

How do Counselling Psychologists Make Sense of  
Their Clients' Psychiatric Diagnoses:  
An Interpretative Phenomenological Analysis.

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**Abstract**

Counselling psychology, with its humanistic value base and adherence to certain aspects of the medical model, is in a positional dilemma on issues such as diagnosis. There seems to be a current need to define counselling psychology's epistemological position due to doubts about its independence as a profession. How counselling psychologists respond to diagnosis has been tentatively explored in the literature, but responses in terms of thoughts, feelings, perceptions, and their interpretation of these responses is absent. To address this gap, semi-structured interviews were carried out with six counselling psychologists and the interviews were analysed using Interpretative Phenomenological Analysis (IPA). Two themes were identified: 'diagnosis is something to hang your hat on,' and 'the bigger picture.' Like previous research, these themes highlight the different epistemological positions taken up by counselling psychologists on diagnosis. However, the current findings also describe the lived experience of holding these different positions; for example feelings of tension are expressed and the level of uncertainty that needs to be tolerated is explored. A suggestion is made in terms of defining this changeable position, as one of safe uncertainty (Mason, 1993), in order to facilitate clear communication regarding a position. Specific recommendations are made for research, training and practice, including: the need for tolerance of uncertainty to be made more explicit on counselling psychology training programmes; suggestions for further IPA and Grounded Theory Research; and the development of a special interest group has been suggested, where counselling psychologists and other professionals can share ways of managing the impact of diagnosis on their practice.

### **Researcher's Personal Standpoint**

Before introducing the current research I felt it was important to describe my relationship with the topic and how this may have impacted on the research, in order to contextualise the thesis.

Psychiatric diagnosis is a concept that, in the past, I have given little attention to. This position was influenced by my role within a service that does not diagnose its users, but instead places emphasis on the importance of each individual's personal experiences. I always felt a sense of pride in being able to explain and justify to others, the reasons why this was so valid.

However, when I began my counselling psychology training in 2011, I began to realise that, while there was a place to not use diagnosis, perhaps holding a strong and consistent anti-diagnostic view was quite naïve. The main therapeutic approach that I am trained in is Cognitive Behavioural Therapy (CBT). I found that diagnosis was quite important within my first placement when taking a CBT approach, since it largely informed the formulation and understanding of my clients' difficulties.

Consequently, I found that with my state of not knowing in the early stages of my training, I leant quite heavily on the diagnosis, sometimes at the expense of engaging with the client's experience. This approach was also influenced by my own difficulties with tolerating uncertainty and 'needing to know.' In particular, I worked with one client who had a diagnosis and I approached them in terms of this diagnosis. However, this relationship ruptured and the therapy ended prematurely, partly because I had not paid sufficient attention to their experience or some of the relational difficulties that became quite apparent.

Following this early experience in training, I began to question my views on diagnosis and was also left wondering if other counselling psychologists have shared the experience of responding to the diagnosis rather than the person. My emerging interest in this area was also influenced by a professional skills module in my first year that covered the topic of diagnosis as a critical issue within counselling psychology practice.

Within the literature review, hopefully it will become clear to the reader, that I found the issue of diagnosis to be very relevant to counselling psychologists, particularly in terms of how we position ourselves on diagnosis. While I have come to realise that this position is hugely flexible and uncertain, I think it is important not to shy away from this, but to embrace it and communicate it to other professionals.

Given my very personal interest in this research topic, I believe it is very evident throughout the thesis how this research has been a learning experience for me and how my position on diagnosis moved quite quickly from a very anti-diagnostic realist position to a more critical realist one, where I pay some attention to diagnosis, but also pay a lot of attention to the individual, acknowledging that the diagnosis cannot tell me all there is to know about the person. Furthermore, my ability to tolerate uncertainty and realisation that this is necessary for my chosen career has developed and is very evident within the research. Similarly, during my training I have really got in touch with the fact that my felt experience of something is often different from my expectations. For instance, I was really excited about the training when I applied for it and was focused on the end goal of qualifying. However, I soon realised that the felt experience was far more challenging than I had ever imagined. This may have influenced my interest in highlighting the internal felt

experience of counselling psychologists' responses to diagnosis. So I suppose on reflection, this thesis was not only about clarifying issues around diagnosis for the profession, but also clarifying these issues for myself.

While a reflexive statement at the end of the thesis has attempted to highlight the specific impact of my interest in the topic at particular points in the research process, I hope that this explanation of my positioning will help to inform the readers' understanding of my relationship with the research as they read on.

## Introduction

“To diagnose, or not to diagnose, that is the question” (Frank, 1975, p. 63).

As is highlighted here, the use of psychiatric diagnosis in the mental health field is one of longstanding debate. Psychiatric diagnosis is, according to Segal, Corcoran and Coughlin (2002), “the identification and labelling of a psychiatric disorder by examination and analysis” (p. 13). Psychiatric (or mental) disorders, according to *The Diagnostic and Statistical Manual of Mental Disorders* (5<sup>th</sup> ed.; *DSM-5*; American Psychiatric Association (2013) are:

A syndrome characterized by clinically significant disturbance in an individual’s cognition, emotion regulation, or behaviour that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning. Mental disorders are usually associated with significant distress or disability in social, occupational, or other important activities. (p. 20)

The term ‘diagnosis’ will be used interchangeably throughout the thesis with ‘psychiatric diagnosis,’ but refers to the same term defined above.

Given the longstanding nature of the diagnosis debate, there are many different perspectives in play. For instance, there are those who believe in the benefits of diagnosis, such as those within the psychiatry field, who argue that diagnosis facilitates communication between professionals and provides a shorthand for disorders that share features (Tyrer & Steinberg, 2005). However, there are others who are more critical of diagnosis, claiming that diagnosis pathologises experience and misses important parts of individuals (Parpottas, 2012). It has also been argued that diagnosis can lead to stigmatisation (Biggs, 2010) and that

clinicians often diagnose according to their own biases (Boyle, 2002). This tendency for bias adds to an ongoing argument regarding the lack of validity in diagnostic manuals such as the *DSM* which have been referred to as “a great work of fiction,” (Davies, 2003, p. 21).

In terms of where psychologists stand within this debate, according to the British Psychological Society’s (BPS, 2013) Diagnosis Policy and Guidance, they recognise benefits brought about by having a diagnosis, such as access to services, but are also aware of possible harm from a diagnosis, such as pathologising individuals. More specifically, counselling psychology has its own division within the BPS, which does not have a position statement on diagnosis.

Counselling psychology, as a profession has a unique philosophy at its foundation which is summarised by Bury and Strauss (2006):

At its core, counselling psychology privileges respect for the personal, subjective experience of the client over and above notions of diagnosis, assessment and treatment, as well as the pursuit of innovative, phenomenological methods for understanding human experience. At the same time however, we find ourselves working within mental health teams and other health-care settings, where notions of “sickness” and the associated labels that go with the concept of mental illness prevail. (p. 120)

As such, counselling psychology’s philosophy is grounded within humanistic values, but also incorporates more scientific philosophies such as positivism and empiricism (Strawbridge & Woolfe, 2011). This positivist philosophy is one that is shared with the medical model, and views knowledge and fact as valid only when it is observable and measurable (Freeth, 2007a). These views held by the medical model oppose

those held by the humanistic position which, according to The Association for Humanistic Psychology in Britain (AHPb, 2013), views people as more than the sum of their parts, they cannot be condensed to component parts, people have choices and responsibilities, and emphasis is placed on personal growth. These opposing views have led to a debate within counselling psychology about how they are positioned on issues such as diagnosis (Bury & Strauss, 2006).

There have been several calls for counselling psychology to define its position on diagnosis. For example Sequeira and Van Scoyoc (2000) identified a divide in terms of how counselling psychologists position themselves on diagnosis, with some supporting the use of the *DSM* as a diagnostic manual and others opposing its use, and identifies this as an issue worthy of further attention. Furthermore, Kindermann (2009) suggests a defined position is necessary at a time when counselling psychologists are struggling to maintain a unique identity and are at risk of being merged with other professions. In addition to this, it has been suggested that counselling psychology needs to do more research as a profession, in order to survive (Jordan, 2009).

Consequently, this thesis endeavours to contribute to research within the diagnosis debate in order to build upon the minimal research that exists regarding counselling psychology's position on diagnosis. The ontological and epistemological underpinnings of the researcher's stance, as well as that of the research, are considered in order to help contextualise the thesis before a literature review will consider literature relevant to the humanistic position, the medical model position, and finally that of counselling psychology. The terms "humanistic perspective" and "humanistic position" will be used throughout as all-encompassing

terms to include those such as person-centred approaches, existential-phenomenological and Gestalt psychotherapy, because they all sit within the humanistic perspective (Plock, 2010).

This review then goes on to consider a specific element of the diagnosis debate that features quite predominantly, and that is the issue of bias in diagnosis.

Poland and Caplan (2004) outlined bias as:

any inclination or tendency toward responding or acting in one way rather than another[...]many biases result from deep-seated personal, social economic or political interests and values, some arise from the practical demands of specific situations or from human cognitive limitations. (p. 9)

What this term refers to will be explored and how it applies to counselling psychology specifically will be considered before a contribution to counselling psychology research is proposed. Following the literature review, an Interpretative Phenomenological Analysis (IPA) methodology is justified and described. Following the methodology, a detailed analysis of the research data is provided and discussed in relation to existing knowledge, and recommendations for how the findings can contribute to practice are proposed. Final conclusions are then drawn and the researcher's own reflexivity and how their own experiences, views and positions may have impacted upon the research process are considered.

### **Ontology and Epistemology**

Ontology is the fundamental philosophy concerned with assumptions regarding the nature of the world. Epistemology, on the other hand, is a philosophy concerned with how and what there is to know in the world. The stance that I have taken with this research is one of critical realism because, while I acknowledge that

there are realities and truths to be discovered in the world, not all can be known about these realities (Willig, 2013). This position is underpinned by my realist ontology, that there is a real world beyond my perception of it (Maxwell, 2012). For instance, I believe that laws, religions, and political perspectives exist beyond my own beliefs about them. However, when it comes to epistemology, I believe that my interpretation of the world is constructed by me, which is more in line with a relativist epistemology. As such, this position of critical realism that I have taken, means I have integrated ontological realism with epistemological interpretivism (Maxwell, 2012). Consequently, I do not believe that any data I collect will give me direct access to reality, and will need to be interpreted to gain further understanding, but not full understanding of reality (Willig, 2013). Therefore, I hope to say something about, but cannot directly access the reality of, participants' responses to diagnoses in terms of their thoughts and feelings.

However, as is acknowledged by The British Psychological Society's (BPS) Standards for Doctoral Programmes in Counselling Psychology, as a trainee counselling psychologist, I am also able to recognise the diversity of ontological and epistemological positions (BPS, 2014). Consequently, what will become apparent to the reader is that the research incorporates different ontological and epistemological positions at times and this is considered to be a demonstration of the plurality in counselling psychology. The reader may also find that this reflects the nature of the findings in this research. Similarly, this fits with the humanistic approach featured within the thesis, which arguably lends itself to a pluralistic epistemology (Ashley, 2010). This is consistent with the previously acknowledged idea that humanism can be considered an umbrella term for a number of perspectives (Plock, 2010). One

example of the positions held by the humanistic approach is a phenomenological position in terms of its approach to both therapy and research, particularly when using qualitative methodologies (Plock, 2010 & Ashley, 2010). This plurality in humanism's epistemological position suggests an ontology that is similarly pluralistic and therefore incorporates both realist and relativist ontologies. For example, a phenomenological position considers experience to be constructed and a product of interpretation, but is still a reality to the person who has the experience, and is considered to be ontologically positioned somewhere in between realism and relativism (Willig, 2013).

In contrast, the thesis incorporates the medical model position which makes assumptions based on reductionism, realism, essentialism and naturalism ontologies (Patil & Giordano, 2010). Furthermore, the thesis includes the psychoanalytic position at certain points, from the perspective of Klein and specific concepts such as splitting (Klein, 1946). Similarly to the medical model and myself, Klein was a realist (O'Shaughnessy, 2013). This is evident in her concepts, for instance, the concept of splitting suggests a person and the world around them are split in to pieces and projected outwards, which implies that the individual and the world exist in reality in order to be split, thus resembling the realist ontology that the world is made of structures and objects (Willig, 2013).

Therefore, given the conflicting ontologies of realism and relativism that feature in the thesis, my epistemological position of critical realism is in some ways necessary in order to incorporate these different positions, since it sits in-between the two (Willig, 2013).

## Literature Review

### Overview

The following literature review will begin by considering literature related to the medical model and humanistic perspectives on diagnosis. While counselling psychology's pluralistic stance can consider a number of different perspectives and approaches, these two perspectives have been chosen because, as was outlined in the introduction, holding these two positions together creates a dilemma for counselling psychology (Bury & Strauss, 2006). Therefore, these positions seem important to consider when exploring the relations between counselling psychology and diagnosis. Consideration is given specifically to the counselling psychology perspective before considering the literature on diagnostic bias both in the process of diagnosing and in terms of how clinicians respond to diagnoses. From this literature, consideration is given to the use of the term bias and the number of different terms used within the literature to refer to a similar phenomenon. Consequently, the term 'response' is proposed as an appropriate alternative and counselling psychology literature concerning responses to diagnoses, and epistemological positioning on diagnosis, is then considered before a gap in the existing literature is identified and a research question is proposed.

### The Medical Model Position

The medical model has a focus on the expert treating the patient (Hammersley, 2010) and problems of mental health are viewed in terms of a disease, in the same sense as physical illness (Laungani, 2002). Therefore, mental illness, like physical illness is assessed, diagnosed and treated, taking an experimental approach aiming to collect data, interpret it and categorise it (Freeth, 2007a).

Furthermore, Freeth suggests that the medical model is the dominant approach within the NHS and Western societies. Golsworthy (2004) is in agreement with Freeth with his reference to diagnostic categories forming the “dominant language” in mental health care (p. 23).

Many benefits of the medical model’s diagnostic approach have been highlighted in the literature. Segal et al., (2002) and Freeth (2007b) have both outlined largely similar benefits of diagnosis: diagnostic categories help to organise, structure and understand client information; diagnosis facilitates understanding and communication among professionals; diagnosis is supposed to determine treatment; and finally, diagnosis can assist research in to the causes and treatments of different disorders. In addition, Freeth recognises some benefits for the individuals who receive diagnoses, such as legitimising distress and providing a sense of not being alone.

### **The Humanistic Position**

In humanistic therapy, the role of “expert” is held by the client rather than the professional (Plock, 2010). The subjective experience of the client is the focus of the therapy, and the humanistic practitioner seeks to understand a person’s inner world and how they construct reality, with an emphasis on the therapeutic relationship and “being with [rather than] doing something to” the person (Strawbridge & Woolfe, 2010, pp. 10-11).

Carl Rogers, (as cited in, Vincent, 2005) one of the founding fathers of the humanistic movement, refers to diagnosis as destructive. Furthermore, Vincent describes diagnosis as judgemental, which is not harmonious with the unconditional positive regard, empathy and congruence that the humanistic approach promotes.

Freeth (2007b) indicates a number of criticisms of diagnosis from a person-centred perspective. She suggests that diagnosis is dehumanising, reducing people into categories; that the medical model focuses on what can be objectively described rather than on someone's subjective experience; and finally that the humanistic approach challenges the validity of mental illness existing through the voice and views of mental health professionals. As is implied in this final critical point, it can be argued that diagnosis can never be completely objective; people will always be diagnosed through the subjective lens of the clinician. While this can be true of the diagnostic process, the same can also be true in the context of therapy, whereby the individual phenomenology of the therapist and their existing knowledge of diagnostic labels can influence how they make sense of the client in terms of their expectations, attitudes and responses. In some literature, this phenomenon has been referred to as bias.

The humanistic approach has not avoided criticism. As Martin, Carlson and Buskist (2010) highlight, the humanistic approach has been criticised for its key concepts being empirically untestable. Today's emphasis in the mental health field is on evidence-based practice and empirically supported treatments (ESTs) and humanistic approaches, which tend to privilege qualitative approaches to research, do not easily fit into the EST paradigm, (Bohart, 2005). So while the humanistic approach highlights faults in the system in terms of diagnosis, it does not offer an alternative that would be accepted within the current mental health field.

### **Counselling Psychology's Position**

Frost (2012), in his theoretical paper on the humanism versus the medical model debate, describes a dilemma for counselling psychology in terms of their

epistemological position. While he does not explicitly address diagnosis, it is an inescapable element of this debate because of its roots in the medical model. Frost suggests that the two views are present in counselling psychology philosophy, but oppose each other, creating a conflict. He asserts the need to find a common ground between these two viewpoints, by which counselling psychologists can define themselves, rather than fighting the medical model. He stresses this not only for his own clarity, but also to define the profession at a time when it is under question in terms of its identity, where others such as Kinderman (2009) and Cooper (2009) have suggested that clinical and counselling psychology are so similar that they could be merged together as professions.

In the context of treating depression, Frost proposes a need for Cooper and McLeod's (2011) pluralistic approach to treatment as a way of "bridging the gap" (Frost, 2012, p. 60) between the medical model and the humanistic position. This seems an appropriate proposal, rather than choosing a single epistemological position, why not promote counselling psychology's ability to hold multiple positions since, according to Milton, Craven and Coyle (2010), counselling psychology takes a pluralistic stance when it comes to practice. In addition, James (2010) in her opinion paper presented at the DCoP (2010) conference discusses the position of counselling psychology and suggests that with its philosophical base, it is different to clinical psychology, which does not have a philosophical base. Therefore this highlights all the more reason for counselling psychology to communicate their philosophy and epistemological position as a way of maintaining a separate identity. Jordan (2009) in her opinion paper, also considers the survival of counselling psychology with the transition in health care to evidence-based

practice, and suggests that counselling psychologists need to do more research as a profession, in order to survive. This seems a sound suggestion since research is something recognised by the dominant medical model, so is likely to be heard and understood.

In parallel, to Frost's article, Larsson, Brooks and Loewenthal (2012a) review literature on the conflict between epistemological positions that exist for counselling psychologists. They highlight the dilemma for counselling psychologists: there is a drive to use diagnoses so that counselling psychologists can fit in with other professions. However, at the same time, there is a resistance to their use because of the concerns associated with labelling and the risk of losing their identity, for example, by moving away from humanism. They conclude by suggesting that counselling psychology's ability to hold on to different epistemological positions may be a positive attribute. This is a similar conclusion to that proposed by Frost, to take a pluralistic stance that welcomes input from more than one perspective. However, like Frost, some element of anxiety remains for Larsson et al. with a concern that counselling psychologists are at risk of losing their identity, calling at the end of their review for an exploration of "views, opinions, and ways of working for counselling psychologists that are outside their traditional roles as applied psychologists" (p. 64).

Perhaps by focusing on one specific element of the diagnosis debate, a contribution can be made to what will hopefully become an abundance of research that together will communicate counselling psychology's position. As earlier indicated, the issue of diagnostic bias that has frequently featured in the literature will be considered next.

## **Diagnostic Bias**

Biases associated with diagnostic labels have frequently been highlighted throughout the literature. For example, Nehls (1998) explains how clients with a diagnosis of Borderline Personality Disorder (BPD) have often been viewed to be untreatable and therefore, in some instances, have been denied treatment. Poland and Caplan (2004) stress the importance of being aware of one's biases and their impact on clients. This tendency to act or respond in certain ways to diagnostic labels can be labelled as bias, but has been labelled using other terminology within the literature. An exploration of the literature may help to make better sense of and potentially define this phenomenon.

## **Bias in the Process of Diagnosing**

Clarke and Rowe (2006), in their study, set out to find if psychiatrists view individuals with a diagnosis of schizophrenia as more likely to be violent than individuals with a different diagnosis. They sent vignettes of a non-specified clinical case, one of which contained information about a history of violence and one that did not, to 818 psychiatrists and asked them to rank diagnoses of schizophrenia, schizoaffective disorder and bipolar affective disorder in order of which they thought would be most likely. They found that the vignettes with a history of violence contained significantly more schizophrenic diagnoses than bipolar diagnoses. The authors suggest that this apparent bias in diagnosis could affect treatment and may add to the negative stigma associated with the schizophrenia label.

While this result provides interesting insight into bias in diagnosing, it may not truly highlight what the authors claim. While, as the authors suggest, this could show that psychiatrists view people with schizophrenia as more violent than others,

it could also show that psychiatrists think that violent people have more chance of being schizophrenic: the cause and effect is unclear. Therefore, these findings potentially have two implications. Firstly, a bias that individuals with a diagnosis of schizophrenia are more violent, suggests that those with this diagnosis may be treated as violent individuals, which may not be the case. On the other hand a bias that violent people are more likely to be schizophrenic may lead to violent individuals being inappropriately diagnosed with schizophrenia. Consequently, rather than adding to the stigma attached to schizophrenia, it could actually create a stigma for violent individuals.

Mendel et al. (2011) investigated confirmation bias in diagnosis. They describe confirmation bias as “a tendency to confirm a favoured hypothesis” (p. 2651). For diagnosis, this would mean, following a preliminary diagnosis, one only seeks information that confirms the initial diagnosis and any contradictory information is ignored. Mendel et al., presented vignettes of a clinical case to psychiatrists and medical students. They were asked to make a preliminary diagnosis of either Alzheimer’s disease, or severe depressive episode. They were then given access to additional information to either confirm or revise their diagnosis choice. They found that 13% of psychiatrists and 25% of students showed a confirmation bias when looking for additional information and those who showed confirmation bias were significantly less likely to make a correct diagnosis than other participants. Furthermore, there were significant differences in treatment choice between those choosing the incorrect diagnosis and those who chose the correct diagnosis. This study highlights how a biased diagnosis can affect treatment, and so have a direct impact on clinical practice.

