an identified initial *"overuse"* of goals earlier on in his career, as well as carrying a defensive function by separating his current therapeutic practice from his past, may have also unfolded as part of a countertransference response to his clients. In these terms, it seems plausible that working therapeutically with a client who is feeling helpless or disempowered (transference) as part of their presenting distress and reasoning for seeking therapy might be responded to by Tom (his countertransference) with excessive focus towards goal working, as a means to 'rescue' his client, with processes such as goal working. Likewise, for Pippa then, it seems possible that goal working might become part of an enactment itself, from the therapist, as part of their

countertransference response to difficult feelings and processes emerging within the therapeutic relationship.

Comparably, for Alessandra too, who I conjectured may also be utilising a defensive structure to make sense of goal working with her clients: "*It could be that the person doesn't want to address whatever it is that's causing them the most distress for whatever those reasons are. Unconsciously they are avoiding that goal and it could be that they're just too vulnerable, or too frightened to achieve that goal… (Alessandra; 9/266-277).* In this instance, on an explicit level, Alessandra seemed to discuss her perceptions of clients' emotional processes linked with goal working, however, at a deeper level there also seems a lack of clarity regarding her own positioning as a therapist, as part of the therapeutic dyad, constructing goals with her clients. For example, I interpreted that Alessandra could be, at least in part, describing her own feelings of anxiety about what goal failure may induce in the client and what this might signify about her as a practitioner, rather than as merely reflecting the anxiety of her client. Again, this process seems inevitably connected to the transference dynamic emerging between client and therapist.

All together, these findings perhaps highlight that goal processes do not unfold within a vacuum but rather are intimately connected to micro-processes emerging within the therapeutic relationship between client and therapist, including (counter)transferential responses. In so doing, these processes emphasise the integral importance of the therapeutic relationship, as a means to introduce and negotiate GBP.

22.4 Criticisms of a Directive and Non-Client Led Stance

In connecting the previous two sub-themes (21.1/21.2), both seemed to revolve around a form of non-client led practice, in which goals were imposed onto clients and therapists risked not sitting with the immediacy of the client distress. In attempting to make sense of the potential dangers of such a way of working, I endeavored to draw on a body of

literature and school of thought, which posits the necessity of working in active conjunction with clients, conceptualising clients as purposeful beings. By accepting a position closely aligned to the core principles of humanistic psychology – that individuals are unique, can exercise autonomous choice, and are able to fruitfully grow towards change (Bugental, 1964), I felt the criticisms levelled against GBP by my participants were closely aligned with the framework suggested by the humanistic psychology approach, that the central focus of the therapeutic endeavor should be that which is acknowledged by the client (Cooper & McLeod, 2011b).

22.5 Client Failure

An interesting observation throughout the transcripts was that whilst many felt GBP often kindled a sense of hope and belief in the potency of the therapeutic frame, there also emerged a dualistic possibility that GBP could risk instilling a sense of failure in clients, if goals were not achieved. Within the psychological literature, it is broadly acknowledged that in any experience of goal striving, individuals will likely encounter problems which function as impediments to goal achievement. In a study by Brunstein (1993), participant subjective wellbeing was associated with prior beliefs regarding their ability to have control, opportunity and support to attain significant personal goals. By contrast, goals which are felt as unattainable and lead to sense of personal failure, often coincide with negative emotions such as; hopelessness, despair, futility and demoralisation (Emmons, 1986; Frank & Frank, 1993).

Furthermore, as Hope Theory suggests, effective goal attainment results in positive emotions while less effective outcomes produce negative emotions (Snyder, 2000). Indeed, qualitative research of client experiences of GBP by Di Malta et al., (2019) reported that many clients experienced GBP as sometimes leading to a feeling of a lack of achievement, which felt disheartening, or carried a meaning of failure for clients.

Many of my participants, reported feeling as if their client's sense of failure towards goals often diminished their client's sense of self, and risked feeding into the very psychological difficulties they were attempting to ameliorate. I interpreted this danger as being of particular pertinence, when therapists felt the task of therapy becoming one of goal attainment, rather than emotional processing. Hence, the relative 'success' of therapy became measured by achievement of the goal. This process of the therapist perceiving a client goal failure emerged as a factor which seemed to contribute to decreased feelings of self-efficacy or positive affect for the client. As Alessandra remarked: *"…which then would feed into their depression. Do you see what I mean? Becomes a negative spiral" (Alessandra; 16/494-499).* Similarly, Tobias and Tom felt cautious of goal use in therapy due to the often personalised and idiographic nature of these measures, which they felt carried a deeper meaning for their clients when these were not achieved, than otherwise psychometrics would carry. Indeed, this finding seems especially pertinent considering within the literature, the onset of depression, for example, has been directly connected with client's experiences of chronic failure to meet personal goals (Miller et al. 1960; Jones et al., 2009). As such, it seems that experiences of the practitioners in the present study, alongside past empirical research, both seem to caution that goal working carries a potential to exacerbate, as well as to, ameliorate client distress. Within this study, goals were felt to be particularly risky in this respect due to the personal significance and meaning they carried.

22.6 Self-Fulfilling Prophecy

Evidence from a vast body of socio-cognitive research has explored how efficacy beliefs contribute significantly to the level of motivation and subsequent performance (Bandura & Locke, 2003). Of note to me, was how participants variously emphasised this risk of failure for their clients. Specifically, for some, this was more prominent when they felt that their clients set unobtainable goals, which in turn, set them up for failure. For example,

they were cautious of the process by which clients with low self-esteem might set unachievable goals, thus confirming their negative beliefs about self, when they failed to achieve these. In attempting to make sense of this process, I consulted several strands of literature. Firstly, within the psychological literature broadly, the concept of the self-fulfilling prophecy (Merton, 1948) seemed significant. This refers to the socio-psychological phenomenon of an individual predicting or expecting a particular outcome, and then enabling this prediction through belief in its inevitability, which feeds the resulting behaviours, which in turn, fulfil those beliefs. In connecting this theory, to my participant experiences, it seemed in many ways, participants were more mindful that goals risked becoming of more negative valence or failure inducing for their clients, when their clients had negative views about themselves. These negative views, were felt, by Alessandra and Tom in particular, to sometimes, lead into negative goal attainment through a process of self-prophetic fulfilment (Zulaika, 2007).

23. Maintaining the Client Led Story

For all of the participants, it seemed a dialectic emerged between GBP and a need to provide adequate emotional and relational connection to their clients. In these terms, a reflection on their experiences of working with GBP therapeutically seemed to permit participants a means of negotiation that allowed for the integration of a relational goal working.

Specifically, participants seemed to prioritise the need to maintain the therapeutic narrative, which at times took precedence over goal working. Participants also appeared conscious of bracketing their own agenda and expectations of goal attainment to prevent intrusion on the client's narrative, sense-making and frame of reference. Goals that were set over a longer period, once the therapeutic relationship had been firmly rooted, were felt to be more meaningful and carry more therapeutic value. Whereas past research has previously,

largely, dichotomised approaches to GBP, the findings from this theme offers insights into how practitioners themselves have integrated goal working into a relational frame.

23.1 Preserving Space for Therapy

In connecting my participants experiences to psychotherapeutic literature, I felt the field of humanistic psychology offered some insight, in particular, through the significance it places on providing an unencumbered therapeutic space, in which clients can focus on their difficulties, so that emotional processing and reorganisation can begin (Rogers, 1942). As previously mentioned, participants seemed wary of non-client led goal use with their clients and a directive therapeutic frame that departed from what they felt really mattered for their clients. For five participants, this fear centered around a neglect towards the emotional material their clients brought into the therapeutic encounter, which gave rise to attempts to preserve time for therapy, as Rico remarked: *"So sometimes I just, I just let that story run for, you know for a whole session and we might not then ever get to a goal initially" (Rico; 28/797-804).* Similarly, Maura too, seemed to emphasise the importance on maintaining the here-and-now of the therapeutic encounter: *"It's more about sensing client's direction as well as being with them in the present moment" (Maura; 18/563-569).* Such a position, which advocates 'being with' the client, rather than solely, 'doing to' seems to resonate strongly with Fromm (2005) who wrote on the importance of being alive in life, rather than continually gravitating towards change. Similarly, this notion is present in the Heideggerian reflection: *"the pure delight of the beckoning stillness"* (Heidegger, 1971, p25).

Within the psychotherapeutic literature, more specifically, it has been proposed that goal-oriented practices should be utilised adaptably (Feltham et al., 2018): for instance, permitting clients to shift to an *"off-goal"* topic if this is felt to be significant for the client. This seemed a common thread across participant experiences in this subtheme and Rico felt this palpably as he demonstrated his flexibility in adjusting GBP to his client's needs: *"If*

someone has just suffered a loss.. I'll hold back on asking them about goals, because they just need to get it off their chest right" (Rico; 28/797-804). It appeared that such a flexibility from the therapist was felt to balance attention to the process of therapy, without discarding an appreciation of goal focus. Indeed, qualitative support from the perspective of clients, suggests that GBP which allows for actual therapeutic process were felt to be more helpful (Di Malta et al., 2019).

23.2 Therapist Goals

A significant development in twentieth-century philosophy was a movement which drew attention to the relational nature of human existence: that to be a person involves relationship (Gergen, 2009). Within psychotherapy and CoP, a relational perspective has carried large ramifications for understandings of the ways in which clients describe and explore therapeutic goals and how these are inevitability shaped and co-constructed dialogically within the relational context (i.e. therapist) that unfolds around them (McLeod & Mackrill, 2018).

Although no qualitative literature seems to have explored clinical processes unfolding when therapist goals diverge from those of their clients, some literature which has explored goal congruence between therapist and client, has reported surprisingly small correlations (Schöttke et al., 2014). This perhaps suggests the presence of therapists' own goals for their clients, which deviate from those of their clients. Indeed, within the context of goals, several studies, largely initiated by Bargh & Ferguson (2000) support the notion that goals can be triggered, selected and pursued without conscious awareness of the processes (Chun et al., 2011; Moskowitz, 2012). This perhaps suggests that even if therapist goals do not exist at a conscious level, some level of implicit goal framework may still remain. This seems particularly pertinent considering Pippa's reference to goal ownership: *"well, I think us therapists also come, whether we own them or not we come with our goals but as well"*

(Pippa; 3/83-94). Specifically, this acknowledgement by Pippa of the almost subconscious existence of therapist goals, seems to support developments within motivational literature, which increasingly acknowledge unconscious motivation as directing goal behaviours (Aarts & Custers, 2012).