However, like Clarke and Rowe (2006), the authors made use of vignettes, which can be criticised for not resembling real life. Moreover, as is acknowledged by the authors, participants were asked to choose between two diagnoses when in practice the diagnosis options would be a lot broader. Consequently, their methodology may lack ecological validity. While the findings from psychiatrists and medical students were different, this difference was not discussed in any great detail. A greater consideration of this difference would have been useful in terms of the implications for training. For instance, there may be a need for a greater focus on being aware of bias in training programmes. Finally, it is worth noting that this study alludes to a “correct” diagnosis that exists. This implies that a diagnosis is an objectively true entity to be applied to an individual when even the *DSM* does not assume objectivity. *The DSM-5* articulates that it is not possible to portray the full diversity in psychopathology within the available diagnostic categories and places emphasis on paying attention to an individual’s aetiology, expressing that it is not satisfactory to just tick off symptoms during the process of diagnosing an individual (American Psychiatric Association, 2013). Thus, diagnosing is a process that considers a best fit with each individual’s circumstances, rather than a process of selecting a “correct” diagnosis.

The studies considered so far did not find bias in 100% of the sample, which highlights the complexity of this concept. Furthermore, both samples were made up of psychiatrists, but the potential impact that bias can have on treatment are also of interest to therapists. This impact on treatment, as suggested by Clarke and Rowe (2006), can add to the stigma of some diagnostic labels. In addition these studies made use of quantitative methods, which is in line with the scientific and objective

approach taken by the medical model. However, as is indicated by Poland and Caplan's (2004) earlier definition, bias forms part of one's subjective experience, the deep examination of which may be achieved using qualitative methods (Eatough, 2012). Finally, the existence of bias for professionals who diagnose has been considered, but biased responses to someone with an existing diagnosis, has not yet been considered, and will be next.

### **Biased Responses to Diagnoses**

Brody and Farber (1996) focused their quantitative study on the diagnoses of depression, schizophrenia and borderline personality disorder (BPD). They recruited psychologists as participants and were concerned with whether level of professional experience affects therapists' countertransference reactions or their attitudes toward these reactions, and whether these reactions differed depending on the client's diagnosis. While acknowledging the difficulty in defining the term countertransference, due to the number of definitions available, they acknowledge that nearly all definitions describe the therapists' conflicts and emotions that arise when working with their clients.

They recruited 336 participants, 71 of whom were in graduate school for clinical psychology, 39 of whom were on internship or had completed all requirements of the course except their dissertations and 218 were qualified and licensed practitioners. Participants were given three vignettes describing a depressed, schizophrenic and borderline presentation, following which, they were asked to rate the degree to which they imagined that working with each client in the vignettes would evoke positive, negative countertransference feelings, and countertransference-related behaviour. They found that countertransference

reactions differed significantly between diagnoses. More specifically, depressed clients elicited positive countertransference reactions, borderline clients elicited negative countertransference reactions and schizophrenic clients elicited more complex countertransference reactions.

Brody and Farber also considered level of professional experience and the affect this has on attitudes towards countertransference reactions. They found that students are significantly more likely to regret saying things to clients, and are more likely to feel their emotions are too strong, frequent and need to be defended against. Brody and Farber's concern with the attitudes towards countertransference reactions, rather than the reaction itself, is interesting in highlighting how psychologists make sense of their responses, and how this can change with experience. This is promising because, as is indicated by Poland and Caplan (2004), it is important to be aware of one's responses because awareness alone can prevent one from acting in accordance with biases that can potentially be harmful to clients.

However, this study has its limitations, some of which do not go unnoticed by the authors. They acknowledge that their measures, which have been designed by themselves, may lack validity; the use of vignettes may not closely resemble real life situations; and the measures used may not accurately tap into countertransference, which is an unconscious process. In addition, it seems unclear how the countertransference responses can be associated solely with the diagnostic label since they may have been a response to the vignette description as a whole.

Brody and Farber (1996) do not refer to bias per se, but speak to the strong reactions that mental health professionals can have to diagnostic labels. The phenomenon in both studies is arguably the same thing, as participants demonstrated

an “inclination or tendency toward responding or acting in one way rather than another” (Poland & Caplan, 2004, p. 9).

Similarly, Colli, Tanzilli, Dimaggio, and Lingiardi (2014) carried out a quantitative study that did not refer to bias, but to an emotional response, which like Brody and Farber, they also refer to as countertransference. In their study they considered the relationship between therapist emotional response and client personality disorder and they claim that an understanding of clinician responses is important for understanding client relationship patterns. Specifically, they hypothesised that specific personality disorders elicit noticeable countertransference responses in therapists. Participants were randomly selected clinicians from various locations, some of which specialised in personality disorder.

Participants were asked to randomly select an adult client that they have worked with, who had no psychotic or other symptoms that may confuse the difference between psychological states and personality traits. Participants were asked to rate their emotional responses to their chosen client using a therapist response questionnaire and one to three weeks later to complete the Shedler-Westen Assessment Procedure-200 (SWAP-200). The SWAP-200 is a psychometric measure that provides assessment of personality and personality pathology.

The authors found that there were consistent, significant links between personality types and countertransference types. For example, when working with clients with a narcissistic presentation, clinicians are likely to feel bored, distracted, disengaged and frustrated. The authors conclude that their findings demonstrate how transference feelings can be used to recognise interpersonal patterns. As such, it seems that this study does not indicate that clinicians respond to their clients’

diagnostic labels per se, but respond to relational themes that can then be used to produce a diagnosis. So, it might be argued that they are diagnosing themselves rather than their clients. It can also be argued that rather than responding in a biased way, the authors have in some ways created a bias or a categorisation system in order to simplify human responses.

The authors themselves acknowledged limitations with the study including the possibility of a measurement bias due to participants measuring their own responses as well as their clients' personality characteristics. Moreover, they suggest that participant self-report may have led to defensiveness and difficulty recognising their unconscious feelings. This limitation may have been exacerbated by the use of a quantitative methodology. Participants may have felt restricted in how they responded with the use of specific measures which then could have seemed defensive to the researchers. In addition, quantitative measures are arguably more likely to miss valuable information about a participants' responses that fall outside of the measure; such as unconscious feelings. Therefore, it may be the case that a qualitative methodology would have been more likely to capture unconscious processes and more detailed information regarding participant responses.

It seems that there is some evidence within the literature that biases in response to diagnostic labels do occur, and that individuals can also hold attitudes about these responses. However, it also seems evident that while diagnostic labels may elicit biased responses, responses can also be used to create biases or diagnostic categories. There is also a tendency to use quantitative methods, when the study of countertransference or emotional responses form part of subjective experience, which is perhaps more suitably explored with qualitative methods (Eatough, 2012.)

It is apparent from the literature considered that clinicians' responses to diagnosis cannot necessarily be categorised as any one kind of bias. Different types of bias have been referred to and there have been other terms used, such as countertransference, to describe a similar phenomenon as bias. Furthermore, Colli et al.'s (2014) study demonstrates that bias may simply be a label for a response. However, regardless of the terminology used within the literature, it seems that what all the literature described is a human response, whether it be bias, countertransference, or any other kind of response. Therefore, the most appropriate all-encompassing term that will continue to be used is that of 'responses' to diagnosis. Counselling psychology's contributions to this area of literature will be considered next.

### **Counselling Psychology and Responses to Diagnoses**

The British counselling psychology empirical literature concerning responses to diagnosis seems limited, however other literature is considering responses to diagnosis. For example Hutchinson and Lema (2009) wrote a paper that explores ways of working with trauma, speaking mainly from their own perspective, but also drawing on research. They consider diagnosis and argue that placing labels such as post traumatic stress disorder and sexual abuse on traumatised clients can limit and constrain individuals and that negative labelling can enhance effects of negative outcomes. They suggest that this is due to peoples' responses to labels, for example in terms of assumptions or behaviours. They argue that diagnostic labels are "dominant narratives" (p. 10) that restrict interpretation and action, and form part of a story co-created with clients about what has been experienced and what may be experienced.

Similarly Biggs (2010), in his examination of literature, explores and discusses the negative stigma associated with borderline personality disorder (BPD) and suggests that counselling psychologists, with their humanistic roots, would be best placed to challenge this stigma. Biggs stresses the importance of acknowledging the whole person and where their problems originate, as well as therapists exploring and working through their countertransference responses to clients with BPD through supervision and personal therapy, rather than acting them out in a prejudiced way to the client.

Milton (2012) is the editor of the book “Diagnosis and Beyond: Counselling Psychology Contributions to Understanding Human Distress” which is an illustration of how counselling psychologists make sense of and understand human distress. The contributors have written chapters that consider a variety of diagnoses and speak from their own experiences of working with clients with these diagnoses, but also highlight how they “go beyond diagnosis” (p. xiv) and attempt to understand the individual experience. In the preface to the book, Milton refers to a conflict between the narratives of pathology and the meaningful, personalised client account that counselling psychologists and other therapists have to navigate. He explains that the book demonstrates how, while they engage with the medical model, counselling psychologists also challenge it and work with clients in “creative and flexible ways” (p. xiii). In his epilogue of the book, Milton acknowledges how the contributors encourage therapists to go beyond assumptions about diagnoses and engage with the meanings that people bring, and that diagnosis is only a part of experience. Milton ends with inviting others to “go beyond diagnosis” (p. 136).

Milton's book excellently communicates counselling psychology's position on diagnosis: a capacity to work with diagnosis, but also to acknowledge and attempt to understand the person as more than just a diagnosis. The importance of being aware of responses to diagnostic labels and going beyond assumptions is implied. Furthermore, it demonstrates how counselling psychologists' ability to do this serves to demonstrate their position on diagnosis. However, as Milton himself acknowledges, this is just the beginning, which implies that further steps need to be taken to communicate this position, such as further research.

While British counselling psychology empirical literature has so far been limited, one fairly recent contribution comes from Larsson, Loewenthal and Brookes (2012b) who investigated 'how counselling psychologists experience working with clients diagnosed with schizophrenia and how they construct this diagnosis when working with these clients.' They were curious about the organisation of talk and how socially and culturally significant interpretative resources are drawn upon in terms of the diagnosis of schizophrenia. Consequently, they carried out a critical discursive psychology analysis of semi-structured interviews with trained counselling psychologists.

They found that there was particular emphasis placed on the therapeutic relationship and its importance over technique and that there were attempts to normalise experience. They suggest that these findings are indicative of how counselling psychologists construct experience of working with individuals with a diagnosis of schizophrenia in a relational way, in line with their humanistic value base. However, they also found that the use of language that pathologises is always evident. They highlight how this mirrors the epistemological conflict for counselling

psychology that has been previously outlined. They suggest that future research may want to consider whether sitting in between two epistemological positions is a hindrance or a help. It seems that counselling psychologists are becoming more active in diagnosis research, which is helping to communicate their position within the debate. It seems to be a valuable finding that counselling psychology's epistemological position is evident through their talk about their experience of working with individuals with a diagnosis of schizophrenia. While the question remains as to whether this is a hindrance or a help, this may become clearer with time as more research comes to the fore.

While Larsson et al. (2012b) considered the diagnosis of schizophrenia, Craven and Coyle (2007) considered diagnosis more generally in their qualitative study on "how counselling psychologists talk about psychopathology and diagnostic categories" (p. 235). They interviewed qualified counselling psychologists and a Discourse Analysis of these interviews revealed two repertoires that participants drew upon when constructing their position: empiricist repertoire and contingent repertoire. It seems that the empiricist repertoire featured more medical model language and the contingent repertoire featured more concerns about client experience. Again, this finding reflects counselling psychology's positioning on diagnosis, in that they are able to speak from more than one position.

Both Craven and Coyle (2007) and Larsson et al. (2012b) made use of a form of Discourse Analysis in their research, which is a social constructionist methodology concerned with how individuals construct their social reality (Langridge & Hagger-Johnson, 2009) and suggests that experience is mediated by history, culture and language (Willig, 2008). Discourse Analysis is also concerned

with the role that language plays in the construction of social reality and is critical of cognitive perspectives. However, it would be interesting to explore what a more phenomenological methodology may have highlighted, which is concerned more with how phenomena emerge in conscious awareness as individuals engage with their environment (Willig, 2008). While the experience of diagnoses, as constructed through language, could be considered a response, it may be interesting to consider responses in terms of interpretations and perceptions of diagnostic labels, and the thoughts and feelings about these labels, all of which are of concern to phenomenological approaches. Furthermore, the perception, interpretation, thoughts and feelings about these responses may also be interesting to explore.

It seems that counselling psychology's position on diagnosis is beginning to be communicated through research. It also seems apparent that while other literature concentrates on biased or stigmatised responses to diagnosis, the counselling psychology literature seems more focused on minimising such negative responses by going beyond the diagnosis and considering the impact on the whole person rather than being concerned solely with the response itself. This is not to say that counselling psychologists do not respond in a biased way to diagnosis or in any other unhelpful way, but they may use their reflective capacity to help make sense of their responses to reduce the extent to which they act on prejudiced responses.

### **Conclusions and Research Question**

It seems clear that there is a need to clarify counselling psychology's epistemological position in terms of diagnosis. There seems to be a current pressure to define their identity as unique from other professionals. In considering therapist responses to diagnostic labels, it seems to be an area of research that counselling

psychology is beginning to embark upon. The existing research provides insight into how counselling psychologists construct their experience of diagnosis through language. However, how counselling psychologists respond internally to their external world, such as thoughts and feelings, as well as how these responses are interpreted, has yet to be considered. Furthermore, following existing research, there are unanswered questions such as whether or not holding more than one position on diagnosis is a hindrance or a help (Larsson et al., 2012b). A question that focuses more on counselling psychologists' experience of their positioning's may be more able to answer these sorts of questions. Consequently, this research asked the question: "how do counselling psychologists respond to their clients' psychiatric diagnoses and how do they make sense of these responses?"

This research aimed to offer some clarity to counselling psychologists and other professionals about counselling psychologists' responses to and positioning on diagnosis. It was also hoped that the findings will be useful in training for counselling psychologists because it may foster a shared understanding of counselling psychology's epistemological position on diagnosis. Finally, as Biggs (2010) suggests with their humanist orientation, counselling psychologists have an ability to see the whole person and to self-reflect and work through responses rather than react in a prejudiced way. Consequently, if this self-awareness is communicated through research, it could stimulate other mental health professionals' own self-awareness and reflective capacities which could potentially lead to a fairer and more effective therapeutic experience for clients.

## **Methodology**

### **Choice of Methodology and Rationale**

A qualitative methodology was adopted for this research which is concerned with individuals' experiences and sense-making and aims to understand individual experiences (Willig, 2012). Quantitative methods, on the other hand, approach knowledge empirically and hold the position that we can make accurate measurements of phenomena that allow claims to be made with some certainty. Quantitative methodologies also focus more on predictions about behaviour and aim to be objective. Unlike quantitative methodologies, qualitative methodologies do not believe that there are truths waiting to be uncovered and take an inductive approach to research rather than the hypo-deductive approach taken by quantitative methods (Langdridge & Hagger-Johnson, 2009). Therefore a qualitative methodology was deemed most appropriate for answering the research question that was focused on exploring counselling psychologist's experiences of, and responses to, their clients' psychiatric diagnoses and how they make sense of those responses.

### **Phenomenological Approaches**

Phenomenological approaches to qualitative research are underpinned by various philosophies, all of which are concerned with phenomena that present in an individual's consciousness as the world around them is experienced, and engaged with, which varies in context and time (Willig, 2008). One key concept in phenomenology is Husserl's concept of intentionality (Smith Flowers & Larkin, 2009). Intentionality suggests that consciousness is always of something, such as a sound or a smell, and there is an intentional relationship between individual consciousness and the object within the individual's consciousness (Langdridge and

Hagger-Johnson, 2009). Therefore, phenomena within the world are not separate from individual experience of these phenomena, but are intrinsically linked (Willig, 2008).

Phenomenological research methods share three fundamental principles: epoché, phenomenological reduction and imaginative variation (Willig, 2008). Firstly epoché, another of Husserl's concepts, also referred to as bracketing, describes phenomena as they are without being influenced by other assumptions. Secondly, phenomenological reduction, refers to the process through which the experience of the phenomenon in consciousness is described in as much detail as possible. The aim of phenomenological reduction is to uncover different layers of meaning. Finally, in order to gain further meaning, imaginative variation allows for the phenomenon within conscious experience to be considered from different perspectives (Langdridge & Hagger-Johnson, 2009).

While there are various phenomenological approaches, they can be broadly categorised in terms of being either descriptive or interpretative. Descriptive phenomenologists, such as Husserl, draw on transcendental traditions and believe that phenomenological research should involve the researcher bracketing all past knowledge and assumptions about the phenomenon they are researching and to focus on the participant's experience of the phenomenon. Whereas interpretative phenomenologists such as Heidegger, draw on the hermeneutic tradition and do not view description and interpretation as separate, but that description is another form of interpretation (Willig, 2008). Rather than bracketing assumptions and views, interpretative researchers interpret what is experienced or encountered, but this

interpretation is always influenced by the researcher's fore-conceptions (Smith et al., 2009).

The phenomenological approach considered most appropriate to address the research question was the interpretative. This is mainly due to the greater relevance of interpretative approaches to counselling psychology than descriptive approaches. Counselling psychology places emphasis on their clients' subjective experience and pursue phenomenological approaches when attempting to understand human experience (Bury & Strauss, 2006). Therefore, phenomenological approaches to research are relevant to counselling psychology. However, counselling psychology places emphasis on the therapeutic relationship and collaboration with clients (Bury & Strauss, 2006). As such, the role of therapist and client are considered important in counselling psychology, much like the relevance of both researcher interpretation and participant experience to interpretative phenomenological research. In contrast, a more descriptive approach would aim to isolate participant experience and would not consider researcher interpretations. Consequently, an interpretative approach was considered more appropriate for the research question, which was very much related to counselling psychology. Of all the interpretative approaches, Interpretative Phenomenological Analysis (IPA) was chosen to address the research question and the reasons for this are considered next.

### **Interpretative Phenomenological Analysis**

Interpretative Phenomenological Analysis (IPA) is informed by the philosophies of phenomenology, hermeneutics and idiography. Firstly IPA incorporates the philosophy of phenomenology and concepts from both Husserl, such as intentionality and epoché, and Heidegger who placed emphasis on meaning-

making and considered the human inter-subjective relatedness to the world (Smith et al., 2009). As such, IPA is phenomenological in that it is concerned with examining lived experience in detail as well as individual perceptions of that experience (Smith & Osborn, 2008).

IPA also incorporates the philosophy of hermeneutics which is concerned with interpretation and Heidegger defined phenomenology as hermeneutic in that what is experienced or encountered is interpreted, but this interpretation is always influenced by the interpreter's fore-conceptions (Smith et al., 2009). Therefore, IPA uses the role of the researcher and the influence that their experience can have on their understanding of their participants' experiences (Smith & Eatough, 2007). In particular IPA entails a double hermeneutic whereby "the participants are trying to make sense of their world; the researcher is trying to make sense of the participants trying to make sense of their world" (Smith, & Osborn, 2008, p. 53).

Finally, IPA is influenced by idiography which considers the particular. More specifically, IPA uses in-depth analysis of data, and small purposeful samples, examining individual cases and then moving on to more general statements. However, it still allows for returning to the perspectives of any one individual and acknowledges that each individual's perspective on their experience must inevitably be considered within a wider context (Smith et al., 2009).

In addition, due to IPA's focus on sense-making it is also considered to be concerned with cognition and assumes that there is a "chain of connection" between what people say and their thoughts and emotions (Smith & Osborn, 2008, p. 54). Nevertheless, IPA does not share the same views on cognition as that of mainstream psychology, but is distinct since IPA considers cognition to be complex, affective,

embodied and difficult to pinpoint. Cognition is considered in IPA to be one part of human experience and is observed indirectly through meaning-making. Cognitive psychology, on the other hand, assumes that cognition can be measured and separated from emotions (Smith et al., 2009).

Consequently, IPA was considered most appropriate to address the research question because firstly, it aimed to explore counselling psychologists' responses to diagnosis, which is part of their lived experience and therefore is consistent with phenomenology in IPA. Secondly, the research question aimed to explore internal responses and IPA, while it acknowledges that an individual's internal experiences, such as thoughts and feelings can never be fully transparent, it seeks to say something about individual thoughts on a topic (Smith, Jarman, & Osborn, 1999). Finally, with IPA's focus on sense-making and interpretation, it may also highlight how counselling psychologists make sense of their responses to psychiatric diagnosis.

### **Alternative Methods Considered**

Foucauldian Discourse Analysis (FDA) was also an approach considered, because it shares with IPA an interest in individual subjectivity within the context of how discourse relates to individual thoughts and feelings and what people do. FDA in particular is concerned with how language constructs social reality, and offers various 'subject positions' to be taken up which then influence subjectivity (Willig, 2008). Therefore, it could be used to examine, for example, the subject positions offered by the discourses of psychiatric diagnoses and which of these positions are taken up by counselling psychologists. However, FDA's emphasis on subjectivity has been criticised because it cannot explain individual differences in choosing

subject positions or individuals' emotional investment in said position (Willig, 2008). IPA, on the other hand, while it recognizes that cognitions are not transparent, it does suggest that through the analysis of interviews something can be said about internal experiences, such as an individual's thoughts and feelings (Smith et al., 1999). Accordingly, while IPA acknowledges that subjective, internal experience is not directly measurable, it speaks more directly to internal experiences than FDA. Furthermore, IPA may be more able to say something about how it feels to take up certain positions.

Additionally, previous research has already said something about the positions on diagnosis that counselling psychologists take up. Firstly, Craven and Coyle (2007) made use of Discourse Analysis (DA) in their research that looked at "Counselling psychologists' talk about 'psychopathology' and diagnostic categories" (p. 235), and identified two repertoires that participants drew upon when constructing their position: empiricist repertoire and contingent repertoire. Secondly, Larsson, et al., (2012b), also made use of a DA method to explore how counselling psychologists experience and construct the diagnosis, schizophrenia. They found that participants constructed experience of working with individuals with a diagnosis of schizophrenia in a relational way, but that the use of language that pathologises is always evident.

However, neither of these studies are able to say how participants felt about taking up these positions. Therefore, for these two previous research questions, DA was an appropriate methodology with its emphasis on how individuals construct social reality, particularly through the language that they use (Langridge & Hagger-Johnson, 2009). Whereas, the current research question aimed to explore internal

felt experience in response to diagnosis and with IPA's recognition that something can be said about internal experience through the analysis of interviews (Smith et al., 1999), it was considered to be more suited to the research question than a discursive approach.

Consideration was also given to using Grounded Theory since it has been considered to be IPA's main alternative method (Smith et al., 2009). This is partly due to the fact that Grounded Theory considers participant talk as offering direct access to participant thoughts and feelings (Payne, 2007). As such, Grounded Theory shares with IPA the belief that something can be said about a participant's internal world through analysis of interviews, but IPA differs in that it acknowledges that this experience is not directly measurable (Smith et al., 1999). This is indicative of the fundamental difference between the two methods in that Grounded Theory traditionally takes a realist position, which believes that data gathered can say something about what is truly happening (Willig, 2013). IPA, on the other hand, suggests there may be a reality to discover in terms of participants' thoughts and feelings, however this is always interpreted by the researcher and is influenced by their own thoughts and assumptions (Willig, 2013). Therefore, IPA arguably takes more of a critical realist stance.

Furthermore, the role of the researcher is considered by IPA to be necessary when developing an understanding of the participants' experiences, whereas for Grounded Theory the researcher is considered to be more of a witness to the observations they make and are careful not to allow their own assumptions to influence the data (Willig, 2013). Consequently, the critical realist stance of IPA was considered to be more compatible with that of the current thesis.

Grounded Theory has also been criticised for not satisfactorily addressing issues of reflexivity, whereas in IPA, the researcher is required to have a reflexive attitude (Willig, 2013). Reflexivity is something that is considered important in counselling psychology research and so, as a trainee counselling psychologist, the researcher was seeking a method to allow for sufficient reflexivity (Kasket, 2011). Nevertheless, while Grounded Theory considers the researcher to be objective in the research and can be criticised for inadequate attention to reflexivity, the method is also able to take a constructivist stance (Charmaz & Henwood, 2008). This constructivist stance lends itself more to address issues of reflexivity and considers the researcher to be more than a witness, constructing their own understanding of the investigated phenomenon (Willig, 2013). Nevertheless, as has been outlined, a constructivist approach is that taken by discursive approaches and the researcher did not consider a constructionist approach to be appropriate to address the current research question.

Furthermore, Grounded Theory seeks to contest existing theories and develop new ones (Payne, 2007). As such, Grounded Theory aims to say something about broad populations whereas IPA tends to consider convergence and divergence in small samples (Brocki & Wearden, 2006). Additionally, IPA does not oppose broad claims, but focuses its attention more on micro level analyses which may then serve to enrich any further development in terms of macro level claims (Smith et al., 2009). The current research question was not concerned with challenging or developing new theories, but was more concerned with understanding the experiences of a small number of counselling psychologists in the first instance. More specifically, the current research question was concerned with the particular

lived experiences of counselling psychologists and how they respond to their clients' diagnoses, rather than aiming for a theoretical account of their experience.

Finally the current research question is very much about experiences of counselling psychologists, and Grounded Theory has been criticised for its ability to address questions of experience over those of social processes. More specifically, Grounded Theory is able to highlight the concepts and categories that participants use to make sense of their experiences in the form of a systematic map, but this is rather descriptive, making it difficult to actually develop a theory. Therefore it may be that questions regarding experience are better addressed using more phenomenological methods like IPA and Grounded Theory is better suited to those focused on social psychological processes (Willig, 2013). Since the current research question intended to consider counselling psychologists' responses to diagnoses and how they make sense of this, it is a question more concerned with experience than social process. Consequently, given the subtle differences between Grounded Theory and IPA outlined above, the researcher asserted preference for IPA over Grounded Theory.

### **Epistemological Stance**

The epistemological position that I have taken in this research is that of critical realism because I am curious about counselling psychologists' experience and sense-making in relation to psychiatric diagnoses, but am aware that I will not fully access their realities, much like the critical realist position (Willig, 2008). The critical realist position recognizes that knowledge, rather than being objective, is specific to its context and can also be influenced by who perceives that knowledge (Lyons, 2007). IPA is a method that also shares this critical realist position with its

aims to understand individual views on a topic while acknowledging that this understanding can never be gained completely (Smith, et al., 1999). Moreover, IPA acknowledges the complications relevant to this understanding brought about by the influence of the researcher's views (Smith et al., 1999).

The critical realist position and IPA are also both consistent with counselling psychology philosophy. For instance, as Kasket (2011) argues, counselling psychologists' therapeutic work is very individualized, viewing each client as unique, but at the same time recognising all the complexities that come with human experience and acknowledging that much will remain unknown.

## **Procedures**

### **Design.**

Six counselling psychologists were recruited and interviewed on a 1:1, face to face basis. The interviews were semi-structured and were analysed using an IPA method.

### **Sampling and recruitment.**

In order to obtain a homogenous sample, as is favoured in IPA studies (Smith & Osborn, 2008), the participant criteria initially included qualified counselling psychologists who live and/or work in or around London, Oxfordshire, Buckinghamshire, Milton Keynes, Bedfordshire or Hertfordshire. However, as recruitment was rather slow initially, the participant inclusion criteria extended to include qualified counselling psychologists who work or live in the UK.

While the inclusion of trainees was considered, they are still in the process of making sense of issues such as diagnosis, and their responses, and therefore may not have established an understanding of such issues. Qualified counselling

psychologists, on the other hand, may have a better understanding of their responses, greater experience of working with clients who have a diagnosis and views about issues such as diagnosis. Markham (2003) suggests that qualified practitioners have a greater knowledge of diagnostic categories, so this may extend to awareness of responses to these categories. Consequently, only qualified counselling psychologists were included.

Participants were required to have worked with clients with an existing psychiatric diagnosis, so that accessing information about the responses that they had to these diagnoses would be possible. They would also need to feel comfortable to talk about what diagnosis means to them, their experience of working with clients who have previously received a psychiatric diagnosis, including what responses they might have had to these diagnoses, and their understanding of their responses.

Participants were recruited using an opportunity sampling method (Langridge & Hagger-Johnson, 2009). Firstly, a recruitment advert (see appendix A) was posted on relevant Facebook pages and Linked-In groups. Other social media avenues were also pursued, for example, posting the advert on an IPA discussion forum. This recruitment advert was updated to a poster format (see appendix B) when recruitment initially proved slow. Furthermore, recruitment via social media did not elicit enough interest, therefore recruitment procedures were extended to include firstly, contacting relevant Member Networks within the British Psychological Society (BPS) to seek assistance in disseminating the recruitment advert. Secondly, universities that offer doctoral counselling psychology training and universities who have psychology departments were contacted, as were the counselling services within these universities. The appropriate contact person within

each relevant department was located and contacted. These people were then asked to disseminate the recruitment advert to any counselling psychologists working within their departments.

Finally, a snowball sampling technique was used (Langridge & Hagger-Johnson, 2009). Participants who were interviewed were asked to inform any other counselling psychologists they know, who may be interested in participating, about the research project. Furthermore counselling psychologists known to the researcher were given the recruitment advert and asked to pass it on to any counselling psychologists they know who may be interested in participating. The majority of participants were recruited from university counselling services, with the exception of one being recruited via Facebook and two from the snowballing method.

When participants contacted the researcher to express interest, they were sent an information sheet (see appendix C). Following this, a time, date and place for the interview that was convenient for the participant was negotiated and booked. Ahead of the interview date, participants were sent a copy of the consent form (see appendix D) to read through before the interview.

### **Participants.**

Participant demographic information is provided in table one. The purpose of highlighting this information is to provide relevant descriptive information about participants that will help to contextualise the findings.

Table 1

*Participant demographics*

Pseudonym	Gender	Age	Counselling psychology qualification	Years since qualifying
Abigail	Female	31-40	Doctorate in counselling psychology	1
			<b>Settings worked in:</b> Adults; groups; inpatients; charity; Community Mental Health Team (CMHT); Improving Access to Psychological Therapies (IAPT); personality disorder; family drug and alcohol; health psychology; GP practice.	
Barbara	Female	51-60	Chartered Counselling Psychologist	5
			<b>Settings worked in:</b> NHS voluntary sector charity; substance misuse; further education.	
Colin	Male	41-50	Masters in Counselling Psychology	20+
			<b>Settings worked in:</b> NHS (HIV, GP services); charity; university counselling service.	
David	Male	41-50	Masters in Counselling Psychology	8
			<b>Settings worked in:</b> NHS (severe & enduring); higher education.	
Eleanor	Female	31-40	Doctorate in counselling Psychology	3.5
			<b>Settings worked in:</b> NHS (adults & older adults); university counselling service; charity; school; private practice.	
Fern	Female	41-50	Doctorate in Counselling Psychology	1
			<b>Settings worked in:</b> NHS, CMHT, GP surgery, charity, university counselling service, private practice, clinical research.	

**Data collection.**

At each interview with each participant, the researcher introduced themselves, and asked if there were any questions. Two copies of the consent form (see appendix D), were read and signed by the participant and researcher and the participant was given a copy to keep. The participant was also asked to complete a demographic information sheet (see appendix E). When it was clear that there were no remaining questions the researcher began the interview and turned the digital recorder on.

The interviews were guided by a semi-structured interview schedule (see appendix F) that was developed with guidance from Smith (1995) and Smith and Eatough (2012). Using this guidance, interview questions were initially formulated in light of the overall research question. Questions were also informed by the researcher's knowledge of existing literature and the gaps in the literature that the researcher intended to explore, such as counselling psychologists' thoughts and feelings about their clients' diagnoses. The questions were re-formulated several times following discussions in supervision and with the researcher's training peer group. Due to the nature of semi-structured interviews, these questions were used as a guide and were not followed rigidly. This was to allow the opportunity for participants to open up about a subjective experience that the schedule did not anticipate and the semi-structured nature of the schedule allowed for this digression, while being careful to stay on topic (Smith & Eatough, 2012). In developing the interview schedule, the researcher also read literature on semi-structured interviews in order to understand the kind of questions that will be appropriate to ask (for

example, Langdridge & Hagger-Johnson, 2009). The interviews lasted an average of 45.72 minutes in duration.

Following the interview, participants were asked how it was to take part in the interview, to give them an opportunity to voice any thoughts or feelings about the interview experience. This final question elicited some detailed responses from participants and so was included in the analysis of all participant interviews.

Participants were then given a debrief sheet to keep (see appendix G). The researcher then made a note of their own reflections following the interview in their reflexive journal.

### **Analysis.**

The data analysis procedure was informed by analysis guidelines for IPA, as outlined by Smith and Eatough (2012), and is described here. However, this guidance was used flexibly because IPA guidance is not supposed to be prescriptive (Smith, et al., 2009). The aim of an IPA analysis is to immerse oneself in the data, and to pay attention to and record evidence of the participants' sense-making of their experience as well as the researcher's own sense-making of the participants' sense-making, in accordance with IPA's double hermeneutic (Smith & Osborn, 2008).

Following the interviews, each interview was transcribed and the researcher formatted the transcripts with both a left and right hand margin. Once all interviews were transcribed, the first stage of analysis began which involved reading and re-reading of the first transcript several times and making initial notes in the left hand margin. These notes contained preliminary thoughts, comments, interpretations and the researcher's own responses.

These initial notes in the left hand margin were then condensed into initial emerging themes in the right hand margin of the transcript. Through this process the researcher aimed to ensure that the link between the participant's words in the transcript and the researcher's interpretation was not lost. An example of these initial stages of analysis, taken from Barbara's transcript, can be found in appendix J.

The next stage of analysis then involved clustering the emerging themes (see appendix K for Barbara's emerging themes) together, according to any connections between them. Some themes that were similar were merged together at this stage whilst others were discarded if they did not group together, or if they had weak evidence supporting them. This process of clustering was completed more than once in order to condense the themes. Each emergent cluster formed groups of subordinate themes that were then given a superordinate label (see appendix L-N for an example of this process from Barbara's transcript).

These stages of analysis were then completed for each transcript, but each transcript was considered independently of the others and the researcher was careful to acknowledge any repetition in themes across transcripts, but also to remain alert to any new themes (Smith & Osborn, 2008).

Following the independent analysis of each transcript, the clusters of subordinate themes, with their superordinate labels, were considered across all six transcripts, looking for connections between them. An illustration of the first stage of this process can be found in appendix O. Again, some themes were merged whilst others were discarded at this stage and as such, some were renamed. Like previous stages of the analysis, during this stage, the researcher moved between the stages of

analysis in order to ensure that the connection between themes and the participants' words had been preserved. Through this process, two superordinate themes were developed that were congruous across the six transcripts, each of which had three subordinate themes within them.

### **Ethical Considerations**

Careful consideration was given to The British Psychological Society's Code of Human Research Ethics (2010), and this section aims to highlight how the research intended to adhere to the four main principles. In accordance with the first principle, this research aimed to have respect for the autonomy, and dignity of the participants and to treat them without prejudice. For example the researcher did not decline the participation of any individuals without a clear rationale based on exclusion criteria. Furthermore, this principle also states that researchers should gain consent from participants and maintain participant anonymity. This was adhered to by, as has already been outlined, participants signing two consent forms. This was prior to informed consent being sought from participants by giving them an information sheet ahead of the interview, within which the nature of the research project is explained as fully as possible (see appendix C). There was no intention within the research to deceive participants and they were asked to read the information through before confirming whether or not they were content to participate. Within this information sheet participants were informed, firstly about their right to withdraw from the research project up to four weeks post interview due to data analysis beginning shortly after the interviews. Furthermore, they were informed that they could decline answering questions that they did not wish to answer, or could request for the interview to be terminated at any point.

Secondly, the information sheet detailed how each participant would be allocated a pseudonym available only to the researcher and that any identifiable information related to participants, their clients, their place of work and any clinical experiences they disclose would be altered in the verbatim transcripts and throughout the write up of the research. Thirdly, participants were informed that all data or information about them would be kept securely in accordance with the Data Protection Act (1998) and that following completion of the thesis, all data will be stored securely for a maximum of 10 years, as is recommended in London Metropolitan University's Code of Good Research Practice (2014).

Finally, the participant information sheet outlined the measures taken to maintain confidentiality. However, participants were also informed that the researcher had an obligation to break confidentiality, in accordance with the BPS Code of Ethics and Conduct (2009), if serious and immediate risk of harm to self or others was revealed during the interview process.

In terms of the second principle outlined by the BPS, scientific value was adhered to by the researcher attempting to be as transparent as possible with the aims of the research, and endeavoured to design research that is sufficiently robust and of a high enough standard. This standard was approved when ethical opinion was sought and obtained from the ethics committee at LMU (see appendix H). In addition, when changes were proposed in terms of extending participant criteria and changes made to the recruitment procedure, further approval was sought and granted.

The third principle, social responsibility, was also considered by acknowledging and contemplating the implications that the research may have for counselling psychologists, trainees, clients and other professionals. Furthermore, the

researcher remained alert to possible unexpected outcomes and, while the intention was for the research findings to be of benefit for the relevant stakeholders, the researcher also acknowledged that this may not be the outcome. For example, if the findings are unexpected, or if a participant reads the research and does not agree with the researcher's interpretations, or if other counselling psychologists do not approve of the findings. While this can never be ensured with complete certainty, attempts have been made to keep this to a minimum by the researcher remaining attuned to the ethical implications of their work whilst writing and seeking supervision where necessary.

In addition, consideration was given to interpretation of the data and findings, and how this can often be problematic. The researcher is inevitably in a position of power during the analysis of interviews in terms of being able to shape the participants' experiences. Therefore, the researcher made every effort to remain engaged with this responsibility during the analysis process so as to aim for ethical interpretations (Willig, 2013). Furthermore, as can be seen in the analysis section of this chapter, efforts were made to maintain a connection between the themes produced and the participants' words in an attempt to leave at least some of the power with the participants.

Finally, attention was given to the fourth principle to maximise benefit and minimise harm. More specifically, careful consideration was given to the potential risks of harm, discomfort or stress that the research may have to participants. For example, risks to psychological wellbeing, mental health, personal values, beliefs or dignity, social status, privacy, personal relationships, and adverse effects of disclosing illegal, sexual or deviant behaviour (BPS, 2010).

The risk for participants brought about by discussing their responses to their clients' psychiatric diagnoses was considered minimal and no greater than that in everyday life, thus was in accordance with this principle. However, the issue of the researcher inevitably being in a position of power in relation to the participants was considered again here, in order to minimise any possible harm brought about by such dynamics. The power in interpretation has been considered already, but additionally, during the whole research process the researcher attempted to remain sensitive to, and maintain awareness of, possible power dynamics. For example, the researcher disseminated the recruitment advert in a way that aimed to minimise any pressure to participate and the researcher met the participants for interview in a place of the participant's choosing, rather than determining where this should take place. Furthermore, the researcher made conscious attempts to not impose their own assumptions on participants during interviews, while acknowledging that this is not fully possible.

Furthermore, this standard outlines the need to minimise harm throughout the research process, right up to the dissemination of the research findings. Consequently, since the researcher's intention was to potentially publish the research in a relevant journal following completion, the researcher obtained participant consent for the research to be published.

Despite these lengths taken to minimise harm, the inevitable uncertainty when it comes to unwittingly causing harm or distress for participants was acknowledged and consequently a distress protocol was in place in case distress did occur (Cocking, 2008; see appendix I). Participants were also provided, in their

information sheet, with details about how they might make a complaint if any harm or dissatisfaction were to occur at any stage.

Finally, following the interviews participants were provided with a debriefing document (see appendix G) that thanked them for their participation, provided guidance on how to make a complaint and provided them with information about appropriate services to access should the interview evoke any distressing or difficult feelings.

While these ethical issues were considered by the researcher, thought was also given to the fact that ethical issues may continue to arise throughout the research process, and so the researcher made a conscious effort to remain alert to ethical issues throughout (Willig, 2013). Consequently, this section does not offer an exhaustive account of ethical concerns, nor does it eliminate them, but it does highlight the researcher's attempts to attend to ethical issues as thoroughly as possible.

## **Quality**

In determining the quality of this research, the four dimensions considered for assessing a good qualitative research proposed by Yardley (2000), were considered. The first dimension is sensitivity to context which has been ensured by making every attempt to remain grounded within the philosophy of IPA. Within an IPA study, this sensitivity begins early on with consideration being given to the existing literature which, in this case, informed the reasons for choosing an IPA study and the research question. Moreover, as is typical in an IPA study, the relevant literature has also been considered in the discussion of the findings. Finally, as in other IPA studies, sensitivity to context has been demonstrated by the raw material

from participants remaining part of the analysis and write up with the use of verbatim extracts from the interviews to support interpretations being made, which has also allowed the reader to check the foundations for the interpretations (Smith et al., 2009).

The second dimension is commitment and rigour. The researcher demonstrated commitment firstly by maintaining engagement with the area of research and secondly, by remaining attentive to participants during recruitment and the interviews (Smith et al., 2009). Rigour refers to how complete the data collection and analysis is and depends in part on how adequate the sample is. Rigour has been demonstrated through choosing a sample that is both homogeneous and is relevant to the research question (Smith et al., 2009). As has been highlighted, every effort was made to carry out a rigorous interview process and as is highlighted below, the process followed for analysis attempted to be as thorough as possible and included both a description of what participants said and an interpretation (Smith et al., 2009).

The third dimension is transparency and coherence. Transparency has been maintained by detailing every part of the data collection and analysis and has been supported by a detailed appendix. In addition, the inclusion of reflexivity and how the researcher's own experiences may have impacted on the research within a reflexive statement has demonstrated transparency. Coherence was ensured by carefully considering the fit between the research question and the philosophy of IPA. Furthermore, as in other IPA studies, the analysis and write up of the research were written and re-written to ensure a coherent argument was formed (Smith et al, 2009).

The fourth and final dimension considered is impact and importance and Yardley states that research is mainly judged on how much impact or influence it has on others. The impact and importance of this research has been ensured by giving detailed consideration, in the discussion chapter, to the ways in which the outcomes of this research can be communicated to others and to the recommendations for training, research and practice that can be made.

## **Analysis**

### **Overview**

Following the Interpretative Phenomenological Analysis of the interviews, two superordinate themes were identified: “*Diagnosis is “something to hang your hat on”* and “*The bigger picture.*” There were six subordinate themes, three in each of the superordinate themes, all of which are highlighted in table two. Between four and six participants featured in each subordinate theme. The following chapter will explore these themes in more detail and quotations from the original transcripts have been included in both the table and the body of the text to aid understanding and to maintain sensitivity to the context (Smith et al, 2009). These quotations are presented in the format of *page number: line numbers*, for example, *1: 15-18* represents page one, lines fifteen to eighteen. Additionally, participant quotations are presented in an italic font in order to distinguish them from the main text of the chapter.