Four of the participants within my study, whilst being mindful of the risks of goal imposition onto the client, also held in mind the felt inescapable nature of their own agenda for their clients. As Pippa commented: *"Then there's our goals, our agendas, and our goals and I say that in a way that owns that (Pippa; 3/83-94).* Alessandra too, acknowledged the existence of her own goals for her clients: *"…and try not impose your-- That's something I have in mind as a practitioner is, people come in and I have goals for them in my mind" (Alessandra; 717-725).* For many, the existence of this almost unavoidable therapist agenda (goals, wishes and hopes), seemed to point to the inherent intersubjectivity of the therapist--that therapists cannot ever extract themselves from the process and task of therapy, but rather act as co-constructors of the client's truth and sense making. Whilst this agenda was mostly felt to be unpreventable, therapists did seem to place value in adopting a reflective position of the self, as a means to untangle the desires and goals of the client, from those of the therapist. Such a position seems to parallel a position of reflective practice advocated by Schon (1983). Schon (1983) introduced the idea of 'reflecting in' and 'reflecting on' practice, with the former referring to conscious consideration of the processes occurring within the therapeutic dyad and the latter reflecting upon a clinical event after the event. Indeed, within CoP as a discipline, reflective practice and being able to reflect both in vivo and post encounter are considered fundamental characteristics of the practitioner psychologist (Lane & Corrie, 2006). Although the participants in the present study were all reflecting on their practice through the process of interviews, they all advocated a reflective position as a means to bracket goal imposition onto their clients. In these terms, it seems humanistic psychology

(Schneider et al., 2014) lends itself well to the containment of therapist's agendas and to the creation of a middle ground/compromise with a view to empower the clients.

Applying the findings of the present study to different therapeutic communities of practice, it seems there are likely to be varying degrees of reflective activity across different psychotherapeutic orientations. For instance, a CoP versus a cognitive-behavioural therapist. Whereas the former is strongly positioned in a reflective basis (Douglas et al., *2016*), the latter, at least historically, has lacked a strong accent towards reflexivity. There are also likely to be differences in service-structures, such as private practice versus more time-limited NHS settings, such as Increasing-Access-To-Psychological-Therapies services, where reflective capacities might be stunted due to service pressures, or economic or political factors (Leonidaki, 2019). All of these variables are likely to impinge on the therapist's ability to hold reflective awareness, including, mindfulness of their own agenda and goals for their client. The findings of the present study, nevertheless, suggest the integral importance of psychotherapeutic practitioners, across all orientations, in maintaining an open and critically reflective stance.

23.3 The Therapeutic Relationship

An understanding of the need to situate GBP within the context of a strong, empathic therapeutic relationship, emerged for seven participants, as a foundation for later relational goal working. For a large proportion of participants, it seemed, GBP carried necessary complexity, as well as risk of therapeutic rupture. From my analysis, I interpreted that in order to mitigate this risk, therapists articulated a position which necessitated supporting their clients to express authentic and meaningful goals. In order to achieve this, participants felt two ingredients were needed: firstly, an acceptance and understanding of goal complexity in that, explicit goals can sometimes have deeper levels of meaning for clients. Secondly, that a strong therapeutic relationship can be understood as intimately inseparable and interwoven

from goal working. These deeper levels of meaning were felt to often require the establishment of therapeutic rapport, so that clients could share their deeper goals without fear of judgement. As Annelie remarked: *"It's [goal working] about having a strong empathetic relationship with the client where they feel comfortable and accepted and able to talk about what matters most to them (Annelie; 38/1196-1205).* In these terms, authentic goal working was understood to be predicated upon the quality of the therapeutic relationship, resembling a bi-directional relationship. The research also seems to support such a position. In particular, process theories of psychotherapy regard agreement on therapeutic goals as a measure of the quality of the therapeutic alliance (Bordin, 1979; Daniels & Wearden, 2011; Tryon & Winograd, 2011). Bordin (1979) reasoned that a good alliance, which consists of the goals, the tasks and the bond, is a precondition for therapeutic change across all traditions of psychotherapy. Bordin (1994) hypothesised that the negotiation of therapeutic tasks and goals, supported in a solid therapeutic bond, is foundational for the construction and development of a robust alliance that will be able to withstand potential ruptures. This understanding seems closely aligned with my participants. Amber in particular, remarked of goals: *"...they're not separate to the relationship, they're part of the relationship (Amber; 35-36/1104-1116).* Accordingly, the therapeutic relationship, emerged as a central means to create a climate of trust, through which meaningful and rich client goals could be allowed to surface. Amber stated this clearly: *"if they don't engage with me [the client], then they're not going to engage with their goal, their therapeutic goal. So something about paying really close attention to the therapeutic relationship" (Amber; 35-36/1104-1116).* In parallel, the emergence of meaningful goals stood in stark contrast to what Tobias felt to be the more superficial goals. Superficial ways of goal working were felt to be connected to the premature use of goal setting, without the frame of a robust empathic relationship. It is worth mentioning that interest in the significance of the therapeutic alliance to the

psychotherapeutic process has recently grown across theoretical domains and is underscored by a historic body of knowledge which situates the therapeutic relationship as paramount for therapeutic change (Arnd-Caddigan, 2012; Bordin, 1979). Moreover, relationship factors, such as level of warmth, empathy and encouragement have been estimated by Hubble et al., (1999) to account for 30% of total therapeutic change, suggesting their significance for valued therapeutic change. This is particularly so, within the context of CoP, which places significance on the process and content of the therapeutic relationship, as a necessary foundation for change (Bachelor, 1995). This body of previous research, thus, seems closely matched with the experiences and meaning-making of my participants; that GBP is necessarily predicated upon depth of therapeutic relationship.

Chapter 6. Conclusion

24. Overview

In this final concluding chapter, I summarise the new knowledge generated from this thesis and its relative contribution to existing literature. I will, additionally, reflect on the potential limitations of the present research, keeping in mind, suggestions for further scholarship. Additionally, implications for CoP, as well as, wider psychotherapeutic disciplines, both academic and practitioner, will be identified. Finally, by revisiting my initial reflections, I will conclude with some closing reflections on how the process of undertaking this piece of research has impacted me, both personally and professionally.

25. Summary

To my knowledge, this is the first empirical study which has qualitatively explored how psychological therapists experience working with GBP, within the context of pluralistic private practice. By employing a phenomenological frame in order to relationally and dialogically explore participant's meaning making, this study has attempted to make sense of the multitude of ways that GBP is experienced within practice from the psychotherapeutic practitioner perspective, that is to say; the benefits, negatives as well as strategies to support best practice. The findings of this study, provide empirical support for that previously reported within the psychotherapy field (Di Malta et al., 2019; Feltham et al., 2018; Michalak & Grosse Holtfort, 2006): that GBP should be integrated in collaborative and relational ways. This study has also extended previous research from the psychological domain regarding the benefits of goal tracking (e.g., Locke et al., 1981) into the psychotherapeutic sphere and in particular, private practice.

Emerging most strongly from the current study is support for previous research which has identified various benefits (superordinate theme one), as well as, criticisms or weaknesses of GBP (superordinate theme two). It particular it emerges that goal-based idiographic

measurement and monitoring is perceived as offering something unique and beneficial to the therapeutic relationship, from the therapist perspective, which differs from more traditional nomothetic tools. As suggested in the literature, idiographic measures permit clients to determine their own therapy foci, allowing the client and therapist to collaboratively define the content to be evaluated or scored in therapy; thereby affording attention to the broadest range of value systems and individualised notions of treatment success (Kiresuk, 2014; Jacob et al., 2017). In particular, in the current study, GBP was reported as supporting focus, grounding the therapeutic task and aiding the generation of positive affect, which carried a deeply personal significance for both therapist and client. In this sense, the findings seem to suggest that GBP may allow for a personalising of the therapeutic task, which might not otherwise be available through nomothetic or standardised measurement or monitoring in isolation. Whilst GBP was reported as being able to ground and focus therapy in this study, which was interpreted as being beneficial, it seems likely that in practice, nomothetic and idiographic (both problem and goal focused) traditions can be reciprocally enhancing and hence combined for maximum benefit.

A novel finding, however, was that whilst identifying helpful and unhelpful aspects of GBP are important, it seems merely reducing goal working to the dichotomous: good versus bad, negates the processes between therapist and client. For example, by positioning goals as either supportive, or of hindrance, for the therapeutic encounter, they idealise or problematise their use, leaving little space for goal negotiation and acknowledgement of therapeutic processes emerging between client and therapist. From listening to the accounts and experiences of therapists within this study, however, I feel therapists have an important function in facilitating effective and relational GBP. In these terms, whilst adopting a directive position in therapy, through GBP, can sometimes hold anti-therapeutic ramifications, this does not mean that there is no space to be directive. Importantly, what

seems to emerge is that when therapists assume an active role, this needs to be merged with attention to the therapeutic relationship between client and therapist, as the foundation for later GBP. With this in mind, the findings act as a reminder, that goal processes do not unfold within a vacuum but rather are intimately interconnected and interwoven with micro-processes emerging within the therapeutic relationship between client and therapist, including (counter)transferential responses from the therapist. Specifically, where GBP might be used as a means to escape from difficult emotions or dynamics present in the therapeutic relationship. These processes, together, therefore highlight the integral importance of the therapeutic relationship, as a means to introduce and negotiate GBP.

Moreover, results suggest that therapists should be mindful of their own agenda and positioning when working with clients therapeutically, as it is likely that their own goals and agendas for their clients will permeate the therapeutic frame without critical self-reflection (Schon, 1983). From analysis of the participant experiences within the present study, it seems that potential processes connected to therapist anxiety, may underline imposed goal use. In these terms, it seems important for therapists to acknowledge their own agenda for their clients in order to support a bracketing of their hopes and wishes for their clients.

In examining the results of this thesis as a whole, a common meta-developmental thread emerged. Specifically, therapists seemed to experience an evolution in the development of their practice, such that their understanding, and use of, GBP shifted from more rigid positions early on in their therapeutic career, towards a more integrationist and less black versus white perspective, as their practice and identity developed. This knowledge may be used to inform practitioner trainings.