Table 2

*Master table of themes*

<b>Superordinate theme: Diagnosis is something to hang your hat on</b>		
<b>Subordinate theme</b>	<b>Quotations with participant pseudonym and transcript</b>	
	<b>line number</b>	
Diagnosis as provision for individuals vs. provision for society.	<p><i>“My experience for, a lot of clients is absolute RELIEF in getting an appropriate diagnosis” (David, 2: 55-56).</i></p> <p><i>“Labelling a person’s problems so that they can get a service” (Abigail, 1: 21-23).</i></p>	
Restriction vs. freedom and creativity	<p><i>“I guess for me when you haven’t got the diagnosis you, often haven’t got all the other restrictions as well” (Abigail, 36: 1166-1168).</i></p> <p><i>“I just think it shuts DOWN a bit of your curiosity” (Barbara, 20: 657-659).</i></p>	
Diagnosis as real and not real	<p><i>“Is it because they’ve got a hidden diagnosis you know they’ve got something REALLY going on” (Eleanor, 42: 1358-1360).</i></p> <p><i>“Those kind of diagnoses, bipolar, much less accurate” (Colin, 2: 57-58).</i></p>	
<b>Superordinate theme: The bigger picture</b>		
<b>Subordinate theme</b>	<b>Quotations with participant pseudonym and transcript</b>	
	<b>line number</b>	
Tension in position	<p><i>“I think this has always BEEN an internal dilemma, for myself” (David, 46: 1503-1505).</i></p>	
Holding diagnosis in one hand, but what does this mean?	<p><i>“What I’m interested in is their journey and their experience, at this moment as opposed to, er any diagnostic label[...]. Um, but that may play a part, of, er, the understanding of their experience” (Fern, 13: 400-406).</i></p>	
Navigating complexity in human experience and	<p><i>“There are two processes but you can’t necessarily tease them apart” (Barbara, 18: 566-568).</i></p>	

**Diagnosis is Something to Hang Your Hat On.**

This superordinate theme encapsulates participants' considerations about how, on the one hand, diagnosis provides something for both them and their clients, and is a reality that can be relied upon, and on the other hand it can be very restrictive, taking away creativity, it is more about provision for society, and doubts are expressed in terms of its validity. Therefore, participants together seem to discuss whether diagnosis is something that they can reliably 'hang their hat on,' or whether it should be used more cautiously.

**Diagnosis as provision for individuals vs. provision for society.**

The initial element of this subordinate theme, is that of diagnosis providing a service. Specifically, Abigail, who generally held quite an anti-diagnosis position, expressed that it is important for individuals to have a diagnosis because without it, they will not receive a service: "*what it means is a way of um, labelling a person's problems so that they can get a service*" (1: 20-23). However, she also implies that this is not her voice, but that of the services she works in and a position she does not feel comfortable holding: "*they HAVE to have that, diagnosis to get, to get the service, ummm, so THAT can be difficult for me*" (2: 35-38). This could be interpreted as diagnosis providing something in the eyes of society, but in fact the individuals receiving services do not necessarily benefit from this as much as the services themselves. It seems that Abigail is saying that clients and clinicians conform to rules outlined by services in order to get their needs met, but this comes at a cost because, for the clinician they may not share the service's position, and for clients they end up with a diagnosis that they may not want.

While Abigail seems to hold quite a negative and suspicious view of diagnosis providing a service, Eleanor voices how the support provided by services is greater when a client has a diagnosis: “*then they’re with their intervention team for three YEARS, with, ABSOLUTELY brilliant support[...] if they didn’t have that diagnosis, they’d be, they’d be wandering around, all sorts of things going on*” (4: 97-105). Eleanor may also be saying that diagnosis is supportive for her as a clinician. The suggestion that without the diagnosis there would be “*all sorts going on*,” suggests an element of uncertainty and anxiety that is taken away by diagnosis. Moreover, the use of the word “*wandering*” suggests that a client is out of the clinician’s control to some extent, when they do not have a diagnosis. This is further implied when Eleanor suggests that diagnosis provides a sense of support from colleagues: “*as soon as they’ve got a diagnosis, HERE I actually feel quite um.....quite kind of um, trying to think of the word, um, it feels a lot more like a team effort*” (8: 237-241). This could be interpreted as diagnosis providing guidance and support for the clinician rather than the client and alleviates some kind of a sense of responsibility that comes with diagnosis, since she is not alone with a client who may wander unpredictably. It could be said that Eleanor is demonstrating the idea that diagnosis is more for professionals and their own sense-making and communication than it is for clients. Furthermore, it can be interpreted that this level of support is provided with a service, thus, as Abigail vocalised, without diagnosis, you do not get the service and therefore the support.

However, there is a sense that diagnosis brings a sense of relief for the client. Firstly, from the client’s perspective, Eleanor states that: “*you could actually have generalised anxiety disorder, or you could have social anxiety, um, more importantly*

*you could have post-traumatic stress disorder which REALLY RELIEVES a client when they, understand what's going on" (5: 153-159).* It seems that the relief Eleanor emphasises here is the answer that diagnosis provides for their experience. David seems to share this view, but names what brings the relief more specifically: "*um, something like depression, the diagnosis can inform, what IS the best intervention" (5: 134-136).* This idea that diagnosis can inform "*the best intervention" can be interpreted as diagnosis providing a sense of knowing and a solution which is relieving for clients.*

This sense of knowing is voiced directly by Eleanor: "*there's a sense of knowing, what's going on there, which is then both helpful for you know for the, for the client and, and yourself" (43: 1398-1401).* This sense of knowing for both client and therapist suggests that relief is felt by therapists as well as clients and that diagnosis provides a shared language between client and therapist.

It seems that within this theme, participants share the view that diagnosis can offer provision in various ways such as providing services and providing relief for both client and therapist. However, where participants diverged from one another on this theme was in terms of whether the provision from diagnosis is for the benefit of individuals or wider society. When combining these two positions, it seems that what is being communicated subliminally here is that diagnosis can provide for individuals, but that this is at times deceptive because diagnosis provides for services and society in advance of individuals. Nevertheless, this is a cyclical relationship between services and individuals because without the individual you would not have a service. Therefore, it can be interpreted that diagnosis provides for both

individuals, services and wider society, but it seems impossible to determine whom it primarily serves.

### **Restriction vs. freedom and creativity.**

Some of the participants shared the perspective that diagnosis provides a focus, for instance Eleanor states: “*and it gives you a real focus and, definitely in short term work, to have that focus is, is great*” (25: 801-804). She later elaborates on this focus, describing a “*path that we could quite easily follow and the treatment model we could go down*” (41: 1343-1346). So it seems that diagnosis provides solutions in that the path that it lays out for the clinician, eliminates any need to think beyond a focused, short term treatment plan, and makes their work easier. While Eleanor spoke quite favourably in terms of this focus, other participants seemed to be more hesitant. For instance, Colin acknowledged that diagnosis provides “*a pointer*” (2: 25), that helps him “*look for certain things*” (2: 25-26), and that: “*It, it's, it'll obviously, keep me ALERT*” (13:390). This focus that diagnosis provides for Colin suggests that without diagnosis he would miss things and so it acts as a reminder of sorts. However, he also acknowledges that: “*I tend not to foreclose just on the basis of diagnosis*” (2: 27-29). The use of the word “*foreclose*” here suggests that there is a risk of becoming too reliant and focused on diagnosis as a guide to the point where all other information is excluded.

In addition, Colin adds a contradictory perspective to the focus provided by diagnosis that is stressed by other participants: “*I use it more often as a, (intake of breath) um, for, elimination rather than support*” (1: 17-19). The use of the word “*elimination*” here suggests that rather than being governed by diagnosis and following its focus or knowledge, he instead uses diagnosis to eliminate what he is

not going to focus on. This contradicts his comments about diagnosis keeping him alert and it serving as a pointer, as well as stating that he does not foreclose on the basis of diagnosis. Perhaps what he is saying here is that diagnosis can provide information, but not all of this should be paid attention to, and that one's own judgement also plays a role in finding a focus, drawing on information that feels useful, not simply following it blindly. Alternatively, this idea of elimination could describe how parts of the person with the diagnosis get eliminated when particular parts of the information provided by diagnosis are ignored. Consequently, to have a diagnosis may in fact restrict a person due to how the therapist responds to them.

This theme of diagnosis restricting featured quite predominantly across participants, offering a contrast to the also very evident theme of diagnosis providing various things. Firstly, Barbara refers to diagnosis as being “*reductionist*” (12:390), and on the one hand she externalises responsibility for this reduction to the medical model: “so it’s JUST, a medical way of CUTTING, into somebody’s presenting problem I suppose” (1: 12-14). The use of the word “*cutting*” here implies something quite violent, intrusive and out of one’s control. It also has connotations of surgery, suggesting that diagnosis is a way of cutting somebody up in order to fix them, much like older psychiatric treatments such as the lobotomy. It is suggestive of individuals not having a lot of choice in the matter and that diagnosis is ‘done to’ people and therefore restricts in that the person and their choice does not come in to it at all. The person is not seen as a whole individual, but they are broken down into parts, which suggests the understanding of that person is also restricted. Later on she refers to people being “*cut up in to tiny, micro, disorders*” (14: 452-453), where the

use of the word “*micro*,” suggests that diagnosis means that the person is no longer seen because they are so reduced by the diagnosis.

This theme of reduction and cutting people down is also reminiscent of Klein’s concept of splitting which suggests that bad parts of the self are split off and projected outwards (Klein, 1946). Therefore, what Barbara may be implying here is that diagnosis serves to narrow a problem down into something that feels more bearable and manageable and the other elements of the person are split off. She seems to suggest that this splitting is done by the professionals and so is making it more manageable for them. However, it may also be that this breaking down can also feel more bearable for those who receive a diagnosis. This concept of splitting echoes Colin’s reference to elimination, but conversely he is splitting parts of the diagnosis off that are not going to help him address the person. Nevertheless, in either scenario, part of the person will inevitably be lost.

Furthermore, the restriction that happens around diagnosis has not only been located in the diagnosis itself. Participants were quite open about the extent to which their own response, or the response of the client to the diagnosis, is restrictive. This was most powerfully acknowledged by Abigail:

*you didn’t have, that restriction of the diagnosis, in terms of me or her because she, you know, i-in that, I guess if the client’s, wanting a diagnosis or likes a diagnosis then you’re,[...] you’re kind of tackling THAT, and then also maybe MY feelings about that. (20: 642-649)*

Here she suggests that when a diagnosis is present, it can be restrictive to the therapeutic process because of the feelings that the client or she may have about it. She speaks about diagnosis as if it is some kind of obstacle that must be overcome in

order to do therapeutic work. However, it could be suggested that the real obstacle is her and her own strong, opposing response to the diagnosis and how this can sometimes conflict with the client's position.

In contrast there was a sense from other participants that the restricted use of diagnosis was due to external forces. Barbara for instance states: "*everything in the CONTEXT CONSPIRES to make you just be a bit cruder*" (23: 757-758). Here, Barbara indicates that when working within a medical model, this impacts on her use of diagnosis. Her use of the word "*cruder*" suggests that diagnosis is used in a way that is simplistic and lacking. The use of the word "*conspires*" suggests that it is something within the wider context that means diagnosis is used in a restrictive way. This is suggestive of an external conspiracy, implying that there is a limit to free will when working with diagnosis. This alludes to some kind of unspoken rule or secret within society that is conformed to. However, this also implies that diagnosis itself may not be restrictive, but it is the context within which it is used, i.e. society, that makes it restrictive.

Barbara is suggesting that there is a loss of control due to an external force when it comes to diagnosis. This is expanded upon by Eleanor who suggests that she has a loss of control when it comes to working within a role that abides by the medical model: "*I was really being, FORCED all the time to kind of come and play with the sort of medical model, [...] diagno- fitting everyone into boxes, when actually, a lot of the time they didn't, really fit (laughs)*" (21: 654-660). Eleanor may also be saying that she is "*forced*" to be restrictive by reducing people to certain "boxes." The use of, and emphasis on, the word "*forced*" also sounds aggressive, as if there is a lack of choice, and suggests she is left feeling powerless. Her laughter

may be an expression of discomfort or embarrassment because she is aware of how she has used diagnosis restrictively, but this does not match up with what she believes in. Moreover, the use of the word “*play*” suggests she believes that the medical model is in some ways a fantasy and that diagnosis is not taken completely seriously.

Eleanor highlights how diagnosis can restrict her own sense of competency: “*but I think that’s an important thing with diagnosis is like where is your competency level*” (40: 1291-1294). Here she is saying that clinicians have a competency level, shaped by diagnosis, for instance she speaks about her competency in working with an anxiety disorder and feeling “*most at HOME*” (40: 1303-1304), but suggests there are more “*extreme*” (14: 455), or “*severe*” (11: 350), diagnoses that she feels less competent in being able to work with. This suggests that in some ways diagnosis places doubts on her capabilities as a counselling psychologist. Equally, this could also be relieving her doubt because if a client has a “*severe*” diagnosis, she knows not to treat them. The use of the word “*home*” implies a feeling of contentment and familiarity and suggests that moving away from this elicits some anxieties. It seems as though her response to diagnosis is to diagnose herself in terms of how capable she is in working with certain diagnostic categories.

Furthermore, Eleanor seems to associate diagnosis with levels of risk, which may also be linked to her feelings of competency: “*anxiety disorders there’s not as much- not necessarily as much of a higher suicidal, [...] risk as, you know someone who’s severely depressed, or someone who’s been psychotic*” (13: 398-403). What Eleanor seems to be saying here is that particular diagnoses elicit assumptions about

the level of risk for the person. There is also a sense of anxiety around this, perhaps in terms of how to manage risk. Therefore, it seems that it is her association between risk and diagnosis that means she responds anxiously to diagnosis and possibly contributes to her feelings of incompetence. It could be interpreted that she is actually responding to the risk, or the fantasy that risk is associated with diagnosis, rather than the diagnosis per se.

It seems that across participants there is a shared view that diagnosis can be restrictive in various ways. In parallel to this, participants also shared a view that diagnosis takes away part of their creativity. This is voiced by Abigail: “*but when someone comes kind of FRESH (laughs), no diagnosis, I guess there's more freedom*” (20: 650-652). This reference to freedom may be suggesting that diagnosis in some way traps the client and therapist, and implies a loss of free will. Her use of the word “*fresh*” to describe clients here implies that diagnosis in some ways decays or spoils a person. Her laughter after saying this could be her vocalising her discomfort with holding such a strong position.

Similarly, Barbara alludes to this sense of freedom: “*what you're picking up are, um, IN THE MOMENT THINGS, that ARRIVE between you and that person*” (23: 731-733). Here she speaks about being with a client without a diagnosis and being “*in the moment*” which resembles spontaneity and freedom. Additionally, the use of the word “*arrive*” suggests that exchanges between client and therapist are new when there is no diagnosis and perhaps they are also fresh and unspoiled, as is suggested by Abigail.

Moreover, Barbara’s reference to being in the moment indicates something naturally evolving and, since diagnosis has been considered absent during these

interactions, it may be that diagnosis does not evolve naturally like the relational process. Consequently, what Barbara may be saying here is that without diagnosis she is free to be with the person. Barbara's use of the word “arrive” suggest that there is space for things to occur between you and the client and to be worked with creatively as opposed to being so focused that she is unable to allow other information to arrive. This reference to the freedom to evolve is shared more explicitly by Eleanor: “*I'd kind of SEE what EVOLVES*” (41: 1337). It is also possible that what both Barbara and Eleanor are saying here is that their ability to use themselves in their work is limited by the diagnosis because of their own responses to it, thus adding another dimension to a relationship.

A further restriction from diagnosis is acknowledged by Barbara: “*STARTED using diagnosis, and I just think it shuts DOWN a bit of your, curiosity perhaps*” (20: 657-659). This can be interpreted as a loss of part of her skill set as a counselling psychologist and being “*shut down*” implies a restriction and a loss of freedom: her ideas and her voice go largely unnoticed when something as dominant as diagnosis is present. Consequently, anything more naturally evolving in the relationship or the work is not going to carry as much weight.

What seems to be implicit in this theme is that diagnosis can provide a focus, but when this is paid attention to, it is important not to lose one’s creativity and to become too restricted by it. Fern vocalised this balanced approach most coherently. She states that diagnosis “*helps you to work with people in specific ways*” (5: 141-142), and suggests that it is “*best not to QUESTION*” (7: 206) when a diagnosis points to a particular intervention. However, she also suggests a more creative

approach in that the therapy “*could go anywhere*” (6: 181), whether there is a diagnosis or not.

Consequently, it seems that Fern values diagnosis and she finds it helpful in providing a focus, but at the same time it is important to be able to let go of the focus at times when it feels more appropriate to be creative. Fern is quite open about not feeling overly guided by diagnosis, but the evidence in her use of language suggests that on some levels she feels the pull from diagnosis to follow a focus, whether she chooses this option or not. However, what she is quite articulately communicating here is that diagnosis can provide a focus, but that even this can be integrated into a more creative approach by using it flexibly.

Within this subordinate theme, participants have voiced how they can experience diagnosis as providing a clear focus, but at the same time this can be restrictive for both the therapist and the client. What seems evident through their use of certain language, is that this restriction can feel quite aggressive. Furthermore, they seem to experience diagnosis as taking away part of their clients, but also part of themselves and are aware of this, as is voiced by Fern. Fern highlights how attempts are made to minimise the restriction as much as is possible and maintain some creativity, but what remains unclear is the extent to which this is possible.

### **Diagnosis as real vs. not real.**

There seemed to be a difference of opinion between participants about whether diagnosis is a real thing or not. “*I think that just shows how, lack-the lack of validity I guess within and there's so much cross over*” (6: 166-168). Here Abigail refers to a lack of validity in diagnosis that implies diagnosis is not a real thing, therefore should not be relied upon so heavily. Her statement that there is, “*cross*

*over,”* between diagnoses suggests she may be confused by diagnosis at times and that she may have a desire to have something to rely upon, and that a reality does exist, but it cannot be found in diagnosis. She herself states: “*I couldn’t come up with a massive alternative*” (5: 155-156). Alternatively, what Abigail could be alluding to here is that the lack of objective validity and the cross over between diagnoses largely resembles an individual’s experience, and this is the ‘reality’ we should be working with.

Colin also questions the quality of diagnosis, but paints a broader picture in terms of what constitutes a diagnosis and suggests that there is variation between these methods in terms of the quality and reality:

*Um, well if someone is depressed, DEPRESSED, the quality of the, the quality of the diagnosis varies massively, often nurses can do it here with a tick box, chart pretty much [...] and then that’s VIRTUALLY a diagnosis so I think that’s not REALLY kind of INFORMATIVE if someone’s had MAJOR depression, er then I think that’s a bit more informative. (7: 218-229)*

The use of the word “*quality*” implies that there is some kind of standard to be met in diagnosis, which could suggest that there is a real truth out there in terms of what constitutes a real diagnosis. He also refers to major depression as being more informative, which is a universally recognised diagnostic category and features in diagnostic manuals such as *DSM-5* (American Psychiatric Association, 2013). Therefore, he may be saying here that there is a shared reality in medical diagnosis that makes problems real and possibly manageable, whereas other forms of sense-making that resemble a diagnostic process are less informative, or real, possibly because this is not necessarily a shared knowledge in the same way that a diagnostic

manual is. His use of and emphasis on the word “*virtually*” resembles a virtual reality which by definition, is not real, so Colin is saying that some ways of diagnosing are more real than others. Consequently, what he may be saying is that the reality of a diagnosis is based on the extent to which it is a shared knowledge.

This is further implied in his distinction between “*psychoanalytic diagnosis*” (11: 322) and “*ICD or DSM*” (11:329) diagnoses. He states that psychoanalytic diagnoses “*VARY between practitioner*” (11: 323-324), are “*PERSONALISED*” (11: 332), and he is “*mistrustful*” (11: 331), of them. Whereas, DSM and ICD, on the other hand, offer a “*positivistic kind of description*” (10: 317). Consequently, it can be interpreted that Colin does not consider the very individualised ways of diagnosing to be real because they are not shared and cannot even be trusted, possibly because of the lack of certainty with them.

This idea of an ultimate truth in diagnosis suggests that individual sense-making may be lost when using diagnosis:

*I can absolutely guarantee that you do NOT have bipolar effective you do NOT have, classic, manic, phases with all the kind of, um, grandiose, delusional ideation and er, you know that would NEED to be part of that. (19: 615-621)*

Here, David is speaking about a client who made sense of their problems in the context of bipolar disorder, which he disagrees with, stating that certain symptoms “*would NEED to be part*” of them for this to be reality. The emphasis on the word, “*need*,” here implies that David needs diagnosis to be real, perhaps so he can use it as a reference point for his clients’ problems. Therefore, it may be interpreted that David may feel quite lost if diagnosis is not a reality to be relied upon. Furthermore, this

idea of an “*absolute guarantee*,” implies something about an absolute reality. The client here was making sense of their difficulties in their own way, but this seems to have been lost because David’s sense that there is an objective reality in diagnosis.

The insinuation that diagnosis can be real is strengthened by the frequent use of personification among participants. For example, David states: “*to, have, that diagnosis something to literally hang, their hat on*” (9: 266-267). Here David is saying that diagnosis is a real thing that can be really helpful for clients in terms of making sense of their problems. It can be interpreted that diagnosis helps to externalise difficulties and that these difficulties can be “*hung*” on something external to the person. This hanging up also suggests diagnosis allows for problems to be tidied away where they do not necessarily have to be thought about or intrude upon day to day reality. This would imply that diagnosis does not form part of day to day reality. Alternatively, it could be interpreted that diagnosis needs to be personified in order to be real. Maybe the reality of diagnosis is actually so vague, that this serves as a way to make sense of it.