26. Limitations and Suggestions for Further Research

There are a number of important limitations to this study. Firstly, whilst all participants defined their practice as ‘pluralistic’, this term does seem to carry ambiguous

meanings within therapeutic discourse. For this study, participants were required to identify as 'pluralistic' at the level of their current practice. Pluralistic practice was defined as: as a general attitude of acceptance towards the diversity of the therapeutic field as a whole, and secondly, as a specific form of practice, which draws on methods from a range of sources, depending on client preferences and therapist skill and is characterised by explicit dialogue and negotiation over the goals, tasks and methods of therapy (Cooper & Law, 2018). Several of the participants, however, did not have core training in the pluralistic approach (Cooper & McLeod, 2011). It is possible that this introduced some degree of heterogeneity into the results of the present study. Nevertheless, as the primary phenomena of focus for this study was GBP, rather than the pluralistic approach, the possible diversity in pluralistic training/identification was not felt to fundamentally disrupt homogeneity. Finally, pluralistic therapy perhaps carries ambiguity in therapeutic discourse and this may have introduced some heterogeneity into the study sample. Future research may wish to utilise a pluralism self- report inventory, to determine therapists' levels of philosophical and practical identification with the pluralistic approach (e.g., Thompson, Cooper & Pauli, 2017).

Furthermore, this research focused on GBP as a constellated set of activities with practitioners working with adult clients in pluralistic private practice, rather than concentrating on specific elements and measures, such as goal setting or goal tracking, or indeed, focusing on particular client presentations, such as anxiety or depression. This broadly defined operationalisation of GBP likely introduced heterogeneity into the sample, with the resultant effect that it became difficult to claim that participants own understandings of GBP carried a singular or indeed unified meaning. Smith et al., (2009) highlight the need for homogeneity of sample across participants, for whom the research question will be meaningful, however, recognise too, that the level of homogeneity available will depend

upon the studies context and focus: *"the extent of this homogeneity varies from study to study"* (p.49).

Whilst the present study cut across a focus on theoretical language owing to its phenomenological orientation, it seems important to highlight this caveat regarding the broad definition of GBP used and to suggest that further research which builds upon the present findings, seeks to define and operationalise phenomena of interest (e.g.., goal setting, goal tracking) more concretely.

Additionally, a further risk to homogeneity within the present study was the variation in years of clinical experience that participants held when taking part in this study. Specifically, one of the participants held just one year of post-qualification experience, whilst others, held up to 24 years (mean = 8.75 years). Again, this arguably introduced further heterogeneity into the sample, as it is likely that therapists' perceptions, identities and developmental journeys as therapists, would be markedly different due to level of experience. Indeed, with the literature, it is broadly construed that practitioners undergo a developmental process post-qualification, in which their personal and professional selves evolve and integrate (Protinsky & Coward, 2001).

Consequently, the therapists in this study likely held heterogenous representations of goal working. Although the current study had several layers of focus (e.g., psychological therapists, GBP, adult clients, private practice, and pluralistic therapy) and hence was sufficiently focused for a qualitative study; further phenomenological research might benefit from concentrating on particular practitioners, within a set level of post-qualification training, to ensure a strengthening of homogeneity of sample.

Additionally, as suggested by Di Malta et al., (2019), it is likely that differing client presentation and service contexts will yield differing and important findings that will advance understandings of GBP practice. As the current study has identified increased positive affect,

self-efficacy and hope as some of the potential positive aspects of GBP, it seems prudent that further research explores these aspects with differing clinical presentations. Other research may additionally seek to explore therapist processes connected with GBP identified in this study, such as; therapist goals and bracketing and therapist anxiety around GBP. It is likely that research which draws on both the client and therapist perspective will be advantageous in this respect. Quantitative and controlled study designs may also be helpful in this respect, in delineating factors which predict effective GBP.

Additionally, with the context of this study being the pluralistic approach—a collaborative–integrative psychotherapy, in which goals are explicitly set and monitored through the therapeutic dialogue —it can be argued that this limits the ability to assume applicability of findings to other practitioners or therapeutic modalities. With this in mind, however, it seems possible to hypothesise, for instance, that therapists working within a CBT or alternative psychotherapeutic modality, may also experience GBP in a similar manner, however, without further research this is uncertain. Further research utilising a qualitative frame may helpfully explore GBP within different settings or indeed across differing therapeutic modalities. For instance, it may be appropriate to explore further research in contrasting settings, such as in the NHS, where a large proportion of practitioner psychologists or psychotherapeutic practitioners may practice. This may be particularly so in service contexts where competing service agendas interact with different psychotherapeutic traditions and practitioner identities. Furthermore, as reviewed by Lloyd et al., (2019), a broad range of idiographic goal measures exist for use in psychotherapy and yet relatively little is known about the use of specific instruments in clinical practice. Future research might usefully focus on exploring how specific measures are experienced in a range of clinical contexts, both from a practitioner and client perspective.

27. Implications for CoP and Psychotherapeutic Practice

The findings from this study have several important implications for GBP and CoP; providing a triangulation of empirical support from previous recommendations, which have singularly emphasised the perspective of clients (Di Malta et al., 2019). In these terms, and most generally, this study suggests that therapists, as well as clients, may find GBP to have potentially positive as well as unhelpful aspects for the therapeutic encounter.

As Ionita et al (2015) argues, in order to reduce the gap between theory and research and its ultimate clinical application through the therapeutic process, it is necessary to examine how clinicians as well as clients experience clinical processes, such as GBP. This is particularly the case as clinicians tend to seek out colleague's advice or guidance for practice information (Cook et al., 2009).

Indeed, data generated from this study seems to complement the existing literature focusing on client's experiences of GBP, suggesting a level of convergence between the experiences of clients and therapist in respect of their experiences of GBP (e.g., Di Malta et al., 2019). Specifically, in their qualitative study focusing on client's experiences of GBP, it was reported that clients benefit from goal working due to the focus and hope it might afford, as well as the common ground it instills between client and therapist. This finding was also present in the current study; that is to say, that therapists also reported goals as supporting a similar process, namely of grounding and concretising the therapeutic task and enabling the generation of positive affect and hope. Moreover, the client and therapist perspectives seem to converge in other ways too. In the present study, therapists reported that goals could also be equally unhelpful if they promoted oscillating feelings of failure and achievement for the client. Di Malta et al (2019) also reported that clients were aware of and acknowledged this risk too, which suggests a level of convergence between the experiences of both client and therapist, which is useful for advancing clinical practice.

Of perhaps more nuance from this study, however, is the highlighting of the dangers of adopting a dualistic position to GBP, with clients in private practice. In these terms, the findings suggest a more helpful perspective for therapists, from all psychotherapeutic traditions, might be to integrate GBP in a relational manner. Specifically, emerging results from the study suggest that understandings which emphasise GBP as either of positive or negative value, or humanistic or non-humanistic, are glossing over important gradations in terms of clinical practice. Whilst working with GBP in private practice may incur both of these positions, maintaining a focus on relational goal working through the formation of the therapeutic relationship is perhaps a more useful means for therapists to support clients towards valued and meaningful change. Within this study, three recommendations for relational GBP emerged.

Firstly, one particular finding would be the recommendation for emphasis to be placed upon the primacy of the therapeutic relationship, as a means to guide GBP and to set and frame meaningful goals with sufficient idiographic depth. This finding seems pertinent for CoP, which emphasises a holistic, rather than dualistic stance, and openness to engagement with the (inter)subjectivity, values and beliefs of the client, as opposed to the medicalisation of mental distress. That is to say, it seems that adopting a rigid dichotomy with client goals (e.g., goals as helpful or unhelpful) perhaps fails to value the uniqueness of clients, as well as, their nonstandardisable othernesses and idiosyncrasies; whose therapeutic needs and wants are more likely to reflect heterogeneity as opposed to homogeneity (Cooper & Law, 2018). It is also likely that this finding might offer particular wider insight into goal working for psychotherapeutic professions beyond CoP, where goal working might function as an integral facet of particular therapeutic approaches. In particular, cognitive-behavioural therapists may find the results of relevance considering the centrality CBT places on client goals as a vehicle to client change.

Secondly, whilst therapists need to be mindful of how GBP may generate hope, they may also carry self-fulfilling effects, which may carry therapeutic ramifications, if clients are susceptible to a sense of failure. Depending on the clinical presentation of the client, there may be adverse effects for client wellbeing. Additionally, therapists may want to be particularly cautious and tentative with goal language, so as to not feed into a therapeutic tonality of performance or achievement. This climate of failure may be particularly heightened if therapists are working with clients whose need for performance feeds into their clinical presentation or formulation. Hence, it seems important for therapists to be attentive to the individual meaning goals hold for their clients, the language used and to support them to set realistic goals over longer periods of time. Such a way of implementing GBP is likely to protect the self-efficacy of clients and reduce feelings of failure, as they strive for what really matters to them. This finding seems especially applicable within the framework of CoP, which has continuously held a leaning towards engaging with clients empathically in their own terms and supporting clients to identify their own strengths, as well as, areas for growth (Orleans & van Scoyoc, 2009).

Thirdly, therapists are likely to have their own goals for clients, even if these are not articulated at the conscious level. These goals may even, at times, deviate from the goals that clients wish to pursue and may function as obstacles to the therapeutic relationship. Therapists should use their own internal supervisor (Casement, 2013), as well as clinical supervision, to maintain awareness of their own agenda and to ensure this is not imposed onto their client. I feel this resonates with CoP ethos and praxis, in that orienting therapeutic interaction around the client's goals balances prioritising the clients subjective experience with psychological understanding of what necessarily works in therapy, indicating to the client that their individualised wants and 'preferred futures' take priority over any diagnosis-based treatment plan (de Shazer, 1991). For CoP, this finding reminds us to cling onto long-

cherished values of reflexivity and perhaps for other practitioners, where reflexivity is not so prominent, offers a caution and challenge to reflect fully upon how their own agenda and goals for their client might steer, direct or even, obfuscate, the therapeutic encounter.

28. Personal and Professional Reflections

In approaching the end of my thesis, I think it is important to revisit and explore how engaging with this research has influenced me, both as a professional and also as a person. Firstly, I feel engaging and listening to my participants' experiences regarding what goals have represented for them, has in many ways, allowed me to come full circle and revisit my own beliefs, assumptions and indeed, experiences of goal working. In this sense, although I recognised in my initial reflections that I was holding onto a perhaps dualistic nature of goals and I was viewing goals as applied to therapy, through a binary lens (e.g., good versus bad), I have come to recognise that this is not the whole picture: goals can be both helpful and unhelpful at the same time but what really seems to determine how they are experienced is the therapeutic relationship. Flowing from this understanding, I have come to appreciate that goal working can be likened to a branch of a tree, that coexists alongside other branches, or therapeutic interventions. The root of the tree, however, is the therapeutic relationship.

On a more personal level, I feel this research has shown to me how easy it can be to return into dichotomous thinking and how this lens can impact my/our interpretation of the world. For example, reflecting on my own lived experience, I acknowledge that being raised in a religious context, imbued a particular ontology of the world that was largely constructed from dichotomies (e.g., good versus evil). This taught me implicitly early on that others might have a different view of reality as broadly construed and that we can not necessarily assume a singular meaning for individuals or groups. In encountering research methodologies and associated teaching regarding ontologies and epistemologies at university, however, I found that I was now equipped with the language and framework for something I had been

exposed to at a young age – reflecting back I realise that I have come to value this exposure for the critical and questioning position I feel it has afforded, however, this has not always been the case. In early experiences in my life, I recognise that through my own attempts to desist and break away from this binary approach, somewhat ironically, I ended up initially on the other side of this binary (e.g., a total rejection of good versus evil). Reflecting further, I wonder whether this rejection of the binary has impelled me towards an interest in pluralistic philosophies and thinking, which at least explicitly, embrace a 'both/and' position and hence a valuing of complexity, rather than a dichotomised "either/or". Reflecting on the impact of this relationship to dichotomies in terms of the present research, I recognise that there has been at times a force within me which struggles with dichotomies. Perhaps I have viewed them as simplistic or overly reductionistic.

Nevertheless, the potential impact of this is seen in my initial resistance to including the first and second subthemes, which map positive and negative aspects of goal working – a binary position but also in the final theme, which seeks to bring together polarised dichotomies (helpful aspects of goal working versus unhelpful). I feel in my ways, this resembles my own developmental journey through life, a breaking away from imposed dichotomies towards an acceptance of contradiction and multiple levels of truth and context. Although I do believe, I was closely attuned to my participants' own experiences, it would be interesting to see how another individual may interpret, or make sense of, the same interview data.

In sum, working through this research has illuminated and reinforced to me how academic research, or even our own experience and existence in the world, can never fully be separated from the personal. In essence, it has strengthened my resolve that this full dispensing of the self, including our presuppositions, bias and lived experience, is not possible. I believe research, and indeed life in general, will always be coloured by worldview

and presupposition, however, I feel there are huge merits to be found in deeply and authentically acknowledging our biases to the best of our abilities, rather than, in my view, naively assuming the existence of value-free knowledge. To me, all knowledge represents a culmination of the object of study, as well as, the particular personal, social, political and historic milieu it was constructed within – this is to be celebrated.

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Appendix A

Recruitment Flyer

GOALS AND PLURALISTIC PRACTICE

Are you a qualified Counselling Psychologist and/ or counsellor who works in pluralistic practice (minimum 6 months experience) ?

IF YES:

✓ Do you work with adults?

IF YES:

✓ Do you regularly work with client's own goals in the therapeutic relationship?

IF SO, MY NAME IS CHRISTOPHER LLOYD; I AM A TRAINEE COUNSELLING PSYCHOLOGIST AT LONDON METRPOLITAN UNIVERSITY. I AM CURRENTLY CARRYING OUT MY DOCTORAL RESEARCH EXPLORING THERAPISTS EXPERIENCES OF WORKING WITH GOALS IN THERAPY.

This study has been reviewed and has received ethical approval from London Metropolitan's Ethics Review Committee.

Participation will involve a friendly one-to-one confidential interview with myself, in a location of your choice or via Skype.

-

If you are interested in participating or have any questions, please make contact: CEL0088@my.londonmet.ac.uk

Appendix B

Study Information Sheet

Participant Information Sheet

Goal Based Practice in Pluralistic Private Practice with Adults: An Interpretative Phenomenological Analysis

Background and aims

Working with goals in the therapeutic context has increased tremendously, in part, owing to attempts to measure therapeutic outcomes. This has predominantly, however, mostly taken place through standardised monitoring. As a consequence, little is known about therapist experiences of goal-based practice and potential for impact for therapeutic process.

My name is Christopher Lloyd; I am a trainee Counselling Psychologist at London Metropolitan University, where I am currently completing my doctoral research. This study has gained full ethical clearance.

I am interested in speaking with qualified Counselling Psychologists, counsellors and therapists who have worked or are presently working within the pluralistic therapy model in their private practice with adult clients and regularly use goals with their clients.

Please take time to read the following information carefully as it sets out more details of the study, should you decide to participate. Ask me if there is anything that is not clear or if you would like more information. Please take time to decide whether or not you wish to take part.

Thank you for reading this.

What will happen to me if I take part?

You will be asked to attend a friendly one-to-one interview in a location of your choice. This can be in person or via Skype. It is envisaged that this will take up to 1 hour. During the interview, you will be asked questions about your experiences and perceptions of working with goals in pluralistic practice. Anything you share with the researcher will not be divulged to the clinic in which you work. The interview will be audio-recorded and subsequently

transcribed. All transcribed data will be anonymised and any audio-recorded data will be password encrypted.

Do I have to take part?

It is up to you to decide whether or not to take part. If you do decide to take part you will be able to keep a copy of this information sheet and you should indicate your agreement on a paper (or electronic) consent form. You can withdraw your data following your interview up to two weeks after the data of your interview. You do not have to give a reason.

Do I meet the criteria to take part in this study?

- ✓ **Are you a qualified Counselling Psychologist or counsellor/psychotherapist who works in pluralistic practice (minimum 6 months experience)?**
- ✓ **Do you work within the context of pluralistic private practice with adult clients?**
- ✓ **Do you regularly work with client's own goals in the therapeutic relationship?**

What are the possible disadvantages and risks of taking part?

Participating in the research is not anticipated to cause you any disadvantages or discomfort. In the unlikely event you experience distress, you are encouraged to contact your GP or the relevant organisations provided below.

What are the possible benefits of taking part?

Whilst we are unable to offer financial remuneration for your time, it is hoped that engaging in the interview will give you formal time to reflect upon your therapeutic practice and work to date. Furthermore, it is hoped that this work will have a beneficial impact on how goal-based practice is understood within the therapeutic context.

Will my taking part in this project be kept confidential and can I remove my data?

Every effort is made to ensure the confidentiality of your data. Your original interview data will be stored on a password-protected computer. Only the researcher will have access to this original data. The interview will be face to face (or via Skype), however data will be rendered anonymous and stripped of all identifying information after collection, and before analysis.

The researcher, supervisor and potential examiners will view and analyse the anonymised data.

What will happen to the results of the research project?

Results of the research will be used to complete a doctoral level counselling psychology thesis. It is possible that result may be published in subsequent academic journals and/or presented at academic conferences. You will not be identified in any report or publication.

Who has reviewed this study?

This study has been reviewed, and been approved by, the London Metropolitan University's Research Ethics Committee.

What can I do if I am feeling distressed?

In the event that you feel emotionally distressed or feel in crisis, please contact an emergency mental health service, such as:

Your GP or local accident and emergency department, or via emergency services (999). Samaritans: a registered charity aimed at providing emotional support to anyone in emotional distress, struggling to cope, or at risk of suicide throughout the United Kingdom and Ireland, often through their telephone helpline. **Samaritans is open 24 hours a day, 7 days a week. Their telephone number is 116 123.**

Further Information and Contact Details

If you would like to discuss the research with someone beforehand (or if you have questions afterwards), please contact me, Christopher Lloyd (CEL0088@my.londonmet.ac.uk).

Thank you for your interest in this research.

Appendix C

Consent Form

CONSENT TO PARTICIPATE IN A RESEARCH STUDY

Goal Based Practice in Pluralistic Private Practice with Adults: An Interpretative Phenomenological Analysis

- I have read the accompanying information sheet and have been provided a personal copy. I have also been given the opportunity to ask questions and discuss these with the researcher, including my involvement in it.
- I understand that there will be a de-briefing at the conclusion of my participation in this study, where I will have the opportunity to ask any further questions about this study.
- I understand that all the data collected for this study is strictly confidential and I will not be identifiable in any report of this study, including any publication in academic journals.
- I freely and fully consent to participate in the study, which has been entirely explained to me. All of my questions or queries have been adequately answered.
- If I withdraw up to two weeks from today, all the data (including the interview transcript and audio recordings) and completed forms will be destroyed. If I request to withdraw later than two weeks from today's date, I acknowledge that my anonymised data will be used in a doctoral thesis and may be used for further analysis and/or academic publication.
- I also acknowledge that for the purposes of possible academic publication, all the data herein (including audio-recordings) will be kept securely for 5 years after which they will be destroyed by the researcher.
- I acknowledge that I have been given the opportunity to ask any questions from the researcher and I am happy to proceed as a participant in this research.

- I am aware of the related risks to data and confidentiality surrounding face-to-face interviews vs. Skype.

I consent to undertaking a (please delete as appropriate):

- Online Skype interview

Participant's Name (BLOCK CAPITALS):

Participant's Signature:

Date:

Date of Interview:

Researcher's Statement

I have informed the above-named participant of the nature and purpose of this study and have sought to answer their questions to the best of my ability. I have read, understood and agree to abide by the British Psychological Society's Code of Conduct, Ethical Principles and Guidelines for conducting research with human participants.

Researcher's Name (BLOCK CAPITALS):

MR. CHRISTOPHER LLOYD

Researcher's Signature:

Date:

Appendix D

Interview Schedule

SEMI-STRUCTURED INTERVIEW SCHEDULE

Note: Initial participants demographic questions will be collected before the main interview begins. Asking the listed prompts will be dependent on the answers given; these are possible prompts and will be subject to alteration during the interview if already answered at other points.

Orientation to Interview & Demographic Questions

What is your age?

How do you identify your gender?

What is your job title?

Where do you currently practice and for how long?

Which qualification route and level of training have you achieved?

What was the predominant psychotherapeutic theoretical orientation during your training?

How many years have you been practicing?

What client group do you work with?

What types of nomothetic measures have you previously used and currently use practice?

What types of idiographic goal-based outcomes measures have you previously and currently used in practice?

Do you have any questions before we begin?

REMINDER: THIS WILL JUST BE A CHAT ABOUT YOUR EXPERIENCES OF USING GOALS WITH CLIENTS IN YOUR THERAPY SESSIONS

1- Can you tell me a little bit about your experiences of using outcome measures in session/your practice?

a. (PROMPT) nomothetic measures?

b. (PROMPT) goal measures?

2- What comes to mind when you think of goals in therapy?

3- What does it mean to you to work with goals in therapy?

a. (PROMPT) What does GBP mean to you?

b. Can you talk to me about examples from your practice of using goals?

4- Can you tell me how you experience working with goals in therapy?

a. (PROMPT) What happens? How do you feel?

b. (PROMPT) Have your feelings/thoughts changed?

c. Do you have any examples?