What is also implied in this use of personification is that individual problems are not real until they have been diagnosed. This is further elaborated on by Eleanor: “*is it because they’ve got a hidden diagnosis you know they’ve got something REALLY going on that could be di- you know, a diagnostic thing or, or is it something that’s...yeah it’s sub-clinical*” (42: 1358-1362). Eleanor suggests that diagnosis can hide, which is another form of personification. Furthermore, the use of “*sub-clinical*” is reminiscent of the medical model and does not seem to value individual subjective experience, but rather an experience can only be real if it is diagnosed.

So the argument as to whether diagnosis is real or not seems to be quite mixed among the participants and is made quite implicitly. However Barbara speaks quite explicitly about this:

*you're talking about, the diagnosis, the EXISTENCE of a diagnosis, of a category, but then you, you DO something to someone when you give them a diagnosis,[...]do you know what I mean? You give them something they've got to carry around. (5: L. 144-152).*

Barbara here seems to imply that the existence of diagnosis is questionable. What can be interpreted from this is that once you admit the existence of a diagnosis it becomes real and is given to someone to carry around. Furthermore, it seems that once a diagnosis is acknowledged as real, it adds to the problem, since it is something else to be carried. So while Barbara acknowledges the same doubts that Abigail does in terms of the reality of diagnosis being questionable, Barbara suggests that admitting the existence of a diagnosis is almost a choice, since we never really know if something exists or not. However, once this choice is made you make a person's problems real and then this is something to carry around.

Within this subordinate theme the participants seem to really grapple with whether or not diagnosis is a reality. They also seem to ask questions about what an alternative reality might be and whether a true reality can ever exist. Nevertheless, participants seem to be seeking some kind of reality and so it may be concluded that diagnosis is at least a shared reality that the participants work with, which may be good enough since there may not be an ultimate truth.

Overall, this superordinate theme represents various dichotomies that the participants move between within each theme, such as diagnosis as real versus not

real, diagnosis as provider for individuals versus for society and diagnosis as restrictive versus not restrictive. This reflects the dichotomous nature of diagnosis itself, as an individual either belongs to a diagnostic category or not. Yet, what seems apparent is that the participants move between dichotomous positions and consequently, their ability to ‘hang their hat on’ diagnosis is uncertain and changeable.

### **The Bigger Picture**

This superordinate theme encapsulates the participants’ expression of how they are always working within a picture bigger than the diagnosis. This bigger picture refers to their own changeable position on diagnosis, the client as a whole person, and the number of complexities that they find themselves navigating during therapy. Participants also acknowledged their own drive to categorise and make sense of the bigger picture. Therefore, participants considered where they sit within this bigger picture and also where diagnosis is positioned, for them.

### **Tension in position.**

Participants seemed to acknowledge their capacity to hold more than one position on diagnosis. However, the impact that this had on them varies somewhat. Barbara spoke about how her position on diagnosis has changed: “*it’s been a process for me, and I did arrive, in the \*\*\*, vitriolic about labels, REALLY vitriolic about them, but I CAN’T say they’re not useful, it’s just WITH caution*” (24: 763-768). Here she uses the word “*vitriolic*” to describe her previous meaning making about diagnosis which suggests a very strong anti-diagnosis position that is quite aggressive in nature. Furthermore, “*vitriolic*” implies something about corrosion which might suggest that holding this kind of position is destructive and unhelpful.

She goes on to say that now she cannot deny their usefulness, and the emphasis on the word “*can’t*,” indicates a sense of not being able to return to her previous position and that she is perhaps forcibly having to hold both the position of seeing diagnoses as useful, but also being aware of possible pitfalls. Specifically, she warns to use labels with “*caution*,” which implies an element of danger and destruction related to diagnoses. Yet, it can also be interpreted that Barbara is able to hold both the position of valuing diagnosis and of knowing the disadvantages of diagnosis.

Barbara describes what it is like to value both working with and without diagnosis: “*it’s just the difference between having, a paint pallet with six BOLD colours in it and a paint pallet with 150 subtle shades of grey, they’re both really interesting*” (23: 742-747). It might be assumed that the six bold colours are the diagnoses and the 150 shades of grey refer to what she is faced with when a client does not have a diagnosis. Therefore, the boldness of diagnosis is indicative of clarity, whereas the grey reflects more uncertainty. Although, what seems implicit here is that the different positions she holds are not necessarily isolated to two. The separation between six bold colours and 150 shades of grey, or working with diagnosis or not, is not a clear cut distinction since six bold colours can be mixed together to form new colours, much like diagnosis being more complex than it initially seems. Barbara goes on to say that “*a counselling psychologist should be using BOTH*” (23: 749-750). Which suggests that counselling psychologists should be able to work both with and without diagnosis.

However, in contrast, Barbara goes on to name an experience of tension around the subject of diagnosis: “*it i-it does say to ME, that, that where I sit as a counselling psychologist is very much, that there’s a tension*” (25: 808-811).

Barbara's reference to where she "sits" as a counselling psychologist is indicative of positioning and may suggest something about what it feels like to hold different positions; that it can feel tense. The word "*me*" is interesting here and could be interpreted as Barbara holding different identities as herself and herself as a counselling psychologist and that this forms part of the tension when thinking about her position on issues such as diagnosis. Alternatively, it could be that Barbara is acknowledging how other counselling psychologists may hold a different view to her.

Barbara goes on to acknowledge her difficulty in talking about diagnosis: "*So it's actually just EVERY bit as hard to talk about it as to work with it (laughs)*" (25: 824-825). This serves to support the idea that the tension she experiences makes it difficult for her to articulate her position. However what seems unclear is whether or not Barbara feels comfortable experiencing this tension.

This sense of tension was shared across participants, but not always in the same way. Abigail, for example, states: "*So that TENSION, so really I'm not giving her what she wants, umm and obviously ME trying to manage my feelings*" (12: 364-366). Here, Abigail is referring to a client she worked with who wanted a diagnosis, but she was not able to give this to her, due in part to her own views, but also due to service restrictions. Therefore, she is not so much expressing an internal conflict regarding what her position is, but is more stating that conflict arises when her position is not shared by a client. She later describes how this feels for her: "*I guess that's something I have to battle with is, I don't like diagnosis*" (34: 1116-1118). The use if the word "*battle*" indicates the extent to which she has to fight to maintain her position, whilst allowing others to hold a different one. She may be

suggesting here is that she is battling with a majority position held within society regarding the acceptability of diagnosis, and that holding a position that opposes the dominant one requires a fight. Alternatively, Abigail may be implying that her experience of tension is not a comfortable, but is a struggle. Specifically, she may be talking about an internal battle within her where she does not like diagnosis, but is also able to consider alternative positions, thus feels she has to battle to remain consistent and true to one position. Consequently it seems, that whether a firm position is held or whether more than one position is held, the experience of tension remains.

What was also evident is that a position on diagnosis is not static. For example, Fern states:

*when I was doing A-level psychology we were discussing, Szasz and Laing and er all the anti-psychiatry movement errr, individuals, and you know as one would at that age and get quite excited about this idea of um, how harmful it is to label people and to um, not get CAUGHT UP in the whole sort of, medicalisation of, of, of er, deviancy,[...]but, I soon came to realise that you can, it's important to, take a FLEXIBLE approach. (12: 361-377)*

Here, Fern highlights how her position on diagnosis has adapted with experience and has become more flexible with time. Throughout the transcript, Fern suggests that she is very comfortable with holding a flexible position on diagnosis, and does not suggest any experience of tension. This excerpt implies that this has taken some time to develop and that it may continue to change over time. Therefore Fern alludes to the idea that her position is adaptable when it comes to diagnosis and that she is comfortable sometimes being in a position of not knowing.

However, this sense of contentment with uncertainty was not shared by all participants: “*everything came in to question because I was kind of thinking, you know in our training we were so critical of it and now I’m just, ha- that’s all I’m having to, all I’ve been able to do*” (20: 649-654). Eleanor here, expresses the impact of adapting her position from being critical of diagnosis to using it all the time in accordance with the work setting. While this is part of being a counselling psychologist, it seems that her internal experience is that “*everything came in to question.*” This can be interpreted as her experiencing anxiety in terms of the uncertainty in her position when this is in a process of transition. She may also be saying here that her whole identity as a counselling psychologist is brought in to question when her position on a topic like diagnosis is challenged and is having to be adapted. The experience she is referring to may also be one of a loss of part of her professional identity and a coming to terms with a change in her identity.

Additionally, Eleanor identifies “*a kind of tense, sort of feeling*” (6: 174-175), when her clients have a diagnosis, explaining that “*there’s labels that come along with diagnosis[ …]which don’t necessarily always benefit the client*” (6: 183-187). It seems that Eleanor is saying that moving to a position of diagnosing clients feels tense because it does not benefit the client and is not in accordance with her training. Eleanor may experience the tension that comes from moving positions as quite anxiety provoking where everything she believes in is questioned and may need to change.

What became apparent, particularly from David is that this ability to hold more than one position can at times sit comfortably within him, and at other times can feel uncomfortable. On the one hand David states: “*For me I can hold them*

*quite easily I, I, I REALLY can*" (47: 1520-1521). Here, he is saying that he can easily hold both a scientific practitioner position and a social constructionist position. However, on the other hand he previously contradicted this by stating: "*I think this has always BEEN an internal dilemma*" (46: 1503 – 1504). This indicates that there are times when he can feel at ease with holding different positions, but at other times, he shares the internal tension expressed by other participants. David speaks more directly about a feeling of tension:

*we all do it as clinicians we start to, (laughs) stereotype a di- 'oh you're just like so and so I saw last year [...] it's an easy trap to fall into and of course it [...] does interfere with you REALLY seeing the person as an individual [...] I think that's a real tension* (36: 1167-1176).

Here David specifies a tension for him between approaching someone according to their diagnosis, or approaching them as an individual. This echoes the tension that both Barbara and Eleanor alluded to, and that is a tension in trying to hold a position of both paying attention to the diagnosis and to the individual. Therefore, this may suggest that no matter how comfortable David is about holding more than one position on diagnosis, an internal sense of tension remains. This contradiction between a sense of tension and one of ease in holding different positions, may be symptomatic of the tension itself in that it feels difficult to admit that there is a sense of tension and uncertainty around diagnosis because the expectation is that counselling psychologists will be able to hold more than one position. As such, the reality that this can sometimes feel uncomfortable may feel like admitting a level of incompetence. Alternatively, it may be that David is

suggesting that the internal dilemma he experiences does not necessarily have to be difficult to manage and is largely advantageous.

Similarly, Fern, although mainly expressed comfort in holding different positions, more implicitly shared the sense of tension at times: “*what is it that would be most helpful for you in terms of where I could start or, what perspective I could talk from?*” (4: 112-115). Here she seemed to hold different positions as part of her lived experience in the room, rather than having to just speak about them and was asking the researcher which of her many perspectives they would be interested to hear from. Implicit in what she is saying here is that she experiences tension in that it is difficult to freely answer questions without first having to consider how to position herself. What Fern highlights is that the experience of tension that other participants describe can be a positive one and that an ability to view things from a range of perspectives, as well as having different things to say about a single topic is a privilege.

It seems that throughout this subordinate theme, participants share in their ability to hold different positions, but it seems that this can lead to a felt experience of tension. It seems that for some this tension can feel bearable and advantageous while for others, it can sometimes feel uncertain and anxiety provoking.

### **Holding diagnosis in one hand, but what does this mean?**

This subordinate theme refers to taking a stance of acknowledging and making use of the diagnosis, at the same time as knowing that this only forms part of the client as a whole person. Colin explicitly refers to diagnosis as being part of a “*bigger picture*” (20: 631). He expands on this by describing diagnosis as “*a triangulated piece of information which includes, MY experience of the individual,*

*how I see the, [...] phenomenology of what it is that they're experiencing, [...] and how they experience the world. Um, and, so it's another piece of information" (19: 618 – 626).* Colin's use of the word "triangulation" is really insightful because it is reminiscent of an interwoven cycle between client experience, therapist experience, their understanding of each other's experience, and accepts that diagnosis forms part of this understanding. Therefore, diagnosis is not considered to be a separate piece of information and his position on it may not even need to be defined, because it is simply part and parcel of experience. In addition, this idea of triangulation may be another way in which Colin is diagnosing his experience.

However, this reference to triangulation is not explicitly shared by other participants, but others do acknowledge that diagnosis, to a greater or lesser extent, is part of individual experience. Fern, for instance states: "*it may be how they've defined themselves or how they've lived, er, with themselves and, it may have, defined their own EXPERIENCE so, that's important to understand that*" (14: 420-425). Here she describes how diagnosis can define experience which suggests an intricate relationship between a diagnostic label and an individual's subjective experience. With Fern's emphasis on the word "experience," it seems she is suggesting that while a diagnosis and individual experience may be closely linked, it is still a priority to consider this experience, possibly irrespective of her own views. Furthermore, she suggests that while it is important to bear in mind a diagnosis, it is important not to respond to it:

*you would, always approach, every individual in the same way so, in the same way, just because somebody has BLONDE HAIR, one wouldn't automatically assume that they ah, that you're going to behave to them or*

*respond to them in a different way than you might do somebody with brown or red hair they're just another human being. (13: 389-398)*

So, she is explaining that just because someone has a particular element to their experience such as hair colour or diagnosis, it is important to acknowledge it as part of them, but it is important not to treat them differently because of it. It may also be interpreted that hair colour is something that an individual will have feelings about, for example, they may not like their hair colour. As such, the impact that one's response to that person's hair colour has may vary, for example, offence may be caused or a sense of pride could be elicited. Therefore, Fern may be saying that individuals have particular thoughts or feelings about their diagnosis, which may have to be carefully considered before responding to the diagnosis. However, bearing in mind human nature, and to a certain degree our inability to control what we respond to, this viewpoint may position counselling psychologists in quite a non-human position. This is quite contrary to her suggestion that she approaches everyone as a "*human being.*" Perhaps what Fern is really saying, is that it is important not to fixate on diagnosis and respond only to that, but to see it as part of the person, as you would their hair colour.

It seems that Fern is implying that diagnosis is part of understanding the whole person, but is not the most significant factor to consider. This is further expanded upon by Barbara: "*Um....it's quite difficult, because actually for ME, the moment I'm working with them it becomes, pretty meaningless*" (3: 78-81). Moreover, Barbara states that: "*I don't remember them by their, diagnosis*" (25: 798-799). This suggests that diagnosis is not consciously meaningful or memorable, but rather is being held, unconsciously in one hand, while paying attention to other

parts of the individual. Alternatively, she could be describing how the diagnosis may form part of the client's experience, but it is such a small part when the whole of the individual is considered that it is not specifically memorable. This contradicts the perspective of Colin who through his reference to triangulation, suggests that each piece of information has equal weighting.

Barbara further illustrates her approach to diagnosis: "*it's the same as saying, "she's got a blue skirt on, and a black CARDIGAN." What does that say about, you know what you think about your clothes*" (24: 771-774). Here she has identified the colours in the researcher's clothes, hence their diagnosis, but she is also suggesting that it is important to know and understand how they perceive their clothes, thus to look beyond their diagnosis to their experience of it. Thus, she is viewing diagnosis as something that lies external to the individual, like clothing, which can tell her something about the individual, and what that means about them. However, clothing is something that can conceal parts of an individual, so perhaps Barbara is saying here that diagnosis conceals part of a person and rather than taking the clothes, or the diagnosis at face value, she is curious about what it means about the individual.

What seems to be shared between these differing views is the idea that diagnosis does form a part of understanding the individual, but the difference in opinion lies in terms of whether this diagnosis is given much weighting once other information comes to the fore. Nevertheless, Abigail took a contradictory position where diagnosis acts as more of an obstacle in the way of understanding the person. She refers to, "*TRYING um to, to go beyond*" (38: 1224-1225) the diagnosis, which to an extent reflects other participants' views, but is also reminiscent of an obstacle course. Furthermore, she is more dismissive of the diagnosis: "*we're throwing that*

*out the room, actually what, we're worried about here is you and what's going on for you*" (27: 859-861). Here she refers to throwing the diagnosis out the room, which sounds quite aggressive and dismissive. Therefore, it seems that she does not consider diagnosis to be an important part of understanding an individual's experience, but more that it is separate from the individual and is an obstacle in the way of viewing the whole person. This contradicts Colin's position of triangulation because it suggests that the diagnosis and the person are separate. This is potentially problematic for the client who, as has been indicated by other participants, may view their diagnosis as an important part of their experience.

Eleanor offered a different stance to the argument that diagnosis only forms part of understanding individual experience: "*So, in the TRAINING, you're really HOLDING diagnosis in one hand, but we're ALL saying, 'what does this mean? What's it about? where's the client in this?'*" (1: 17-21). Eleanor appears to be echoing other participants when she suggests diagnosis can be held in one hand, but there is a broader experience to be explored in addition to the diagnosis. However, the question of, "*where's the client in this?*" implies that diagnosis is being held as the bigger picture, and the client is having to be found within that, which opposes the view that diagnosis is part of a client's broad experience. What Eleanor might be saying here is that diagnosis can be quite a dominant and loud piece of information in the room and so has to be temporarily put to one side in order to hear other information.

It may also be interpreted from her use of the word "*hand*," that, like a hand is attached to a whole body and alone cannot tell you what the rest of the person looks like, a diagnosis alone cannot tell you about the whole person. In addition, her

reference to training here is interesting, as it indicates how a position on diagnosis is shared and feels certain during the infancy of her career, but perhaps she is implying that this changes post-training where things become less certain. Consequently the position of holding the diagnosis in one hand and exploring client experience alongside this, may be an ideal that she does not always feel she holds.

Throughout this subordinate theme, participants all acknowledge that diagnosis forms part of understanding a person, but how this is paid attention to appears debateable. Additionally, it seems that participants share in the view that a person cannot be understood purely as a diagnosis.

### **Navigating complexity in human experience and diagnosis.**

In this subordinate theme, participants shared views on how their own experience, that of the client and the diagnosis itself make for a complex picture and they all grapple with this and what it might mean for them when trying to make sense of their own experience.

There was a sense of clients bringing experiences that do not just belong to them, but those of the wider systems they have been in previously. For example, Barbara states: “*it feels as if, our work together is not, is starting from, not from, her experiences just as a human being, but her experiences in systems, in the \*\*\**” (4: 116-120). Here Barbara articulates this quite clearly. The way that she refers to, “*experiences just as a human being,*” suggests that to be human and to know someone as a human is quite straight forward, it is the interactions that they have with the world around them and the connections that they make that are complicated. Alternatively, she could be valuing the human part of a person and viewing it as separate from the context within which they are from, in order to value them more.

In either case, it seems that working with human experience is complicated and is influenced by many factors.

In addition, cultural implications, as part of the experience that a client comes with and how this impacts on the diagnosis are acknowledged by Fern: “*so they could arrive with a really firm diagnosis, um especially if they come from North America, very sort of medicalised, view of, er, difficulties*” (6: 182-185). Here, Fern suggests that the extent to which the diagnosis is part of the person, i.e. whether it is “*firm*” or perhaps loose fitting, is influenced by their background and in turn will have implications for the role that the diagnosis might play in the work with the client. She may also be suggesting that the way the client relates to their diagnosis may need to be considered and may influence her own experience of that client.

The impact that these background complexities have on forming relationships with clients is acknowledged by Abigail: “*sometimes they come quite jaded, and quite UNHAPPY, with services, so I think THAT'S an impact, on the relationship*” (22: L. 705-708). Here she is acknowledging that when she forms relationships with clients, she is not just forming that with them, she is also forging a relationship with their previous experiences. What she may be saying here is that when a client has had a bad experience in services, she is tarred with the same brush as a professional and feels she has to prove herself as something different. This may mirror the experience of the client in that they too feel they are treated in the same way as others with the same diagnosis and so feel they have to differentiate themselves to be heard.

Furthermore, her strong feelings may also have a part to play in this complex picture: “*not to ENFORCE my, you know my FEELINGS, um, being very aware that*

*I've got strong feelings about, diagnosis*" (7: 221-224). The use of the word "enforce" is quite strong and the emphasis Abigail places on the word implies that she has to work really hard not to do this. She may be saying that not only do the diagnosis and her strong feelings around this impact on her relationships with clients, but their previous experiences with diagnosis also adds a level of complexity to the work. She herself refers to "*a number of levels*" (2: 29), on a few occasions throughout the transcript when describing her experience, which suggests that she, her client and both of their backgrounds all have a number of levels of complexity that come in to play when forming a relationship and working together.

Therefore, it seems that there are a number of things that participants may be responding to at any one time when working with clients. Colin describes a frequent response that he experiences when working with depressed clients:

*I'll be- I'm often, find myself, struggling in the kind of, SWAMP of, their inactivity, the behavioural inactivity, and wondering, about um how to kind of engage with that so I can, I can SWITCH off in sessions and that can be kind of, ah it's a STRUGGLE to stay awake in the way that they'll be experiencing something.* (8: 231-238)

Colin's use of the word "swamp" indicates a sense of him feeling overwhelmed which may be due to the level of complexity that is needing to be made sense of in terms of a client's experience and how he responds to it. This response suggests that it is difficult to make sense of and unpick this experience in the room. Furthermore, he honestly describes how he can "switch off" in response to, and struggles to stay with, the client's experience. However, he goes on later to describe how he does make sense of this complexity: "*actually you can SEE your own counter-*

*transferential experiences and see how that might map onto, kind of categorisation of, of what the person's experiencing" (17: 523-527).* Here, he is suggesting that his own responses, which he labels as counter-transference, can be categorised or diagnosed in some way. He is also saying that diagnosis helps to make sense of his own responses, for instance if he experiences the response he earlier describes, then he will assume that this is because they have a diagnosis of depression. An opposing interpretation might be reminiscent of a self-fulfilling prophecy in that if he is aware of a diagnosis of depression, he will respond in this way because of his own expectations based on the label.