5- How do you feel your clients relate to goals?

a. Any examples?

6- Has working with goals changed the way you think or feel about your practice?

a. (PROMPT) What was your initial feeling/sense/attitude?

b. (PROMPT) How has this shifted? Or remained the same?

c. (PROMPT) How do you feel about this change?

ENDINGS

- Do you have anything else you would like to add or share?
- How did you find the interview?
- Do you have any questions for me?

DEBRIEF AND REMIND TO SHARE WITH COLLEAGUES

Appendix E

Sample Transcript – Notes, Comments and Initial Themes

Emerging Themes		Interview 1: Goals and Pluralistic Practice	Exploratory Comments (Descriptive, Linguistic & Conceptual)
Introducing the possibility of change There seems to be an assumption of desire to change in the client	167	know I usually ask kind of a soft question	Describes initial goal setting – how goals are introduced
	168	erm around "what do you, you know erm	
	169	er, what would you like to change as a	
	170	result of coming here"?	
	171	Christopher: mm	
Client goals as necessarily vague Imprecision, confusion, uncertainty, lack of awareness are all possibilities but clearly not certainties	172	Participant 1: and usually you get kind of	Clients goals as vague initially, however, this can be useful
	173	some, that seems to solicit, well not all	
	174	the time but quite often it's elicits kind of	
	175	a vague answer, "I just want to be my old	
	176	self again" or " I just want to be happy" or	Examples of vague goals
	177	"I just don't want to be anxious" you	
	178	know	
	179	Christopher: mm	
	180	Participant 1: but I still take that, so, I'm	
	181	quite happy to call that a goal	
	182	Christopher: er-hm	
	183	Participant 1: and, erm and then that then	Initial goal setting prompts further exploration
	184	leads me into, er, a discussion about sub	
	185	goals or tasks	
	186	Christopher: er-hm	
Normalising the task ahead: "that's too big to tackle in a oner, so let's break that down"it's the process of concretisation of goals what' it seems they're talking about here	187	Participant 1: so we usually, I usually say	Importance of step by step Awareness of smaller goals/ "steps" as basis to change
	188	something along the lines of err "well,	
	189	just you know, being your old self, that's	Feels goals can be too big Sense that goals can normalised task of therapy by making manageable
	190	too big to kind of just tackle in a oner, so	
	191	let's break that down into stages or tasks	
	192	or steps", whichever kind of just fits for	Need to fit for client
	193	the client and and look at that week by	

Emerging Themes		Interview 1: Goals and Pluralistic Practice	Exploratory Comments (Descriptive, Linguistic & Conceptual)
	194	week and then maybe in hindsight we can	Understands different goal levels
	195	look back at the big overreaching goal	
Here it seems they're talking about concretised goals as a way of *benchmarking* therapy outcomes	196	and see if we've accomplish that and so,	Importance of differing goals with bigger and smaller goals
	197	so that's kind of, how I talk about it with	
	198	the client	Emphasising need to look back to see what "accomplished"
	199	Christopher: how do you think they relate	
	200	to that kind of, that kind of approach, the	
	201	clients?	
	202	Participant 1: well, its, they find it, so that	
	203	I always do that in combination with, well	
	204	not always, there are some things that	
	205	kind of prevent but most often I do it in	
	206	combination with the timeline	
	207	Christopher: ok	
	208	Participant 1: so the timeline, is a visual,	
	209	right, so the way I do the timeline is erm,	States procedure for eliciting client goals
	210	I'll write those goals on the timeline, put	
	211	down words like, anxious, isolated, or	
	212	tearful from the assessments, from the	
	213	assessment forms erm, I will.. erm.. And	
	214	then we'll decide tasks and in those tasks	
	215	we'll decide using the clients own words	
	216	and then i'll colour code those tasks, so	Suggests collaborative working
	217	I've got 5 different colours or highlighter	
	218	pencils and so they will get, so with me	
	219	you get 5 tasks [laughs] but for 6 sessions	Laughing may suggest awareness of potential overload through "tasks"
	220	that's about all you can handle anyway	
	221	you know [laughs] erm, so erm, we will	
	222	have tasks and that might be something	
	223	along the lines of "the relationship with	

Emerging Themes		Interview 1: Goals and Pluralistic Practice	Exploratory Comments (Descriptive, Linguistic & Conceptual)
I hear here something about focussing (and possibly re-focussing in future sessions) and being mindful of the time available	224	your father", erm erm er.."coping with the	
	225	pressures of work" you know, whatever it	
	226	is, you know	
	227	Christopher: mm	
	228	Participant 1: and they'll each have a	Process of writing goals as helpful
	229	different colour and so what and so quite	
	230	often when the client sees it written down,	Emphasising benefits of using client's own words as "co-created" here it seems they're talking about *ownership* of the goals, of therapy, of the progress for the client
	231	sees where they're going, broken down,	
Importance of the written goal	232	it's it's, they really can, and also I use the	
	233	client's own words when I'm writing on	
	234	the timeline and so, it's in their own words	
	235	so it's co-created	
	236	Christopher: er-hm	
	237	Participant 1: erm, it's out of their mouths	
The importance of the client voice	238	so they can't argue with it you know, cos	Using client's own goals/words serves defensive function?
	239	it's like well you know "you said erm, I	
	240	cry myself to sleep every night, you	
	241	know" and I'll say "what's that related	
	242	to"? And then you know well that will	
	243	well "you know my father passing away",	
	244	ok so you know those two bits of the	
	245	timeline both get coloured in green or	
	246	whatever. And what happens of course is	Understands goals as primary for allowing clients to build a visual framework for how benefits clients seems also it enhances effectiveness involving an additional sense (vision) to the process
Facilitating therapeutic containment	247	that, then they are able to see very	
	248	visually how everything over erm,	
	249	overlaps in their lives	
	250	Christopher: mmm	

Emerging Themes		Interview 1: Goals and Pluralistic Practice	Exploratory Comments (Descriptive, Linguistic & Conceptual)
	251	Participant 1: so, "oh finally I can see the	Client's stated feedback justifies use of goal framework
	252	fact that you know I'm tearful, I cry	
	253	myself to sleep every night, I'm not	Believes goal setting allows clients to make connections between their problems
	254	getting a good night's sleep because I'm	
	255	worried about my father dying, is	
	256	affecting my work and buggering me up	
	257	at work the concentration". Right so so...	
	258	Christopher: they can see it's linked yeah	
	259	Participant 1: so they see things, so things	
	260	will happen more than one colour around	
	261	it right, so then the task will be ok, the	
	262	green stuff, the relationship with your	As offering clients containment – "a way forward"
	263	father, with your father passing away, the	
	264	yellow stuff your work thing, the purple	Finds it helps clients take "overwhelming problems" to make them manageable a sense of direction, reassurance is felt here.
	265	stuff, the problems you're having with	
	266	your wife or whatever right and so it's you	
	267	know you get comments like "that's my	Finds it allows clients to "get a grip on" and to "find a way forward" reducing overwhelming feelings (soothing function)
	268	whole life on two A4 pages", erm and "	
	269	ok yeah I've got a way forward, I can you	
	270	know". It takes an overwhelming	
Making the overwhelming, make sense: facilitating therapeutic containment	271	problem that they have and it makes it	Seen as ordering a client's life – to provide "sense" where it may have previously felt unsolvable. (like a formulation does)
	272	into something that they can get a grip on	
	273	you know. So before they come into	
	274	counselling, "it's like I've tried everything	
	275	in my life to solve this and I can't, so now	Seen as beneficial that allows clients to use own words – helping equality in relationship
	276	I've come to you", and here we sat down	
	277	together for an hour and erm and it makes	Negating expertise – "I'm not an expert" – humanising the therapeutic task?
	278	sense all of a sudden you know. So it's	
	279	collaborative and that helps it makes	Collaborative nature of goals aids client understanding
	280	sense, it's in their own words, so that	
	281	helps it be equal erm, so I'm not an expert	

Appendix F

Sample Superordinate and Subordinate Theme table for One Participant, with Quotes and Line Numbers

Box. 1: Table of Super-Ordinate Themes and Sub-Themes from Participant One			
Themes	**Quote**	**Page/Line**	**Key Word(s)**
A Tool for Identifying and Monitoring Therapeutic Progress	This theme draws on therapist experiences of working with goals as a tool to monitor therapeutic progress, including the felt impact of doing so for the therapeutic relationship		
Where I was then, Where I am now	"So I hear things like erm "well I never thought of things like that" or " when I read that, erm er I realise where I was a couple of weeks ago and where I am now but I also realise how far I am from where I want to be".	4/81-86	Where I am now
"A marking of the journey": Enabling progress monitoring	"So, it feeds into all of that, all of that work, also in the final session we'll use it as a kind of a marking of the journey that they've gone through you know erm, so.. "we came in 6 weeks ago, you said that you were er er felt terribly upset and isolated everyday you know and that and now you say, not at all", so you know, sometimes our point things like that out".	6/138-147	Journey
"It's actually moving me forward": Strengthening the relationship through belief in counselling	"When the client when the client can see that they are making progress on something that they haven't been able to make any progress on up until they went to counselling, it then helps them believe in counselling, it helps them	17/477-489	Progress Forward

	believe you know, this is something different and it's actually moving me forward in my life, helping me get over whatever I'm stuck doing right so, um, it's a good thing".		
Enabling client self-efficacy	"and then that helps people to um... er.. To realise that they have the resources in their lives to actually you know, get to reach that goal you know, it takes it from something abstract, just something something firm and achievable and kind of concrete and so yeah".	31/882-889	Resources
Grounding and Normalising the Therapeutic Task	This theme encapsulates therapist experiences of goals as providing a grounding and normalising force for the therapeutic relationship, in particular, those aspects of goal working that supported therapeutic working		
A grounding and realistic force	"and, it seems to me to mimic the way people erm live their lives you know. "I want to save up x amount of money so I'll I'm going to do this, this and this", "I want to lose x amount of pounds so I'm going to do this, this and this", so it's it mimics everyday life and from that standpoint it makes, it grounds therapy in real life, and so I'm a big believer in that, so for me, that's er, it's it's yeah a grounding kind of thing".	14/372-382	Mimic Grounding
Normalising the task ahead: "that's too big to tackle in a oner, so let's break that down"	"so we usually, I usually say something along the lines of err "well, just you know, being your old self, that's too big to kind of just tackle in a oner, so let's break that down into stages or tasks or steps", whichever kind of just fits for the	7/8/187-194	Break that down Stages Steps

	client and and look at that week by week".		
Bursting the counselling bubble	"it grounds the work and keeps things real and it makes that counselling bubble that you kind of get caught up in, it makes that something which is much more everyday life and makes sense and so you know once everything becomes common sense, once everything falls into place, once everything is kind of like how I live my life then all the mystery has gone and then that helps people".	30/31/873-883	Real Everyday life Counselling bubble
Making the overwhelming, make sense: facilitating therapeutic containment	"It takes an overwhelming problem that they have and it makes it into something that they can get a grip on you know. So before they come into counselling, "it's like I've tried everything in my life to solve this and I can't, so now I've come to you", and here we sat down together for an hour and erm and it makes sense all of a sudden you know".	10/270-278	Makes sense
Removing therapist uncertainty	"so for me, erm, it takes a lot of the uncertainty out of the work right so, one of the most unsettling parts of being a counsellor is you know, not knowing what you're going to get and although I've been in practice long enough where erm, you know it's not like an anxiety can I cope with this, you know"	11/306-313	Uncertainty
The importance of the written goal	"everybody should kind of make at least a big enough deal about them to get them articulated and written down and	30/866-873	Writing it down

	er even written down you know, I'm a big fan of writing it down so that you can actually have the client read it, you know "you said 3 weeks ago that..blah I wrote it here in my note to see"		
Deeper Therapeutic Conversation and Challenge	This theme involves therapist experiences of goals as facilitating compassionate challenge and hence deeper therapeutic intervention.		
Making the unspoken, spoken, through compassionate challenge	"...If kind of everything grinds to a halt we can bring that back account and say look you know, we've covered all this stuff but you know you haven't ever spoken about you know this last one here. And so quite often... Things, tasks are revealed aspects of the overall goal are revealed on the first session and then the client then you know when that pops up I'm not talking about that, so they back off of that and you've got it there in their own words, in colour, in front of them and it gives you a good opportunity for a compassionate challenge then to move things forward, maybe for the last couple of sessions in a significant manner".	13/342-358	Compassionate challenge
Challenging avoidance through goals	"it's something to pin the client back to, you know when, you know..when people spend all their time trying to like slide out from under what they are there for you know and it's quite useful to be able to say "well you said you wanted to whatever".. You can bring them back to the goal and so helps with	30/856-865	Pin the client back to

	compassionate challenge as well, which so, I think it's really quite fundamental".		
Maintaining the Client Led Therapeutic Story	This theme explores therapist experiences of the importance of holding goals tentatively and with respect for the client's experience and narrative		
Letting the "story" of therapy run	"if someone has just suffered a loss, they just lost someone in their lives right, then sometimes they just need to, you know tell the story of that person and to try and you know so, sometimes I'll hold back on asking them about goals, because they just need to get it off their chest right".	28/797-804	Hold back
Sitting with distress vs. determining direction	"so sometimes I just, I just let that story run for, you know for a whole session and we might not then ever get to a goal initially right erm and then the next session we'll have to say "ok now that you've kind of got that off your chest, in relation to that story, what direction do you want to go?"	29/817-824	Let that story run
Emphasis on goal fluidity	It might change, it might get totally thrown out of the window, it might get ignored, explicitly in our work but at least in my mind there is this implicit order of things that erm helps the er you know, the beginnings, middles and endings.. the process of counselling move forward.	12/322-329	Implicit order of things
Working with vague goals	"and usually you get kind of some, that seems to solicit, well not all the time but quite often it's elicits kind of a vague answer, "I just want to be my old self	7/172-181	Vague

	again" or " I just want to be happy" or "I just don't want to be anxious" you know.. but I still take that, so, I'm quite happy to call that a goal"		
The Case for Goals	This theme explores therapist experiences of the importance of a implementing a goal framework, including the management of client expectations, the importance of direction and how this might support the therapist		
No goal? "What are they talking about"?	"I supervise as well you know, and I say to my supervisees " well, how can you be 4 sessions in of a 10 session thing and have not decided on the goals? It doesn't make any sense. It doesn't make any sense to me as your supervisor, how can it make any sense to the client? You know, what are they talking about? Erm, if they don't have, you gotta have something to talk about. So I think it's very important to decide something to talk about and that's what goals give you".	24/687-698	Gotta have something to talk about
Managing expectations	"if the goal is to come to terms with all of that you can say "well let us be more realistic about that and come up with a smaller goal that will then feed into this bigger one, and people can identify, so they don't get pissed off right. So if you say "ok fine we'll do that" but we've only got six sessions and then at the end it's like you know " flipping heck I just got the courage to talk about it" and so	23/639-650	Pissed off Let down

	everybody's let down when really they shouldn't be".		
Direction necessary for destination	"you know and so there's not time to waste, so you know when you have a goal and you know where you're going, then fine. If you get there and you want to carry on then that's great but you know if you don't know where you're going you never know when you got there and you never know when you're finished and um so I think".	22/612-619	Not time to waste
A plan of action	".. it gives it gives me a plan of action as well. So for me, to work with goals and actually have those goals broken down into sub goals erm, is like ok so, I have a way forward working with this client".	12/317-322	Plan of action

Appendix G

Earlier Version of Master Table of Themes and Quotes

Table 9. Master Table of Themes for Group			
Themes	**Quote**	**Interview**	**Page/Line**
A) The Journey	***All of the participants seemed to make sense of goal working as facilitating the therapeutic task. This facilitation seemed to centre around progress monitoring, which in turn, enabled focus towards the therapeutic task, for both client and therapist, which in turn, increased client self-efficacy. These aspects together, seemed to point to a positive representation of goals held by participants.***		
Tracking Direction	*All of the participants seemed to make sense of goal working as enabling a monitoring of therapeutic progress. Goal working seemed to be understood by several of the participants through the metaphor of a "journey" or voyage with checkpoints, as an arbiter to therapeutic progress. This subtheme captures their experiences as they make sense of ways in which goal working supports progress monitoring within the therapeutic relationship. Many of the participants spoke of goal working as representing "a journey" for both client and therapist, that could be used to keep track of, navigate and mark progress, as well, as changing direction.*		
	"…it's the bit where after cutting our way through the jungle, its the bit where we climb up a tree.. together [laughs] and look down over the jungle that we've been travelling through to assess how far we've come. I think that's important. And also what, what's left to do how far is yet to go and do we need to.. I think this for me the the most the most valuable part of that conversation about goals allows you to adjust the the next part of the journey, you know.. it allows you to review your journey through the counselling work and then it allows you to look ahead and to tweak and change the journey that you're both on"	2/Tom	17/521-573

	"Which is the idea of a kind of, kind of a sea voyage where you have these, kind of marker buoys. And I think that's where goals are quite useful is just kind of marking out a sense of where it is that you're going to and how to navigate that. And yeah, having your sense to kind of orientation and direction"	4/Tobias	7/194-201
	"So, it feeds into all of that, all of that work, also in the final session we'll use it as a kind of a marking of the journey that they've gone through you know erm, so.. "we came in 6 weeks ago, you said that you were er, er felt terribly upset and isolated everyday you know and that and now you say, not at all", so you know, sometimes I point things like that out"	1/Rico	6/138-147
	"For specific clients where the work has been useful, I would say it has to do with monitoring progress mainly, where we are come back to goals on a regular basis even when they are in long term therapy and I would assess together where we're at on this goal, or how we can get closer to that goal, what we can do to work on that goal"	6/Maura	4/110-118
A Grounding Focus	*Most of the participants experienced goal working as grounding the therapeutic work in the immediacy of the therapeutic work. This was experienced as necessary, valuable and ethical for therapeutic work in private practice. The enablement of support for therapists acquired through goal setting was discussed by several of the participants. The participants seemed to position goal working as also of support for therapists. This largely took the form of affirming the positive impact of the therapeutic process, when client progress seemed limited or to perhaps stagnate. In this sense, holding onto the direction was felt helpful. All of these experiences were felt to offer therapists a level of certainty in what was understood to be an often-uncertain journey.*		

	"it grounds the work and keeps things real and it makes that counselling bubble that you kind of get caught up in, it makes that something which is much more everyday life and makes sense and so you know once everything becomes common sense, once everything falls into place, once everything is kind of like how I live my life then all the mystery has gone and then that helps people"	1/Rico	30/31/873-883
	"I see it as being useful. I see it as giving some focus for the client to the work and introducing the idea about thinking about what they might want, or what they might need. It sort of looks like a little imagery about sometimes if someone is in a real fog of distress, that maybe the goal is like a little lighthouse. For some people"	8/Alessandra	12/372-380
	"..it helps clients to be more aware of what they want, and what they want in their lives, and what they want in therapy. In that sense it focuses and focuses the therapeutic work. I think it's a really nice way of not wasting time in therapy"	4/Tobias	22-23/690-696
	"And not just in the NHS, but also in private practice. A lot of the time now clients come and say they don't want to be in therapy forever. They want to have something to take out with them and they want to have clear objectives"… "With one of my clients, he really wanted to focus on goals, and he was happy to monitor goals and really use that as a structure for the therapy. So, I thought in that sense that was helpful.."	6/Maura	3/69-80 4-5/124-133
	"I think erm in, it gives some structural focus to the work. I think, in going forward it will be particularly valuable in private practice because	8/Alessandra	8/229-240

	it's something ethical about trying to establish a goal with a client, that means you aren't going to meander through therapy with them on, and on..”		
	“It works for me and it works for the clients too because there’s something concrete to, you don't just come in and have a moan for now. There’s something concrete going on”	7/Pippa	17/522-526
	“I-I hope that I’m quite flexible with what a client might need or they're given the, um-- I think they thread a piece of work together, so while the client might come and talk a bit about something different every week, I think that the goal helps tie it together, so whatever that’s kind of the thread that runs through the work”	5/Amber	12/385-393
	“Erm but I do need a goal because otherwise, I'm thinking back to the very early days of my therapeutic work, erm you know, the first few weeks erm going back good few years now and and I remember not working with goals and I realised after a while that we were just going in circles, I didn't really know what that person was there for, I didn't really know what we were attempting to do, and it was very circular, it was a bit of a meander”	2/Tom	13/399-410
	“.. and it still occasionally has-- comes up in supervision is just that I will feel like I’m being pulled in lots of different directions ..,I’m losing focus..and then it’s-it’s important to refer back to the goal uh, you came because you wanted to talk about this. I know that you’re having a conflict at the moment, is that what you’d prefer to talk about instead?	3/ Annelie	9/260-277