This implies that diagnosis takes away any uncertainty in terms of unpicking complexity in experience, but others seemed more comfortable to sit with the complexity and not knowing: "*I can't, TOTALLY, say that inexperience wasn't one of the, VARIABLES, in my early, kind of, confusion and, you know, not knowingness, it clearly was" (19: 609-613).* Here Barbara is referring to a time when she did not work with people with a diagnosis, but acknowledges that this was at a time when she was less experienced and so this would also have had an impact on how she experienced the work with these clients. The use of the term "*variables*" is indicative of something scientific and perhaps she too is looking for an answer of sorts. "*Variable*" is also indicative of something changeable, which may have added to her sense of "*confusion and not knowingness.*" This reflects the number of complexities in trying to understand her own and the client's experiences which leaves it difficult to detect whether the diagnosis per se is something she is responding to, or another variable. Nevertheless, she does also make attempts to pin things down:

*Managing those strengths of feelings that, that come up because I'm aware of the diagnosis, and/or the way somebody's behaving, cause that's the thing I think, there are two processes but you can't necessarily tease them apart do you know what I mean? (18: 562-568)*

Here Barbara is referring to managing her own strong feelings in a therapy session, but suggests that this response may be to the diagnosis, but it may also be to a person's behaviour and it is difficult to separate these two processes and make sense of them. However, what is evident from other participants is that there are probably more than two processes going on and that this may be evidence of Barbara trying to simplify things in order to make sense of a complex picture.

This difficulty unpicking and making sense is articulated by David:

*it's, very difficult I, I, you know um, to know WHAT, is YOUR feelings, er but, you know literally and it doesn't, it's got nothing to do with the patient, maybe it's something that's happened in your own personal life the patient reminds you of your own stuff, er or literally sometimes what is being projected into you, and I think that's one of the hardest things to do, um, is to work through that. (16: 488-499).*

Here he acknowledges how he not only has to make sense of his own feelings, but he also has to work out whether they are his, where they might have come from and that this needs to be worked through to make sense, or simply excepted for what it is.

Therefore it seems that diagnosis is one of many factors that counselling psychologists could be responding to at any one time and being able to isolate their response to diagnosis is extremely difficult.

To add to this already complex relational picture, it seems that diagnosis itself and how it is applied is multifaceted. As a starting point, Abigail states that “*there’s so many different diagnoses*” (4: 96), and further expresses that one of her “*MAIN issues, with diagnosis is it’s-it’s so BROAD*” (18: 568-569). So Abigail seems to be saying that while diagnosis is designed to be a guide of sorts, it is difficult to navigate her way through this and it has its own complexities. Not only are the diagnoses themselves complicated, but the way that a person can come about receiving a diagnosis seems to be varied. Fern expresses: “*and um, you know because, people arrive at the, point of diagnosis via SO many different routes*” (8: 231-233). This concept of arrival could be interpreted as diagnosis being an end point and that the journey may be tough and complex, but the end point is in sight. Alternatively, the use of the word “*arrive*” can suggest that arrival is temporary and an individual can continue to travel following an arrival. This is reminiscent of the fact that individuals can have multiple diagnoses which can add a layer of complexity when making sense of a person’s experiences. Nevertheless, Fern states that diagnosis does not “*ring any alarm bells*” (2: 46), which suggests that she does not feel overwhelmed by diagnosis or the complexity involved and does not have a particularly strong response to it.

What seems apparent from this theme is that human experience is complex and how the therapist, the client and the diagnosis all offer something complex to the picture. Consequently, participants have expressed that it can be difficult to identify what they are responding to at any one time. However, what is also implied is that we may not need to know what we are specifically responding to at any one time and that it is enough to accept the complexity for what it is. Despite this acceptance there

also seems to be a drive to categorise and make sense of the complexity in one way or another. It may be that what the process of diagnosing represents is a very human drive to simplify and make sense of something complicated.

Overall this superordinate theme represents how diagnosis can only form part of a bigger picture that is the complexity in human experience, it cannot provide an understanding of human experience in isolation, and how much attention is given to it may vary. The bigger picture does not only refer to the client, but includes complexities around the therapist and the diagnosis itself. Consequently, this theme is saying something about what it is to be human and that while participants shared a drive to categorise and make sense of experience, it was also acknowledged that it may be enough simply to accept the complexity and not knowing for what it is.

## **Discussion**

### **Overview**

The following discussion will consider the findings from each superordinate theme in turn in relation to existing theory and research. There will then be an exploration of possible limitations, and recommendations for how the findings may be applied to practice and future research are then outlined and explained. The chapter ends with the researcher's reflexive statement that considers the impact their own experiences may have had on the research process, before final conclusions are made.

### **Diagnosis is Something to Hang Your Hat On**

The participants discussed within this theme, whether diagnosis was real and something that could provide various benefits or whether it was quite detrimental in that it is restrictive, provides for society rather than individuals and it is not even a reality to be relied upon. The discussions within each subtheme seemed to provide something of a dichotomy in terms of participants' responses to diagnosis. These dichotomies included firstly whether diagnosis provides for individuals or society, secondly whether diagnosis provides a useful focus or whether it restricts and finally whether diagnosis is real or not.

What seems apparent is that this dichotomous nature of participant responses reflects the act of diagnosing itself since it mirrors the categorical and structured approach of diagnosis (Freeth, 2007b). This is also acknowledged within the counselling psychology literature, for instance, Strawbridge (as cited in Sequeira & Van Scoyoc, 2001) who featured as an invited speaker in Sequeira and Van Scoyoc's discussion paper regarding the use of *The Diagnostic and Statistical Manual of*

*Mental Disorders* (4<sup>th</sup> ed., text rev.; *DSM-IV-TR*; American Psychiatric Association, 2000) and testing, acknowledged that diagnosis provides a dichotomy between the sick and well. What also becomes apparent from Sequeira and Van Scoyoc's paper is that the counselling psychologists discussing the issues of *DSM-IV* (American Psychiatric Association, 2000) and testing were split in terms of their views, in a very dichotomous way with some supporting its use whilst others opposed it, thus reflecting the very nature of what they were discussing. It seems that Sequeira and Van Scoyoc (2001) offered some insight into counselling psychologists' response to diagnosis in this paper, and this research in some ways echoes the notion that counselling psychologists respond in dichotomous ways to diagnosis. However, Sequeira and Van Scoyoc's paper focused on both psychometric testing and diagnosis as different forms of categorisation, whereas the current research offers a perspective based purely on diagnosis. Furthermore, they imply that counselling psychologists take one dichotomous position or another, whereas the current research highlights that they also move between dichotomous positions rather than this being a static divide in the profession.

Klein's (1946) concept of splitting seems relevant here. The dichotomous nature of the themes indicates that the participants' sense-making was in some way split. Consequently, it seems that participant's responses were either that diagnosis is good, for example, it provides a focus, or bad, for example it questions their competency. Moreover, this splitting extends from their responses to diagnosis to the individual psychologists in that part of them may have to be split off each time they take a new position on diagnosis.

The specific dichotomous responses that the participants had were not dissimilar to those already acknowledged elsewhere within the literature. Firstly, there was a theme of diagnosis being quite a powerful and dominant presence within society in that diagnosis on some level may be providing for society, and this has been acknowledged many times before, for instance Laungani (2002) voices how the medical model is very much the dominant approach to mental illness and has so far held unquestionable power over other approaches and Golsworthy (2004) suggests that diagnostic categories provide a “dominant language” (p. 23). Furthermore, participants made the link between diagnosis and provision of services, which has been acknowledged by Eriksen and Kress (2006) who refer to the use of *DSM* diagnosis as a means to reimburse services.

Secondly, participants spoke at length about the various ways in which diagnosis can be restrictive, and again this is acknowledged elsewhere in the literature, such as Golsworthy (2004) who argues that diagnostic manuals, take a “one size fits all approach” (p. 26). More explicitly, there was a theme of the participants feeling restricted in terms of their own skills, creativity and competency. This is not something that has been ignored, for instance Larsson et al. (2012a) acknowledged that counselling psychologists have voiced concerns that the use of diagnostic labels can lead to a loss of identity. This can also be made sense of in terms of part of the individual being split off (Klein, 1946), as previously indicated; leaving a sense of part of their identity being lost. However, what the participants in the present research bring is a sense of what this feels like. Participants spoke about diagnosis contributing to them working in a more simplistic way and they voiced a sense of powerlessness when working with diagnosis, as opposed to feeling a sense

of freedom when a client does not have a diagnosis. Moreover, they referred to a relationship between diagnosis and a sense of competency with some diagnostic labels, and a sense of incompetence with others.

Finally, there was a difference of opinion amongst the participants as to whether or not they considered diagnosis to be real and what makes something real. For some it seemed that diagnosis is a shared knowledge and this also made it real, whereas for others the lack of validity in diagnosis made it seem unreal, and complex human experience is the reality we should be working with. There were also suggestions that admitting diagnosis exists is what makes it a reality, whereas others implied that a client's difficulties do not exist until they are diagnosed.

Consequently, it seems that the participants could not agree on what reality might look like and indeed whether diagnosis is real. This reflects a parallel process within wider society where psychiatric diagnosis is accepted as something real or challenged. For example, the National Institute for Health and Clinical Excellence (NICE, 2015) guidance for depression suggests that the first step in treating someone with symptoms that resemble depression is to recognise, assess and manage them. This idea that depression is something to be recognised, implies that it is real. Other literature has heavily criticised the validity of diagnosis and has also questioned its reality. For instance, Bentall (2004) suggests that the *DSM* offers a sense of a consensus that is illusory and describes the use of diagnosis as comparable to the use of horoscopes. Similarly, Davies (2013) questions how real diagnosis is based on his knowledge of how the *DSM* was devised. Davies uses the comparison of God's existence with the existence of diagnosis claiming that just because a group of theologians say God exists, it does not mean God exists. Therefore, just because

those devising the *DSM* say that a set of disorders exist, it does not mean that they do. Rather than this difference of opinion among counselling psychologists needing to be problematic, it forms part of the pluralistic stance taken within the profession (McAteer, 2010).

As has been touched upon, participants did not all position themselves in any one part of the dichotomies outlined above, but rather all varied in terms of where they were situated. This reflects counselling psychologists' ability to hold more than one position (Larsson et al., 2012a). Furthermore, this dichotomous position echoes Frost (2012)'s paper with his reference to the debate between the medical model and humanism in counselling psychology and urges the gap between the two to be closed. It seems apparent from the participants that this gap may be smaller than is implied by Frost, given the amount of movement between positions. This is indicative of counselling psychologists finding it difficult to clearly define their position because this is constantly changing.

The consequence of this may be that a level of incompetence could be communicated to other professionals because counselling psychologists are unable to coherently articulate their position on important issues such as diagnosis. Similarly, this will have an impact on both trainees and qualified counselling psychologists since, considering Bion's concept of containment (as cited in Spillius, Milton, Garvey, Couve & Steiner, 2011), it may be very confusing and uncontainning to be constantly moving between positions. This lack of containment can lead to a spilling over of feelings as well as a limited ability to contain the feelings of clients (Casement, 2013). However, if counselling psychologists developed an increase in confidence in terms of holding a changeable position, this may add to a feeling of

containment and help to prevent any negative impact on themselves, their clients and trainees. These implications for practice and recommendations will be considered later.

As has been outlined the theme of, ‘diagnosis is something to hang your hat on,’ resembles the process of diagnosing itself. However what seems apparent is that this sense of order is quite illusory because of the amount of movement across dichotomies and so the participants’ positioning on diagnosis becomes unclear. In a similar way, diagnosis offers something ordered and categorical, but this too is viewed by some as illusory Bentall (2004). Scott (2010) suggests that diagnosis can be used as a defence against the client, and in a similar way, it may be that these dichotomies are an attempt to simplify and defend against the feelings that come up when faced with the number of positions taken up by counselling psychologists. ‘The bigger picture’ theme explores further what the participants may have been defending against.

### **The Bigger Picture**

This theme provided quite a stark contrast to the dichotomous quality of the previous theme with its offerings of something a lot more explosive and complex. The theme of the bigger picture has articulated how the complexity within human experience is overwhelming and difficult to make sense of. This can be understood in terms of participants letting their defences down and connecting to their felt experience, in contrast to the defensive nature of the previous theme.

Participants voiced how they feel able to hold two or more positions on diagnosis, which is reminiscent of other literature such as Larsson, et al., (2012b) who found that counselling psychologists construct experience of working with

individuals with a diagnosis of schizophrenia in a relational way, in line with their humanistic value base. However, they also found that the use of language that pathologises is always evident. They highlight how this mirrors the epistemological conflict for counselling psychology. Similarly Craven and Coyle (2007), following a Discourse Analysis of interviews with counselling psychologists, found two constructions which they called ‘empiricist repertoire’ (featuring more medical model language) and ‘contingent repertoire’ (featuring concerns about client experience). It could be argued that the present research also found evidence of counselling psychologists holding these positions of seeing value in diagnosis, but also valuing the individual. Yet, what the present research contributes is the participants’ felt experience of holding these positions. More specifically, they name a feeling of tension, but whether this tension felt uncomfortable or advantageous varied among participants.

Consequently, this research has gone some way to answering Larsson et al.’s (2012b) question regarding whether sitting in between two epistemological positions is a hindrance or a help, and it seems that the answer is both. The extent to which each individual counselling psychologist may view their positioning as a hindrance or a help at any one time, will depend on how they manage this feeling of tension. For a profession that changes position, it seems appropriate that they would consider this to be both a hindrance and a help because this in itself represents how they do not want to commit themselves to one position.

The participants also shared in the theme of diagnosis forming part of understanding the client’s experience, but the extent to which the diagnosis is acknowledged varied between participants. What seemed clear was that diagnosis

alone is not enough to understand a person and that it is important to go beyond it and acknowledge the person more broadly. This is reminiscent of Milton (2012) who, in his book, urges readers to “go beyond diagnosis” (p. 136) and attempt to understand the individual experience. Like the participants in this research, Milton also acknowledges that diagnosis is only part of experience and suggests that his book is only the beginning. So perhaps the present research has provided empirical evidence to support Milton’s views that counselling psychologists acknowledge diagnosis as part of an individual’s experience, but that it is also important to go beyond it. In addition, what this research indicates is that what is beyond the diagnosis is complex.

Cooper (2009) also discussed how counselling psychologists, with their humanistic value base, are in a position to go beyond a client’s diagnosis and see them as a whole person. He suggests that this is something that counselling psychologists bring to the field. Cooper goes on to suggest that in order to make this clear, an evidence base would need to be developed through research and asks the following specific questions: “How do we most fully acknowledge and validate the uniqueness of our clients?” and “How can we draw on diagnoses and psychiatric knowledge without falling prey to it?” (p. 127). While Larsson et al. (2012b) and Craven and Coyle (2007) offered a starting point in terms of this evidence base, they only partially answer Cooper’s (2009) questions. They demonstrate that counselling psychologists ‘fully acknowledge and validate the uniqueness of clients’, and that they ‘draw on diagnoses and psychiatric knowledge,’ but they do not clearly communicate how this is done or whether or not counselling psychologists ‘fall prey’ to diagnoses. This present research, in a similar way has added to this research

base in answering these questions, but is also able to say something about ‘how’ this is done. The changeable position that participants highlighted, suggests that this enables them to avoid ‘falling prey’ to diagnosis and to continue to ‘fully acknowledge and validate the uniqueness’ of their clients. This is not to say that counselling psychologists never ‘fall prey’ to diagnosis. For example, participants highlighted that they sometimes simplify their practice when clients have a diagnosis. However, their changeable position enables them to recognise this and make appropriate adaptations to their position.

The present research also brought the theme of “navigating complexity in human experience and diagnosis,” which acknowledged that this process can be disorderly and confusing. While previous research has seemingly simplified the number of positions that counselling psychologists may take up in terms of diagnosis, this research has acknowledged that the lived experience of this is challenging in terms of having to make sense of complexity and tolerating this while never fully committing to any one position. Not only were client complexities acknowledged, but participants also acknowledged their own complexities in terms of their level of experience and their own strong views on diagnosis, thus adding to a complex picture. Specifically, it was noted by participants that there was a difference in positioning and response to diagnosis between when they trained, or early on in their career, and currently. This may be because training institutions encourage trainees to practice defining their position on issues such as diagnosis when in fact the reality is quite different since counselling psychologists are supposed to negotiate between different positions (Frankland & Walsh, 2005). This is a crucial finding which has important connotations for training, in that there needs to be a more

explicit outlining of the complex position counselling psychologists take on diagnosis, within training programmes. How this may be applied to training programmes is outlined in the implications and recommendations section of this chapter.

Participants acknowledged that to pinpoint their response purely to the diagnosis of their clients, within this bigger picture was difficult to do. This difficulty has been evident in previous research, for example Brody and Farber (1996) who examined countertransference responses to vignettes, which made it difficult to identify whether the countertransference responses were associated solely with the diagnostic label or were a response to the vignette description as a whole. However, the present research goes one step further to explain why this might be quite so difficult or even impossible, for example, it highlights what it is like to work with the complexity of human experience. While some participants attempted to categorise and simplify the complex picture, in a similar way to how diagnosis does, others were more willing to accept that the complexity is the reality that needs to be tolerated in order to work with clients. This apparent difference in position adds another level of complexity, but also reflects the pluralistic stance of counselling psychology (McAteer, 2010).

### **A Position of Safe Uncertainty**

It is evident so far that the participants were able to move between positions of valuing diagnosis, and of valuing the individual, as well as all their complexities. With this in mind, it may be argued that counselling psychologists are able to adopt a position of safe uncertainty; a position proposed by Mason (1993). More specifically, it seems that diagnosis provides a position of unsafe certainty whereby

it offers an answer for a person's problems (Mason, 1993). However, this consensus is an illusion once the person and all other complexities are acknowledged (Bentall, 2004). On the other hand, when there is no diagnosis and one simply meets the person with all their complexities, a position of unsafe uncertainty is adopted where the level of complexity can seem overwhelming and difficult to navigate. Furthermore, while a position of certainty can diminish creativity and lead to paralysis, a position of less certainty can open people up to other possibilities. A position of safe uncertainty, on the other hand, offers a position that is not fixed, but that flows and evolves (Mason, 1993). Therefore it seems that participants have demonstrated an ability to hold a position of safe uncertainty when it comes to diagnosis in that they are aware of the certainty that diagnosis has to offer, but they do not solely cling to that, integrating this into the client as a bigger picture to a greater or lesser extent. This positioning also reflects counselling psychologists' ability to work in "creative and flexible ways" (Milton, 2012, p. xiii).

Nevertheless, while it has been argued that counselling psychologists can tolerate uncertainty (Kasket, 2011), it seems from this research that not all participants were able to tolerate uncertainty as well as others. Frankland and Walsh (2005) state that there is an expectation that counselling psychologists will be able to manage complexity. Part of managing complexity and working flexibly, inevitably involves having to adapt one's position, which may bring periods of uncertainty. However, the participants have acknowledged that this does not always feel comfortable and, in one instance, described feeling as though they were left questioning everything which resembles Klein's (1946) concept of fragmentation. As has been indicated, when faced with complexity, some participants demonstrated

a drive to make sense and pin things down, much like a process offered by diagnosis, while others were more able to accept the complexity for what it was. Both of these processes involved adapting to a new position, much like the move from paranoid-schizoid anxieties and defences to a more depressive position (Klein, 1952). While this reflects a healthy adaptation to new positions, the experience of feeling fragmented when a position is uncertain may have important implications for practice that are worth considering.

This process of feeling fragmented at times may mirror a process that occurs in the counselling psychology field as a whole. If this is the case, fragmentation usually involves a projective identification defence (Segal, 1988), which would mean that anxieties regarding a need to find a position may be projected outwards and picked up by other professions who then feel it is unacceptable to not have a position. Alternatively these anxieties could be projected into clients which would be very unhelpful for them and their own process, for example, feeling they need to take up a position that is not necessarily appropriate for them or that they may not be ready for. Furthermore, if counselling psychologists are not able to tolerate their own uncertainties, then it may be difficult for them to help clients do the same. As such, it is important for counselling psychologists to be aware of and manage this fragmentation by developing some confidence in their ability to change positions and communicating this rather than projecting anxieties.

This issue of fragmentation, seems to be about how well individuals are able to tolerate the uncertainty and anxiety involved during the movement in their position. The best way to address this would be to accept that counselling psychologists take a position of safe uncertainty. How this might apply to training

and practice is considered in more detail in the implications and recommendations section of this chapter.

### **Implications and Recommendations for Practice**

The findings of this research offer something quite paradoxical. They suggest that counselling psychologists hold a changeable position on diagnosis that is full of uncertainties. On the one hand, participants seemed able to tolerate this uncertainty and on the other they attempted to pin down and label their experience. While this uncertain position is in itself one that could be viewed as very advantageous and adaptable, but difficult to pin down, it has been suggested that this changeability and uncertainty in a position could, and in some ways needs to be, labelled as Mason's (1993) position of safe uncertainty; thus forming a paradox. This labelling is reminiscent of the act of diagnosing, but seems to mirror counselling psychology's position on diagnosis and the dilemma highlighted in terms of abiding by their humanistic roots and working with the person's experience, versus abiding by the medical model and its use of diagnosis. However, this research has highlighted a felt experience of tension in holding this kind of position, which can be tolerable for some, but for others it can be less so. Similarly the uncertainty can be tolerated more so by some than others.