Enabling Positive Affect	*Several participants felt goal working enabled client belief in the self and the therapeutic frame.*		
	"And I think there's a sense of satisfaction, not for everybody, but I have definitely seen clients achieve the goals they stated they wanted to achieve, and feeling a sense of immense satisfaction that is very beneficial to self-esteem, to confidence, and in their belief that they can tackle other problems for themselves as far as therapy"	8/Alessandra	8/242-250
	"And then that helps people to um... er.. To realise that they have the resources in their lives to actually you know, get to reach that goal you know, it takes it from something abstract, just something something firm and achievable and kind of concrete and so yeah".	1/Rico	31/882-889
	"… it then helps them believe in counselling, it helps them believe you know, this is something different and it's actually moving me forward in my life, helping me get over whatever I'm stuck doing right so, um, it's a good thing".	1/Rico	17/477-489
	"I think to me it's, I would like to think mainly, it energises hope and creates a sense of hope in clients because I think, you do- you should be talking about when you say to the client, "ok this is what you want to work on", and then we can do that"	4/Tobias	13/405-411/
	"I think there can be real confidence around goals. If-for example. A client's goal is to become more assertive and they during the week, they come back and tell me about that in an excited way like a kid does with a parent. So, I guess that-so there's something about that…."	5/Amber	22/674-677

	"…and I think that that conversation about goals is a great opportunity for them to really experience how much progress they've made to feel satisfaction in that, pride in that, maybe relief, all sorts of emotions"	2/Tom	18/19-567-577
B) Inauthenticating the Journey	***All participants seemed to experience several characteristics of goal working that they felt had the potential to cause ruptures and harm to the therapeutic alliance. For many, this seemed to include goal setting that either gave too rigid a focus, or, was introduced prematurely into therapy. Additionally, many experienced goal setting as potentially detracting from the therapeutic session. Here, therapists were cautious of the possible dangers of goal setting, such as a tendency to "move clients on" from their distress too soon, rather than sitting with clients. For many participants, the goal language itself gave rise to problems and introduced the possibility of failure for clients.***		
Rigid Goals	*From some of the participants, it emerged that working with goals in a "rigid" or "strident" way, often diverged therapy away from the client's wants and needs. Several participants experienced early or premature goal setting as detrimental to the therapeutic task, often identifying their own anxiety as one of the drivers for premature goals work. Premature goal setting was felt to "distort" or "impose an agenda" on the client's material.*		
	"I can think of folk who come in.. in a very distressed state for example, or perhaps not not distressed, a perhaps almost subdued mute state, where they are really struggling to express anything and in those sorts of scenarios it just it feels so clunky and.. erm non-humanistic to ask that person: "could you please give me a specific measurable achievable realistic and time bound goal"? [laughs] obviously you wouldn't use those those words, but my experience has been that most people in that situation really struggled to articulate."	2/Tom	8/245-258

	"I was just saying that I think if you were too strident about them and too rigid that goals about goals work, there's a danger that you could really -- Take clients away from the things that really matter to them"	4/Tobias	24/738-743
	"If the therapist comes up with the goals form or with the goals work, it's kind of infringing on the client's space and putting a positive frame for them, which they haven't welcomed and they aren't really ready to work with"	6/Maura	12/369-374
	"and you have to not force people into boxes or to-to give that to you early because that's distorting what they're wanting to. Then the message they're giving me, you're-you're putting it through your own lens and that's-that's not good anymore than-than just disregarding it completely is"	3/Annelie	26/801-808
	"...to impose a structured and explicit erm discussion about goals at that stage erm and I'm not sure if it'd be helpful and moreover I think if you, if I did it, erm and I think it it wouldn't be on.. I think the other person might reasonably look across at me and say have you not been listening? Do you really need me to spell this out for you?"	2/Tom	10/294-302
(Not)Sitting with Distress	*For many of the participants, goals were felt to introduce a tension into the therapeutic relationship, one in which endangered the therapeutic containment of their sessions, by placing too much focus on end destination and not "sitting with" client's distress.*		
	"So, I feel like goals can feel like pressure. That you have to be different or a change or that even you know what that goal is. I think sometimes clients come to counselling because they just	5/Amber	10/303-311

	don't want to feel like how they feel, but they've actually got no idea what they want. They just know that they don't want to feel this shit. [laughs]"		
	"I think to some people, to some clients, as I said before, it could be you see goals as if they are something finite and we are trying to achieve something that can be finished or achieved, but I think in therapy, it's not that black or white. It's very much a work in progress and a process. So, when you reach the end of therapy, an important goal wouldn't be a tick, this is achieved probably"	6/Maura	16-17/509-519
	"…I think goals at times can be a little bit… misused in the sense that they can be an artificial structure where we talk about them because we're used to talking about them and maybe it comes in the way of the actual process of doing the therapy and we're just talking about the meta-therapeutic skeleton of the therapy as opposed to doing the therapy"	6/Maura	5/145-154
	"I think when it's done in a mechanistic way, when therapists really put a focus on goals but the client isn't receptive or willing, or it was imposed in a sense that's not very good practice, hence could lead to bad outcomes"	6/Maura	15-16/474-480
	"So, it has to be goals can be as useful as they can, but they can also be damaging if we don't understand how-- I see this with new therapists. I'm 12 years in but when I'm supervising new therapists, they're trying to get- and families do this too. We want to move you out of the despair to somewhere else and cheer you up, but we struggle to hear the struggle and to really hear	7/Pippa	13/386-397

	that because it's too distressing. So we're trying to kind of move you out"		
	"I wouldn't leave it more than a few initial sessions, but I wouldn't just go, "Great. So, you're here and you're anxious, but what do you want to do about that?" It's, it's that I-I think-- Well, I've- I've made that mistake in the past and I've learned from it. That isn't a good way of approaching some clients they get, they get very discouraged and very, um, resistant. Not resistant is not the right term. I'd say frightened about, you know, that um, it makes it more difficult for them to engage with the counselling because they see the goal as I don't know a chore or, um, a struggle that they have to contend with. If that makes sense"	3/Annelie	27/841-856
Client Failure	*Many participants felt goal working carried the risk of creating a climate of failure, which might feed into the client's difficulties, if they could not reach their goal. For several participants, it seemed the goal terminology itself was imbued with achievement related meaning, that was felt to detract from a therapeutic climate.*		
	"Because quite often there is- there's a huge kind of like, you don't want clients to get discouraged or to feel like it's insurmountable right at the very start or equally if they're anxious to become avoidant because of that"	3/Annelie	27/831-836
	"Erm and maybe having to work with the client, especially if they had a goal that reasonably would be unobtainable for them at the moment, which then would feed into their depression. Do you see what I mean? Becomes a negative spiral"	8/Alessandra	16/494-499
	"It feels like for some people it could be there is a goal if you don't achieve the goal then you've	8/Alessandra	21/653-657

	failed, for other people to stay motivating. It very much depends what it means to someone"		
	"… they set people up to fail, you know, so if somebody comes in and they set a goal and you're, you're working way towards it and erm it creates, it can within some people, create the sense that if they're not achieving that goal that they're they're failing."	2/Tom	32/1009-1015
	"I also think it can be really difficult because I think a client can feel like they're failing if they're not achieving their goals.."	5/Amber	12/370-379
	"It can become a little bit overwhelming for clients who need counsel or depressed and find it difficult to reach or achieve in their lives…"	6/Maura	18/539-547
	"It can be hard if you're not getting towards... There was a client who's been saying to me actually, it was-- you know, where they seem to measure it kind of fluctuates up and down and you expect that, but with the goals measure that's like really important and you want to progress on that, and if you're not, then that feels more personal and that feels actually more demoralising than getting worse on the symptom tracker"	4/Tobias	15/450-460
	"… I see a lot of blaming clients for when they can't move forward as quick as we want them to. Then and then clients get labelled as challenging, difficult, resistant" "So, people can blame people who can't hit their goals, or we set goals for people that are too big and too scary"	7/Pippa	11/343-347 14/436-438
C)Maintaining the Client Led Story	***In the prior themes, participants variously positioned goal working as helpful for the therapeutic relationship but also of carrying the potential for harm***		

	and therapeutic rupture. Reflecting on these experiences together seemed to permit participants a means of negotiation that allowed for the integration of a relational goal working. Hence, whilst all participants had previously discussed the benefits of goal working, it emerged that many were aware of a simultaneous dialectic in the therapeutic relationship, if goals were not held tentatively or integrated relationally, with respect for the client's narrative. This final theme explores therapist understandings of balancing goal integration into a relational frame. Specifically, participants prioritised the need to maintain the therapeutic narrative, at times taking precedent over goal working. Participants were also mindful of a necessary fluidity when working with goals into addition to issues of vague and implicit goal work. Participants seemed conscious of bracketing their own agenda and expectations of goal attainment. Goals that were set over a longer period of time, once the therapeutic relationship had been firmly rooted, were felt to be more meaningful and to carry more therapeutic value.		
Negotiating the "Story"	*A majority of the participants seemed to make sense of goals working as one part of the therapeutic story. Effective goal working, however, was not to negate the main therapeutic task of therapy: a "gentle balance" was understood to be important, which balanced being with the client in the process of their distress versus supporting them move towards a new and valued direction.*		
	"If someone has just suffered a loss, they just lost someone in their lives right, then sometimes they just need to, you know tell the story of that person and to try and you know so, sometimes I'll hold back on asking them about goals, because they just need to get it off their chest right"	1/Rico	28/797-804
	"It's got to be a gentle balance of pushing and pulling and sitting with. As I said, they can be as destructive as they can be helpful if you don't get the balance and the timing"	7/Pippa	19/588-592
	"so sometimes I just, I just let that story run for, you know for a whole session and we might not	1/Rico	29/817-824

	then ever get to a goal initially right erm and then the next session we'll have to say “ok now that you've kind of got that off your chest, in relation to that story, what direction do you want to go?”		
	“I don't think it's a sin or something to do it that way but I think usefully it might be good to focus on the process, the direction of the counselling with intentionality of the client, "I want to go this way, I want to-to work on this as opposed to-- this is where I want to be at the end of this"	3/Annelie	43/1350-1357
	“..I think I say, I go to great lengths to explain that, but it's not about getting from A to B it might be just getting comfier at A. [laughs]”	5/Amber	28/868-875
	“I'm more-- yeah, and I'm okay if the goal-the goal is only partially achieved or not achieved. I kind of trust the process if the-- if a client has come and we've reviewed then I've, you know, and I’ve collaborated as much as I can, then I kind of trust more in the process as something that has been helpful”	5/Amber	38/1206-1214
	“that goals are important for the process, but maybe not with the meaning that we ascribe to them a lot in our modern society of achieving a clear target. It's more about sensing client's direction as well as being with them in the present moment”	6/Maura	18/563-569
Bracketing The Therapist Agenda	*Several of the participants reflected on their own agenda and role in goal setting. Hence, it was felt a reflective and questioning position of self was useful in detangling therapist goals vs. those of their clients.*		
	“Then there's our goals, our agendas, and our goals and I say that in a way that owns that. When you're working with somebody who's very depressed and demotivated then our goals may be	7/Pippa	3/83-94

	to liven up the client and maybe to get them to explore coping strategies, maybe to get them to explore creative pursuits as expressions for themselves. Well, I think us therapists also come, whether we own them or not we come with our goals but as well”		
	…”and try not impose your-- That's something I have in mind as a practitioner is, people come in and I have goals for them in my mind, I have-- Again, going back to what I said before, which will be wishes or desires for them and trying not to impose them on to the client. So to me, that's really important as well”	8/Alessandra	23/717-725
	“I would say they should see goals as a way of being empathic as opposed to a way of directing”	6/Maura	16/487-489
	“So, going alongside them aligned with their direction and helping them reach or go where they want to go as opposed to having our own goals and assumptions. Really respecting their direction, not what plans we have for them”	6/Maura	18-19/569-575
	“The important thing is to know it's you who's clinging on to there [laughs]. I think it's important to know that distinction for yourself. For me, it's like, "Okay, what's happening here today, with this, who's using this?" Are using it more than the client, do you need it more than the client today?”	8/Alessandra	26-27/819-826
	“I think they're important but again they have to be held loosely otherwise we can end up either bullying clients or getting overly frustrated because they're not hitting the goals that we might want them to”	7/Pippa	31-32/984-989
	“I think initially when I was working with the measure, I felt a certain anxiety that, "I need to	8/Alessandra	4/111-121

	get this measure filled in. We have to have a goal, we have to have a goal." Once I kind of sat back and reflected on that and thought about what was going on for me, A, what was this anxiety about? B, was I imposing an agenda on the client by trying to force this goal in a way?"		
Finding Meaningful Goals Through the Therapeutic Relationship	*A large proportion of participants seemed to experience the need to build a relationship before rushing into goal setting. Goals were, therefore, felt to be complex and multi-layered and to work with them appropriately required emphasis on the primacy of the therapeutic relationship. It seemed to emerge that goal setting with clients could take time and this was felt to be necessary in order to reach meaningful goals.*		
	"It's about having a strong empathetic relationship with the client where they feel comfortable and accepted and able to talk about what matters most to them and to feel like the counsellor is responding to that and taking on board what-what they want, so they feel, um, empowered to achieve that because they've got someone supporting them through that.."	3/Annelie	38/1196-1205
	"So, there's actually a kind of a hump that you have to get past first for the client before I feel they are in a position where they can comfortably give that information to you as a counsellor. Not universally, but there are some clients where, like I said, I-I-I see, you know, don't worry if you don't know what you want yet, we'll get up two or three sessions for you to find out what's going on that matters"	3/Annelie	24-25/761-771
	"So, the first thing that springs to mind, is that goals, goal consensus, goal achievement, happens within the context of a therapeutic relationship. So to my mind, without that, nothing happens	5/Amber	35-36/1104-1116

	anyway. So that they're not separate to the relationship, they're part of the relationship. That a client's not- if they don't engage with me, then they're not going to engage with their goal, their therapeutic goal. So something about paying really close attention to the therapeutic relationship"		
	"There's the explicit goals that clients come with in therapy. I want to work on an eating disorder or I want to work on this argument that I've had with my dad. Actually, what happens is as we explore what's going on for them, other goals materialise"	7/Pippa	2-67-73
	"I remember one woman. She said I asked her if she had a particular issue that she was struggling with erm but she, she said she wanted to "feel less meh". That was it [laughs]. You know, she did this thing with her, her shoulders and her arms, you know. She wanted to feel less meh .. I completely got that the way [laughs] because of the way she articulated that, the look on her face, the use of her body. She was able to articulate that goal in a way that if we'd written it down or just used words erm I think it probably would have left out half, the half quality and meaning, but because it was it was erm, it was multi-dimensional I suppose erm, then I, I knew perfectly well what she meant.."	2/Tom	11/324-346
	"And I think the challenge is to find goals but I think also the challenge is finding goal that are meaningful to clients. Um, you know, and if you do goal work very early [coughs], and I say this probably more in terms of supervision. I think	4/Tobias	16/481-490

	goals-- setting goals takes a lot of work, and I think if you just ask them what your goals are, then I don't think you get anything particularly rich"		
	"I think quite often clients come with goals that they have been told that they should have by other people and I think that that takes a long time to emerge" "So that actually, in clients having the confidence to articulate their own goal. It can be quite far into the work. Um, I think goals are multi-layered"	5/Amber	14/422-426 14/430-434
	"As therapists, the presenting issue is often the safe thing that they come into therapy with and there's often other stuff going on, wobbling around elsewhere. There's that bit, client's explicit goals that they may be coming to therapy with then there's the unexplicit goals of whatever else is wobbling around in their world"	7/Pippa	3/73-81
	"I think that from my point of view, what I've learned about goals and working with them is that, don't rush them into the first session. If you get to almost get a sense of your client and what their issues are and what you're going to be working with. See if I could get some sense of what their vulnerabilities are..".	8/Alessandra	23/704-715
	"I think that my experience with clients is that even when we're trying to be as collaborative as we could-- can and set goals, I'm-I'm conscious that we have the power and I'm conscious that quite often clients want to please us. So I'm really aware of that when I'm talking about goals, that	5/Amber	39-40/1230-1251

	I'm really-I'm really aware that-that they might be trying to please me”		
	“you know and so there's not time to waste, so you know when you have a goal and you know where you're going, then fine. If you get there and you want to carry on then that's great but you know if you don't know where you're going you never know when you got there and you never know when you're finished and um so I think”	1/Rico	22/612-619

Appendix H

Ethical Clearance

Angela Loulopoulou 06:12

Re: Ethics feedback process

To: Christopher Lloyd

Hi Chris,

The Head of the Reasearch Ethics for the School of Social sciences has signed off your form, so can proceed with your recruitment.

See More from Christopher Lloyd

--
Kind Regards,

Angela

Dr Angela Ioanna Loulopoulou, PhD; AFBPsS; FHEA

Principal Lecturer in Counselling Psychology
Programme Director of the Professional Doctorate in Counselling Psychology
School of Social Sciences
Chair of Subject Standards Board for PG Psychology
Chair of Ethics Review Committee for PG Psychology

Office hours 9.30-17.00 Tuesday to Thursday

Please email me if you would like an appointment, as I am not often at my desk.

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Appendix I

Distress Protocol

Distress Protocol

The following is the specified protocol, which will be followed by the researcher, should participants become distressed during the course of their participation in the aforementioned research study.

Although it is not expected that the research area will provoke distress for participants' as it is not investigating a sensitive area and participants are themselves clinically trained psychologists, this protocol has been devised in order to best manage and support participants in the event that distress is triggered, as a result of their participation.

The lead researcher, in the present function, will work as a researcher, although also as a trainee counselling psychologist at London Metropolitan University, he holds experience in supporting individuals sensitively in situations in which distress arises. His experience, therefore, will be used throughout the research process in order to manage situations in which distress arises.

A three-step protocol is presented below, which details actions to be taken depending on the level of distress presented.

1. MILD-MODERATE DISTRESS:

Signs to be vigilant for:

1. Tearfulness.

2. Voice becomes filled with emotion and/or trouble in speaking.

3. Participant becomes preoccupied and/or restless.

<u>Action to take:</u>

1) Ask participant if appropriate/happy to continue in the study.

2) Offer the participant pause and break.

3) Prompt them of their right to halt the interview.

2. SEVERE DISTRESS:

Signs to be vigilant for:

1. Crying and/or incapacity to talk coherently.

2. Panic attack- for example, hyperventilation, shaking.

3. Intrusive thoughts of any traumatic event.

Action to take:

1. Termination of interview.

2. The debrief will begin instantaneously.

3. Relaxation techniques will be advocated in order to normalise breathing and reduce agitation.

4. The researcher will recognise participants' distress, and attempt to normalise emotions and experiences.

5. If any unresolved issues emerge during the interview, the researcher will accept and validate their distress, but reaffirm that present interaction is not meant to be therapeutic in nature. As such, clear boundaries will be maintained and the researcher will not attempt to provide clinical and/or therapeutic interventions.

6. Details of support agencies will be offered to all participants.

3. EXTREME DISTRESS

Signs to be vigilant for:

1. Heightened agitation and potential verbal or physical hostility.

2. In rare cases - possible psychotic breakdown where participant loses touch with reality.

Action to take:

1. Maintain safety of both participant and researcher.

2. If the researcher is concerned for the participant's or others' safety, he will inform them that he has a duty to inform any existing contacts they have with mental health services, such as their GP.

3. If the researcher considers that either the participant or other might be in imminent danger, then it will be suggested that they present at the local A&E Department and ask for the on-call psychiatric liaison team.

4. If the participant is disinclined to seek direct help and subsequently becomes violent, then the emergency services will be called (999) (this last option would only be used in an extreme emergency).

Appendix J

Debriefing Form

GOAL BASED PRACTICE AND PLURALISTIC PRIVATE PRACTICE

Thank you for taking the time to participate in my research and for sharing your experiences. I hope you enjoyed the research interview.

The present study was conducted in order to explore therapist's experiences of goal-based practice within the context of pluralistic therapy. As mentioned before, there is a considerable body of evidence pointing towards the benefits of goal-based practice for the therapeutic context, however, as of yet, no research has explored therapists' experiences of this.

The present study was undertaken in an attempt to fill this gap, in order to progress understandings of therapeutic practice in this area. It is also hoped that the findings may go some way to advancing therapeutic practice. **If you know of any colleagues or acquaintances that are eligible to participate in this study, please do share the details of this study with them, however, we request that you not discuss details of your responses with them until after they have had the opportunity to participate. I greatly appreciate your cooperation.**

Who can I contact for further information?

You may contact Mr. Christopher Lloyd (CEL0088@my.londonmet.ac.uk)

Thank you again for taking part in this research!

Feeling distressed following your participation in this study? *Please consider contacting your local GP or present at your local A&E department. For confidential listening support, call Samaritans 24/7 line, on 116 123.*