The implications for those who are able to tolerate this uncertainty may be quite positive because they will be able to assertively adapt their position appropriately and with ease. Bion's concept of containment is relevant here (as cited in Spillius, Milton, Garvey, Couve & Steiner, 2011), in that those able to tolerate uncertainty may be more able to offer a containing experience for their clients. However, those who feel less comfortable with the uncertainty and changeable

position, may feel less contained and therefore less able to contain their clients due to a spilling over of their own feelings (Casement, 2013). Furthermore, this may also be detrimental for other professionals in terms of understanding what position counselling psychologists take on diagnosis, because it may not be communicated so assertively. Finally, it could be detrimental for the counselling psychologists themselves and the anxiety it could raise.

A further finding that may have important implications for practice is that there seems to be a difference in terms of counselling psychologists' responses to diagnosis once qualified and when in training. It seems that in training there is more of a fixed perspective on diagnosis, but that this becomes more flexible with time. This may be indicative of counselling psychologists building up a tolerance for uncertainty over time and becoming more comfortable with a changeable position on diagnosis. This may simply be symptomatic of counselling psychologists' ever evolving professional identity. Alternatively, it could be that the changeable position and tolerance for uncertainty is not realised during training and this could potentially lead to confusion and uncertainty in terms of positioning on diagnosis.

In terms of the implications highlighted here, it is hoped that naming a position of safe uncertainty may help reduce any negative implications. Firstly, while a position of safe uncertainty is not something that can be taught, it may be beneficial for training programmes to be more explicit about it by teaching through the lens of not knowing, adaptability, and developing a position of safe uncertainty. This would be important in terms of keeping it a live issue for trainees and to maintain awareness of this positioning on diagnosis during their early professional development, rather than implying that a position on diagnosis is fixed.

Secondly, for counselling psychologists less able to tolerate uncertainty, naming a position and keeping it live may help with this and may help them to build more confidence in their position. Furthermore, once named, it can be communicated more clearly to other professionals and it may show counselling psychologists in a good light since it highlights an adaptability, which suggests that they can work in a number of different settings and adjust to the ways of using diagnosis within each setting. These implications for taking a position of safe uncertainty would also have a positive impact on clients because an increased confidence in positioning among professionals may lead to a more containing experience for both therapist and client.

Furthermore, this position of safe uncertainty proposed may be relevant to how counselling psychologists position themselves on other critical issues such as age, gender, and class. Positioning on these issues are inevitably informed by a belief system and philosophical underpinnings, which then inform one's professional identity (Gazzola, et al., 2011). As has been suggested by those such as Frost (2012), positioning on diagnosis is influenced by a conflicting philosophical base. Consequently, this conflict contributes to uncertainty, and such philosophical underpinnings may also apply to other critical issues. Therefore, further research into these critical issues may be able to clarify whether taking a position of safe uncertainty would be of benefit or not. More specifically, IPA studies that explore each critical issue independently may be useful initially to offer micro level analyses of counselling psychologists' experiences of each issue in the first instance, with a view to enriching any further developments and macro level claims (Smith el al., 2009). Alternatively, as these topics for research would be concerned with

positioning, it may be more relevant to carry out research focused on social psychological processes rather than experience. Therefore, Grounded Theory studies that consider each critical issue independently may be able to offer theoretical level insights into counselling psychologists' positioning on such issues (Willig, 2013).

Another important finding was in participants feeling a loss of creativity and a sense of feeling restricted when working with diagnosis. Moreover participants expressed that their sense of competency is related to the kind of diagnosis they are working with. Together these feelings can contribute to a sense of one's professional identity being challenged. This has important implications for counselling psychology practice since the feelings described could impact upon client work in that the therapist may not be fully in the room with their clients if they are feeling part of them is restricted. Therefore, the quality of the therapeutic relationship would be affected. In addition, this questioning of competence may be indicative of a limited confidence that counselling psychologists have in their own profession. This may be due to the quiet voice that counselling psychology has so far had in terms of their position on diagnosis. As such, a building of confidence for counselling psychologists is necessary because this again, may negatively impact on client work through an unconscious process whereby their limited confidence leads to their clients lacking confidence in them (Lemma, 2003).

This sense of diagnosis restricting practice does not seem to be an implication for counselling psychology alone but is experienced by other professions, for example, within psychoanalysis it is felt that some areas of psychotherapy are being destroyed by medical model practices (Mollon, 2010). In addition, the BPS issued a position statement on behalf of all psychologists during

the development of DSM-5 (American Psychiatric Association, 2013), expressing concern that diagnostic categories have been reduced to the point of pathologising normal behaviours (BPS, 2011).

Consequently, it is important that professions work together to develop ways to work through these restrictions that come with diagnosis so that there are not negative consequences for clients. One way that this collaboration could take place is via a BPS special interest group on diagnosis, where regular discussions and meetings could take place. Similarly, networking and presentations at multi-disciplinary conferences could serve a similar purpose. These kinds of communications could also enable counselling psychologists to share and build confidence in their position on diagnosis.

### **Limitations**

Possible limitations to this research include firstly, that the themes seemed to converge at certain points. For instance the subordinate themes within “the bigger picture” were only subtly different from one another. More specifically, the subordinate themes went from referring to a tension in holding different positions on diagnosis, to saying a bit more about what these positions are, to then saying that actually working with human experience and diagnosis is confusing and complex. As such, each subordinate theme was related to and built on the preceding one. Consequently this could potentially indicate a limitation in the quality of the data and analysis in terms of a lack of rigour (Yardley, 2000). However, a rigorous process, as is outlined in the methodology chapter, was followed throughout the research process. Therefore, rather than a lack of rigour, this overlapping of themes is more likely to be symptomatic of something else. Firstly, this converging of themes may

be understood as representing a parallel process that is evident within the counselling psychology profession as a whole, that counselling psychologists do not isolate themselves to any one position, much like the themes cannot be fully separated.

Secondly, this may be understood as a reflection of my stage of training. I am at a stage of trying to make sense of my own epistemology and am trying to develop a sense of autonomy and trust in my own judgements. As such, I often find myself in a state of confusion and not knowing, where I view all options, in terms of positioning on issues, as valid. The convergence of themes reflects my own identity as a counselling psychologist whereby it is still developing and it is not yet coherent. Consequently, during the analysis and development of themes, my own sense-making would have been done through the lens of this confusion and not knowing, therefore impacted on the themes developed. It is worth noting that this is characteristic of the double hermeneutic process within an IPA methodology, which acknowledges that the researcher is trying to make sense of the participants' world while they are trying to make sense of their world (Smith & Osborn, 2008). Thus, the researcher's experience will inevitably have an influence on their understanding of their participants' experiences (Smith & Eatough, 2007). Nevertheless, further IPA research from a different researcher may be advantageous in order to determine whether this convergence of themes is indeed due to my own stage of training, or whether it is shared by others and is therefore more indicative of a process in the counselling psychology profession.

Similarly, given the idiographic nature of IPA, an in depth analysis of interviews with six participants has provided an understanding of responses to diagnosis specific to these individuals, but more generalized claims about

counselling psychology have been made cautiously (Smith et al., 2009). However, in accordance with the concept of Dasein in phenomenology, experience does not belong solely to individuals, but is understood as being in relation to other phenomenon (Smith et al., 2009). Furthermore, as is suggested in IPA, links have been made between the findings, the researcher's experience and the existing literature and is therefore able to make implications about the wider context (Smith & Osborn, 2008). As such, participants' responses to diagnosis may be in relation to the experience of other counselling psychologists, and the profession as a whole, so can say something, but certainly not everything about counselling psychologists' responses to, and position on, diagnosis.

However, it is also possible that some findings may not be relevant to the wider context. For example, Mason's (1993) position of safe uncertainty, could be representative of my critical realist stance and belief that, while counselling psychologists take a position or positions that are real, this position is changeable and uncertain, and is constructed by each individual. Consequently, other counselling psychologists may not share this perspective. While a position of safe uncertainty allows for this flexibility, it would be important to carry out further research to clarify whether a position of safe uncertainty is one that makes sense to other counselling psychologists. Therefore, following further IPA studies with other researchers, as has been suggested, perhaps research that utilises a Grounded Theory methodology may be able to say more about this position of safe uncertainty and whether this is a position taken up by counselling psychologists. The IPA studies may be able to offer micro level analyses which will then enrich any macro level claims (Smith el al., 2009). Such broad claims could potentially come from the

Grounded Theory analysis proposed (Brocki & Wearden, 2006). Furthermore, Grounded Theory is compatible with research concerned with social psychological processes and it could be argued that, whether counselling psychologists take a position of safe uncertainty or not, is a social psychological process issue (Willig, 2013).

Finally, as is evident in table one, the majority of participants who took part in this research were aged 41-60, and had not been qualified as counselling psychologists for significant lengths of time. This made the sample reasonably homogenous, as is preferable in IPA (Smith & Eatough, 2007). However, I am left wondering in what ways the research may have been different with a sample of individuals who had been qualified as counselling psychologists for longer. While the current research suggests that positioning on diagnosis is fixed during training, but becomes more flexible with time, this may vary at different points within counselling psychologists' careers and possibly between newly qualified and more experienced individuals. Similarly, if a position is fixed during training, the lived experience of uncertainty when it comes to positioning once qualified may initially come as a shock to those newly qualified. Consequently, they may be left feeling quite confused about their position and this may impact on their ability to make sense of their responses to diagnosis. If this is the case, the convergence and divergence in the themes may not only be due to the researcher's stage of training, but also that of the participants.

Alternatively, it may be that more experienced counselling psychologists have become less aware of issues around diagnosis and therefore, are less able to discuss such issues and so may have been less forthcoming in terms of participation.

For instance, Brody and Farber (1996) suggest that, in relation to countertransference reactions, experienced therapists do not want to acknowledge doubts regarding their interventions. In a similar way, engaging in a discussion about diagnosis that may potentially lead to participants doubting their responses to, or positioning on diagnosis may have felt too difficult for more experienced counselling psychologists.

Counselling psychologists' responses to and positioning on diagnosis, is arguably an issue of professional identity. Professional identity within counselling psychology can be considered to be a formation of beliefs and actions that reflect their philosophical base (Gazzola, De Stefano, Audet & Theriault, 2011). It could be argued that responses to diagnosis will be influenced by this belief system and it has already been noted that the positional dilemma for counselling psychologists stems from conflicting views within their philosophical grounding (Frost, 2012). As such, it may be the case that newly qualified counselling psychologists actually felt more able to take part in this research because issues such as diagnosis are present in their minds post-qualification when they have been giving thought to their professional identity. Perhaps it feels more relevant to individuals who are still focused on developing their professional identity whereas for those more experienced, they may feel more content with their evolving professional identity, so feel less able or inclined to talk about it.

Conversely, it might be argued that individuals who have been qualified for greater lengths of time may have a more established professional identity and therefore, are more able to articulate their responses to diagnosis and navigate the complexity and uncertainty in their position. Furthermore, it has been argued that issues of professional identity are not easily resolved in training because it continues

to develop post-training (Gazzola et al., 2011). Such claims may support the idea that professional identity becomes clearer over time. Alternatively, it might be argued that issues of professional identity are never resolved and continually evolve and therefore, the length of time since counselling psychologists have trained would have had minimal impact on the findings.

A final point worth noting is that there were significant differences between the lengths of time that participants had been qualified as counselling psychologists, for example, one year versus twenty years. Given that the research found a difference in responses and positioning on diagnosis during and post-training, it may be that this difference in experience among participants reduced the homogeneity of the sample. If this is the case, it may have consequences regarding the applicability of the findings (Smith et al., 2009). For instance, the convergence and divergence in the themes may be due to the participants being at different stages in their professional development, rather than it being a reflection of a process in counselling psychology more generally.

The participants' qualification status may or may not have limited the research and while the possible impact on the research has been briefly discussed here, any conclusions drawn would be purely speculative at this stage. Nevertheless, this may be something to consider when recruiting participants in any future research regarding counselling psychologists' responses to diagnosis. Further IPA research with samples of participants that are more homogenous when it comes to qualification may be worthwhile so that claims can be made more assertively with regards to the impact of experience on responses to, and positioning on, diagnosis.

### Concluding Comments

It seems that the participants were able to reflect on and make sense of their responses to diagnosis and through this, some clarity has been reached in terms of their position on diagnosis. Therefore, this research is able to communicate to counselling psychologists and other professionals something about counselling psychologists' position on diagnosis and their reflective capacity. Furthermore, as has been suggested, the awareness that has been brought about regarding certain responses to diagnosis and positioning on diagnosis, can be shared with counselling psychologists, trainees and other professionals, and can be applied to improve the therapeutic experience for clients.

While each superordinate theme in isolation has said something about how counselling psychologists respond to their clients' psychiatric diagnoses, both themes taken together have something additional to say. When considering the two superordinate themes together, it seems that the theme, 'diagnosis is something to hang your hat on,' resembles a dichotomous process much like diagnosis while 'the bigger picture' theme, highlights the more complicated picture of what it is to be human. The two themes echo patterns in terms of counselling psychologist perspectives on diagnosis found before (Larsson et al., 2012b; Craven & Coyle, 2007; Sequiera & Van Scoyoc, 2001) since participants were able to work with diagnosis, but at the same time did not lose sight of the complexity within human experience. However, this research has offered some insights into what the experience might be of holding these positions.

The themes taken together also serve to answer the research question in that the participants very much responded to diagnosis through the lens of how they

position themselves and what it is like to have a changeable position, including any struggles they have with this. In terms of how they make sense of their response is answered by the themes in that the participants either attempted to pin down their position, represented by the theme of ‘diagnosis is something to hang your hat on,’ or they found themselves navigating the complexity of ‘the bigger picture’ and were either able to accept that their position changes or struggled to make sense of the uncertainty and complexity. This has been an important finding because it has allowed for an in-between and flexible position to be defined in a way that can be communicated to other professionals, and as previous literature has indicated, counselling psychology needs to strengthen its voice in terms of how it positions itself on issues such as diagnosis. For instance Cooper (2009) states that “the one thing we cannot choose is not to choose,” (p. 127).

More specifically, what has been suggested is that rather than seeing different positions as separate or defined, a position of safe uncertainty can be adopted, which is one that “is always in a state of flow” (Mason, 1993, p. 194). This position allows for the flexibility in counselling psychology (Milton, 2012). Most importantly here is that a position of safe uncertainty is not prescriptive, but allows for individual constructions of what it may mean to them (Mason, 1993). However, it has also been highlighted that some participants are more comfortable than others at tolerating uncertainty, but that this should be an encouraged characteristic of all counselling psychologists in the future.

### **Reflexive Statement**

Reflexivity in research relates to how the researcher’s own experiences impact upon the research process (Etherington, 2004). Therefore, as a reflexive

researcher, I attempted to maintain awareness of how my own experiences would have an impact on the whole process. One of the ways in which I did this was to keep a reflexive journal which helped me to bracket my own views and minimise the impact this had on the research, although as has been highlighted, some impact is inevitable. Furthermore, the importance of methodological, epistemological and personal reflexivity are stressed as important for counselling psychology research, as is transparency regarding the impact of one's own subjectivity on the whole research process, in order to demonstrate rigour (Kasket, 2011). In addition, reflexivity has a particularly important place within IPA research since reflexivity closes "the illusory gap between researcher and researched" (Etherington, 2004, p. 32). This resembles the double hermeneutic circle in IPA research that acknowledges how the researcher's sense-making and that of the participant are inter-linked (Smith, & Osborn, 2008). In light of this rationale for reflexivity, I have written the following reflexive statement.

My curiosity with diagnosis began when I started work in a mental health service that does not diagnose. My focus was on working with individuals, not people with named problems. However, when I began my counselling psychology training, working within a cognitive behavioural framework, I came into contact with clients who had diagnoses and the work I did with them was influenced by these diagnoses. I found myself meeting diagnosed clients with a series of assumptions, expectations and biased views about how they might present and what treatment may be necessary. I found in one instance that this obscured a relationship and the therapy, which ended prematurely. While I was aware that my expectations and reliance on the diagnosis to guide me in my state of unknowing, rather than

concentrating on meeting the individual, was partly due to my inexperience, I wondered if others shared this experience. In hindsight, I am curious about my choice of research question since this experience early in my training led me to doubt my capabilities and doubt how aware I was of my own responses. My ability to understand this influence upon the research question could only have been realised at the end of the research process and at the end of my training because it is through these experiences that I have been able to develop self-awareness. Moreover, my own reflexivity has helped me to realise this since reflexivity is about being aware of one's responses (Etherington, 2004).

When writing a literature review in order to formulate a suitable research question, I embarked on the diagnosis literature with an almost anti-diagnosis view. However, my extreme all or nothing view reflected my inexperience, and through supervision, I was able to broaden my perspective and acknowledge the complexity of the diagnosis debate. Once immersed in the literature, I took a step back, bracketed my views, and considered literature that held different perspectives. Through broadening my perspective, I found myself overwhelmed by the number of perspectives within the diagnosis debate. I narrowed the literature down to two perspectives; the humanistic position and the medical model because these are the positions that seemed to most coherently stand out to me, and seemed to be relevant to counselling psychology.

Once I had reached a question, I became particularly aware of certain biases that I had in the early stages of the research process. For example, whilst developing an interview schedule, I became aware of my own assumptions that counselling psychologists would not be in favour of diagnosis and how this was influencing

some of the questions that I was developing. When I became aware of this I attempted to bracket my own assumptions in order to not overly influence the questions. Through discussions in supervision and redrafting the schedule several times I was able to develop questions that were open and not leading in the direction of my assumptions. This bracketing of my assumptions continued whilst conducting the interviews by paying close attention to each participant's words (Smith et al., 2009).

While the impact of my own experiences on the themes developed have been considered, it is also worth acknowledging the impact on the recommendations. The position of safe uncertainty (Mason, 1993) proposed reflects my stage of professional development since the anxieties about something coming to an end are very live for me and with that comes a lot of uncertainty. I have often had a limited tolerance for uncertainty and it is something I have had to challenge through the training. Therefore, my proposal for counselling psychologists to more loudly take a position of safe uncertainty, may be partly driven by my own experiences. In addition, naming a position of safe uncertainty resembles a need to pin things down where even a position of changeability and not knowing has been given a label. As such, it may be that my own need for certainty in some ways led me to diagnose the participants and their positioning.

Further to this position of safe uncertainty is that it resembles a critical realist position in as much as it is an in-between position (Willig, 2008). This may come as no surprise since, as was outlined in the methodology, the epistemological position of IPA resembles that of critical realism and it is the stance I took when embarking on the research. Consequently the themes identified may have been influenced by

my critical realist stance, such as the subordinate theme: “Holding diagnosis in one hand, but what does this mean?” which highlights a position taken between diagnosis, and knowing this is only part of the person. This reflects the hermeneutic process in IPA whereby in order to see the participants’ phenomenology, the researcher’s own interpretation would be needed and thus inevitably will have an influence on the findings (Smith et al., 2009).

What this research has highlighted for me, is that while I have evolved as a practitioner over the course of my training, I still have a long way to go in terms of building a sense of confidence in my own abilities and who I want to be as a practitioner. While I initially came from an anti-diagnostic position, I am aware that my position on this, and other critical issues, has become more flexible with time and experience. I have learned a lot from the participants and there is one participant quote I will take away that will influence my developing professional identity by reminding me that there are benefits to working both with and without diagnosis: “*it's just the difference between having, a paint pallet, with 6 really BOLD colours in it and a paint pallet with 150 subtle shades of grey, they're both, they're both really interesting*” (Barbara, 23: 742-747). By keeping this in mind I can develop a flexible position of safe uncertainty.

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## Appendix A - Recruitment Advert

Dear All,

I am a second year student at London Metropolitan University (LMU), presently reading for a Professional Doctorate in Counselling Psychology. I am currently recruiting qualified counselling psychologists as participants in my research project. The title of the research project is: How do counselling psychologists make sense of their clients' psychiatric diagnoses? An interpretative phenomenological analysis.

This research aims to explore the responses counselling psychologists have to different psychiatric diagnoses given to their clients, whether they are aware of these responses and how they make sense of these responses. Responses can be both positive and negative and refer to an internal emotional or cognitive response such as assumptions and biases.

Participation will involve taking part in a semi-structured audio-recorded interview. Interviews will be held at a location and time convenient to participants and will last approximately one hour. This research has obtained a favourable ethical opinion from the ethics committee at LMU.

I am looking to recruit counselling psychologists in the UK who have experience of working directly with clients in therapy who were diagnosed with a psychiatric illness. This research is being supervised by Dr. Marta Sant, Lecturer in Counselling Psychology at LMU (**Email:** m.sant@londonmet.ac.uk, **Tel:** 0207 1332140)

I would sincerely appreciate your participation in this research project. If you would like to take part in this research and would like an information sheet, please contact me at:

**Email:** how0055@my.londonmet.ac.uk.

**Tel:** 07580491618

I look forward to hearing from you, many thanks.

Holly Weston

## Appendix B - Recruitment Poster

### Counselling Psychologists Needed for Research Interview

I am a second year student at London Metropolitan University (LMU), presently reading for a Professional Doctorate in Counselling Psychology.

I am currently recruiting qualified counselling psychologists as participants in my research project.

#### The title of the research project is: How do counselling psychologists make sense of their clients' psychiatric diagnoses? An interpretative phenomenological analysis.

This research aims to explore the responses counsellings psychologists have to different psychiatric diagnoses given to their clients, whether they are aware of these responses and how they make sense of these responses. Responses can be both positive and negative and refer to an internal emotional or cognitive response such as assumptions and biases. Participation will involve taking part in a semi-structured audio-recorded interview. Interviews will be held at a location and time convenient to participants and will last approximately one hour. This research has obtained a favourable ethical opinion from the ethics committee at LMU.

I am looking to recruit counselling psychologists in the UK who have experience of working directly with clients in therapy who were diagnosed with a psychiatric illness. This research is being supervised by Dr. Marta Sant, Lecturer in Counselling Psychology at LMU ([Email: m.sant@londonmet.ac.uk](mailto:m.sant@londonmet.ac.uk), Tel: 0207 1332140). I would sincerely appreciate your participation in this research project. If you would like to take part in this research and would like an information sheet, please contact me using the details below:

Email: [how0055@my.londonmet.ac.uk](mailto:how0055@my.londonmet.ac.uk)

Tel: 07580491618

I look forward to hearing from you, many thanks

Holly Weston.

## Appendix C - Participant Information Sheet

London Metropolitan University  
166-220 Holloway Road  
London  
N7 8DB

**Title:** How do counselling psychologists make sense of their clients' psychiatric diagnoses? An interpretative phenomenological analysis.

Thank you for your interest in the above named research project. If you are still interested in participating please read the following information regarding the project and details about what participation will involve.

### Information about the project

I am a second year student at London Metropolitan University (LMU), presently reading for a Professional Doctorate in Counselling Psychology. This research project is being supervised by Dr. Russel Ayling, Visiting Lecturer in Counselling Psychology, at LMU.

This research aims to explore the responses counselling psychologists have to psychiatric diagnoses given to their clients, whether they are aware of these responses and how they make sense of these responses. Responses can be both positive and negative and refer to an internal emotional or cognitive response that can occur in many forms e.g. assumptions or biases. An awareness of one's own responses can demonstrate a reflective capacity and responses that are either helpful or challenging may be identified and considered in relation to clinical practice. This project hopes to contribute to the limited research regarding counselling psychology's epistemological position on diagnosis, as well as to highlight counselling psychologists' reflective capacity. Furthermore this research project may promote the importance of being aware of one's responses which could stimulate other mental health professionals' own self-awareness and reflective capacities; thus helping to promote a fairer therapeutic experience for clients. Data will be analysed

using an interpretative phenomenological analysis (IPA) (\*Smith and Eatough, 2012). This research has obtained a favourable ethical opinion from the ethics committee at LMU.

I would like to hear from you if you feel comfortable to talk about what diagnosis means to you, your experience of working with clients who have previously received a psychiatric diagnosis, including what responses you might have had to these diagnoses and your understanding of your responses. If you believe that talking about these experiences may be distressing or upsetting in any way and for whatever reason, then thank you for your interest in this research project, however it is considered that you would not be suitable to participate.

### **What would participation involve?**

Your participation in this research project will involve attending a face to face audio-recorded interview, lasting approximately one hour, held at a time and place of convenience to you. Prior to the interview you will be sent a consent form and you will be asked to read and sign two copies, one for you to keep and one to give to the researcher at your interview. Prior to commencement of the interview, you will be asked to fill in a demographic information sheet that will be used to inform the data and you will be given the opportunity to ask any further questions before the interview begins. The demographic information sheet will be stored securely and will not be used for any other purpose other than to inform the data.

### **Is the research confidential?**

By volunteering to take part in this research project, you are also giving permission for the interviews to be audio-recorded and transcribed. Audio-recordings, transcripts, signed copies of consent forms, demographic information sheets and any other participant information will be kept in a secure location in accordance with the \*\*Data Protection Act (1998). However, the consent forms, or any other potentially identifiable information related to you will be stored separately from the rest of the data. Furthermore electronic data, including transcripts, will be saved in password protected files and on a password protected USB which will be stored in a secure

location. Following completion of the project, all data will be stored securely for a maximum of 10 years, as is recommended in \*\*\*London Metropolitan University's Code of Good Research Practice (2014). The research project may be published following completion.

For the purposes of data storage and writing up the project, you will be allocated a pseudonym available only to me. Any identifiable information related to you, your clients, your place of work and any clinical experiences that you disclose will be altered in the verbatim transcripts and throughout the project write up.

While these lengths will be taken to maintain confidentiality, if you were to disclose information regarding harm to self or others, I would have an obligation to break confidentiality in accordance with the \*\*\*\*British Psychological Society (BPS) Code of Ethics and Conduct (2009).

In case that the interview will be conducted at a private address (for example, at your home), I would need to provide my supervisor with the address where the interview will take place and details regarding the time of the interview. This is done in order to protect both student researchers and potential research participants.

### **Participation withdrawal**

You will be given the opportunity to decline answering any of the questions during the interview and the interview can be terminated at any time without question.

Following completion of the interview, you may withdraw your participation up to four weeks following the interview. In the instance of participation withdrawal at any stage up to four weeks post-interview, your data will be deleted and will not feature in the project. As analysis will begin shortly following the interview it will not be possible to withdraw from the project beyond four weeks post-interview.

### **Following participation**

Following participation you will be provided with a debrief sheet. If you would like to obtain information about the research findings, please inform me of this and I will be very happy to forward you a copy of the completed work.

If you have any complaint, concern or question about this research please feel free to contact my research supervisor, Dr. Russel Ayling (contact details given below).

Should you require any further information, or would like to participate in this project,  
kindly contact me at:

I would sincerely appreciate and welcome your participation in this research project and I look forward to hearing from you.

Many thanks for your time.

Holly Weston

\* Smith, J. A. & Eatough, V. (2012). Interpretative phenomenological analysis.

In G. M. Breakwell, J. A. Smith, & D. B. Wright (Eds.), *Research methods in psychology: 4<sup>th</sup> edition* (pp. 439-459). London: Sage.

<sup>\*\*</sup>London Metropolitan University's Code of Good Research Practice (2014). Retrieved from <http://www.londonmet.ac.uk/media/london-metropolitan-university/london-met-documents/professional-service-departments/research-office/handbooks/Code-of-Good-Research-Practice.pdf>

\*\*\*Data Protection Act (1998). Retrieved November 3, 2013, from [http://www.legislation.gov.uk/](http://www.legislation.gov.uk)

\*\*\*\*British Psychological Society. (2009). Code of Ethics and Conduct: Guidance published by the Ethics Committee of the British Psychological Society. Retrieved from

[http://www.bps.org.uk/system/files/Public%20files/bps\\_code\\_of\\_ethics\\_2009.pdf](http://www.bps.org.uk/system/files/Public%20files/bps_code_of_ethics_2009.pdf)

## Appendix D - Consent Form

**Research project title:** How do counselling psychologists make sense of their clients' psychiatric diagnoses? An interpretative phenomenological analysis.

**Name of researcher:** Holly Weston

**Researcher email:** how0055@my.londonmet.ac.uk

**Research supervisor:** Dr. Russel Ayling

**Research supervisor email:** r.ayling@londonmet.ac.uk

*Please indicate if you agree with the following statements by ticking the boxes:*

- I have been given an information sheet and consent form for my perusal.
- I understand the intent and purpose of the research project.
- I have been given adequate time to consider participation and I have been given the opportunity to ask any questions.
- I am aware that my participation will involve an audio-recorded interview.
- I agree to my interview being audio-recorded.
- I understand that I can decline answering a question or ask for the interview to be terminated at any time.
- I understand that I may withdraw from the research project within 4 weeks following my interview.
- I understand that if I withdraw from the research project, all my data will be destroyed.
- I am aware that all data will be kept securely and any verbatim material will be anonymised.
- I agree to and understand the limits of confidentiality.
- I agree to all data including transcripts, audio-recordings, consent forms and demographic sheets being stored for a maximum of ten years post interview.
- I am aware of and agree to anonymised, verbatim material being published.
- I feel emotionally able to take part in this research project.

- I am aware that there will be a debrief following my participation in this research project.
- I am aware of who I will need to contact if I want to withdraw my data or if I have a question, concern or complaint about this research project.
- I agree to take part in this research project.

**Participant name..... Researcher name.....**

**Date..... Date.....**

**Signature..... Signature.....**

**Appendix E - Participant Demographic Information Sheet**

*Please can you answer the following questions. The answers to these questions will be used to inform the research data and for no other purpose. They will be stored and disposed of in the same way as all other data as is outlined in your information sheet.*

**What is your gender?:** Male  Female

**What is your age?:** 20-30  31-40  41-50  51-60  60+

**What is your counselling psychology qualification?**

.....

**How many years has it been since you qualified?**

.....

**Please list the types of settings you have worked in e.g. NHS, charity, or university counselling service and the client groups worked with in each setting e.g. adult, child and adolescent etc:**

## Appendix F - Interview Schedule

### Introduction

- Introduce myself
- Consent form collection
- Demographic information sheet
- Any outstanding questions
- Housekeeping: fire alarms etc.
- Explain withdrawal procedure, e.g. can decline any question or end interview at any time without question.

### Questions

1. Could you tell me about what psychiatric diagnosis means to you?
  - *What are your thoughts/feelings about diagnosis? Does this depend on the diagnosis? How and why?*
  - *Do different diagnoses have different meanings?*
  - *Is there a particular diagnosis that has a particular meaning for you? Why?*
2. Can you tell me about your experience(s) of working with clients who have been given a psychiatric diagnosis?
  - *What were your thoughts?*
  - *What were your feelings?*
  - *Did you consider a client's diagnosis/diagnoses prior to meeting them for the first time?*
  - *How did you experience the therapeutic relationship?*
  - *Have there been any repetitions in your experience? What and why?*
  - *What do you understand of your experience?*

3. How does your experience(s) compare to those when working with clients without a psychiatric diagnosis?

- *Is it any different and how/why?*
- *How do your thoughts compare?*
- *How do your feelings compare?*
- *How does the therapeutic relationship compare?*
- *What do you understand of your experience?*

4. Can you tell me about your awareness of your experience(s) whilst with clients during therapy sessions?

- *Are you aware of thoughts/feelings?*
- *How do you process your thoughts/feelings?*
- *Is this different with different diagnoses? Why?*
- *How does this compare between working with clients with a diagnosis and working with clients without a diagnosis?*
- *How do you think your own experience impacts on the therapy?*

5. Is there anything you would like to add before we finish?

- *What has it been like to take part in this interview today?*

### **Close of interview**

- Any questions?
- Offer debrief sheet
- Thank you for participating

## Appendix G - Debrief Sheet

**Research project title:** How do counselling psychologists make sense of their clients' psychiatric diagnoses? An interpretative phenomenological analysis.

Dear Participant,

Thank you very much for your participation in this research project. Your willingness to participate is greatly appreciated. If you have any questions regarding any stage of the research process, please do not hesitate to contact me:

**Researcher email:** how0055@my.londonmet.ac.uk

If you have any complaint, concern or question about this research, please feel free to contact my research supervisor:

**Research supervisor name:** Dr. Russel Ayling

**Email:** r.ayling@londonmet.ac.uk

If today's interview has elicited any distressing or difficult feelings for you, the agencies below can offer support and advice:

- **Samaritans**

The Samaritans offer the opportunity to speak to someone over the phone, at any time about anything that is troubling you and can offer support.

**Tel:** 08457 90 90 90

**Website:** <http://www.samaritans.org>

- **The British Association for Counselling and Psychotherapy (BACP) and The United Kingdom Council for Psychotherapy (UKCP)** can provide information regarding therapists and how to find one:

- **BACP:**

**Address:**

British Association for Counselling and Psychotherapy  
BACP House,  
15 St John's Business Park,  
Lutterworth,  
Leicestershire  
LE17 4HB

**Tel:** 01455 883300

**Email:** [bacp@bacp.co.uk](mailto:bacp@bacp.co.uk)

**Website:** [www.bacp.co.uk](http://www.bacp.co.uk)

• **UKCP:**

**Address:**

2nd Floor,  
Edward House  
2 Wakley Street  
London  
EC1V 7LT

**Tel:** 020 7014 9955

**Email:** [info@ukcp.org.uk](mailto:info@ukcp.org.uk)

**Website:** [www.psychotherapy.org.uk](http://www.psychotherapy.org.uk)

- You may also contact your **General Practitioner (GP)** for support or to seek a referral to a therapist.

If you would like to see a copy of the research following write up, you can request to do so by contacting me via the contact details above. Estimated date of completion is 20<sup>th</sup> August 2015.

Many thanks again

Holly Weston

**Appendix H - Ethical Approval****London Metropolitan University, School of Psychology,  
Research Ethics Review Panel**

I can confirm that the following project has received ethical approval to proceed:

**Title: How do counselling psychologists make sense of their clients' psychiatric diagnoses? An interpretative phenomenological analysis.**

**Student:** Holly Weston  
**Supervisor:** Dr. Marta Sant

Ethical clearance to proceed has been granted providing that the study follows the ethical guidelines used by the School of Psychology and British Psychological Society, and incorporates any relevant changes required by the Research Ethics Review Panel. All participating organisations should provide formal consent allowing the student to collect data from their staff.

The researcher is also responsible for conducting the research in an ethically acceptable way, and should inform the ethics panel if there are any substantive changes to the project that could affect its ethical dimensions, and re-submit the proposal if it is deemed necessary.

Signed:

A handwritten signature in blue ink, appearing to read "Chris Chandler".

Date: 31/01/2014

Dr Chris Chandler  
(Chair - School of Psychology Research Ethics Review Panel)  
chandler@staff.londonmet.ac.uk

## **Appendix I - Distress Protocol**

### **Protocol to follow if participants become distressed during participation :**

This protocol has been devised to deal with the possibility that some participants may become distressed and/or agitated during their involvement in this research. There follows below a three step protocol detailing signs of distress that the researchers will look out for, as well as action to take at each stage. It is not expected that extreme distress will occur, or that the relevant action will become necessary. However it is included in the protocol, in case of emergencies where professionals cannot be reached in time.

#### **Mild distress:**

##### **Signs to look out for:**

- 1) Tearfulness
- 2) Voice becomes choked with emotion/ difficulty speaking
- 3) Participant becomes distracted/ restless

##### **Action to take:**

- 1) Ask participant if they are happy to continue
- 2) Offer them time to pause and compose themselves
- 3) Remind them they can stop at any time they wish if they become too distressed

#### **Severe distress:**

##### **Signs to look out for:**

- 1) Uncontrolled crying/ wailing, inability to talk coherently
- 2) Panic attack- e.g. hyperventilation, shaking, fear of impending heart attack
- 3) Intrusive thoughts of the traumatic event- e.g. flashbacks

##### **Action to take:**

- 1) The researcher will intervene to terminate the interview/experiment.
- 2) The debrief will begin immediately
- 3) Relaxation techniques will be suggested to regulate breathing/ reduce agitation
- 4) The researcher will recognize participants' distress, and reassure that their experiences are normal reactions to abnormal events and that most people recover.
- 5) If any unresolved issues arise during the interview, accept and validate their distress, but suggest that they discuss with mental health professionals and remind participants that this is not designed as a therapeutic interaction
- 6) Details of counselling/therapeutic services available will be offered to participants

## **Extreme distress:**

### **Signs to look out for:**

- 1) Severe agitation and possible verbal or physical aggression
- 2) In very extreme cases- possible psychotic breakdown where the participant relives the traumatic incident and begins to lose touch with reality

### **Action to take:**

- 1) Maintain safety of participant and researcher
- 2) If the researcher has concerns 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 a Community Psychiatric Nurse (CPN) or their GP.
- 3) If the researcher believes that either the participant or someone else is in immediate danger, then he will suggest that they present themselves to the local A&E Department and ask for the on-call psychiatric liaison team.
- 4) If the participant is unwilling to seek immediate help and becomes violent, then the Police will be called and asked to use their powers under the Mental Health Act to detain someone and take them to a place of safety pending psychiatric assessment. (This last option would only be used in an extreme emergency)

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## Appendix J - Sample Transcript: Barbara pp. 21-25 Inclusive

21

661. to, (sighs) I say, sort of it's, you know

662. there's a difference in, talking about quite a

663. few years ago now,

664. R: Yeah.

665. P: and, as I said my very *recent* experience

666. of 4 years in IAPT where, it's bang, bang,

667. bang and it, supposedly, mild to moderate

668. presentations, (researcher says mmm)

669. diagnoses but actually, quite a lot of quite,

670. you know, sort of, um severe and enduring

671. (researcher says yeah) coming in, and, you

672. know, because you're actually actively,

673. going "what's the disorder, what's the

674. protocol?" and as a counselling (researcher

675. says mm) psychologist I bulked at that so I

676. didn't, I wasn't that crude with it,

677. (researcher says yeah) but the labels, they

678. become part of, what you're looking to

679. work with,

680. R: Yeah.

681. P: do you know what I mean?

682. R: Yeah, and I mean, your own experiences

683. that you've spoken about, um, in terms of

684. what goes on for you, um, how do you think

685. that might impact on, the therapy?

*Difficult to articulate  
not straight forward.*

686. P: I think you hav- I think it's, I think it-

687. again I think it works, two ways, I think,

688. you've got, if you like you've got added

689. information there that's available to you,

690. R: Mhm.

*Diagnosis provides added info*

*research backs up diagnosis  
- sense or security, certainty +  
curing.  
Diagnosis = generalise, nomothetic, available.*

691. P: you've got all the research that comes

692. with that. You've got a wealth of stuff

693. that's kind of, generalise, nomothetic,

*Sessions were diagnostic  
can be pressured  
L. 666-667.*

*Diagnosis can be invalid  
L. 667-668.*

*Risk of losing counselling Psychology  
identity.  
L. 672-675.*

*Caballing. L. 677-679.*

*Diagnosis forms part  
of the work.  
L. 677-679.*

*Complexity.  
L. 687.*

*Diagnosis provides  
information.  
L. 688-689.*

*Diagnosis brings a sense  
of knowing.  
L. 690-691.*

22

## Diagnosis as guide

use diagnosis with caution

@ rely on it too much, you can't see or hear the person

diagnosis helpful, but important to see the person

@ Simple.

## Diagnosis is dominant language in NHS.

diagnosis is focal point in NHS.

Isolated if you don't have the

too reliant and you become brutal, blind + deaf.

(nursing the person?) Inhumane.

impact of our experience on therapy is infinitely different (endless, indescribable)

Labels &amp; diagnoses are about observables.

different no criticisable.

694. available, you know, to help you and guide

695. you, but if you're not careful, youoo,

696. become, a bit blinder and a bit deaf to the

697. person that's sitting in front of you,

698. R: Mhm.

699. P: and that's, all there is to it, having said

700. that, you can't be in the NHS, and not use

701. labels because you can't discuss anyone

702. with anyone else because that's, how they

703. will anchor it,

704. R: Yeah.

705. P: totally, do you know what I mean and

not taken seriously.

706. you'd be regarded as a flake if you said-

? loss of caring &amp; identity? 707. (both researcher and participant laugh). I

708. don't know when I was, with them I just got

709. this feeling that you know, (researcher says

710. mm) an-and you drive everybody mad and

711. they run away so, (researcher says yeah)

712. you need the short-cut, a short-hand, but it

713. you rely in that I think you become a bit

714. brutal and a bit, blind and a bit (researcher

715. says Mmmm) deaf really.

716. R: And so would you say that, that

717. experience, um, you know how does that, it

718. compare to when, somebody hasn't got a

719. label? So your um, yeah so the impact that,

720. your own experiences of working somebody

721. without a label, might be different to, when

722. they have got a label.

723. P: Well yes I mean they infinitely are

724. because (researcher says yeah) you're,

725. you're, you're, as I say you're not, (tuts)

726. labels and diagnoses are about observables,

different no criticisable.

Diagnosis is containing

L. 692 - 695.

Diagnosis provides guidance. L. 694 - 695.

Use Diagnosis with caution  
L. 695.Over use of diagnosis  
misses the person. L. 695 - 697.

Diagnosis is patterned.

L. 700 - 701.

Labelling L. 701.

Diagnosis is dominant language. L. 706 - 703.

Easiest to conform to using diagnosis.  
L. 706 - 711.

Diagnosis provides a short-cut.

L. 712.

Over use of diagnosis  
misses the person.  
L. 712 - 715.Therapy is endlessly different with  
no diagnosis. L. 713.

23

727. R: Yeah.

728. P: but when you're not, when you haven't

Diagnosis is  
objective & quantifiable

729. got, those objectively, recor-you know

730. quantifiable things, (researcher says mm)731. what you're picking up are, um, in the

More focused on in the  
moment things with no  
diagnosis

732. moment things, that arrive between you and

733. that person (researcher says yeah) that's

734. entirely different. It-it- I-I'm probably not

(more about process) (more  
relational)

735. making a very good a j-job of making,

entirely different

736. being clear about this but I think.....how

so different, it's difficult  
to explain

737. somebody makes me feel and what I, say in

738. response to that, and, how we talk about,

metaphors, whole experience  
more tentative with no diagnosis

739. what's going on for them and what they're

740. thinking and, what frustrated them that day,

more and now - close but more experienced

741. is far more tentative, and far more,

Metaphor -> diagnosis or  
no diagnosis, both really  
interesting

742. um.....I mean it's just the difference

743. between having, a paint pallet, with 6 really

744. bold colours in it (researcher says mhm) and

745. a paint pallet with 150 subtle shades of

746. grey, (researcher says yeah) they're both,

747. they're both really interesting,

748. R: Mm

part of of counselling & identity  
to be pay attention to  
process, relational, experience  
and diagnosis

749. P: um, an-and I believe that a counselling

750. psychologist should be using both,

751. R: Yeah.

So impact or work is different with  
without diagnosis - it works at  
both, but certain moments

752. P: but I'm just saying that I think that when

it's really different to be a  
counsellor in medical  
context - more  
reductionist

753. you're in the medical context, in the medical754. model of, working, (researcher says mm)755. it's really, really, tough, to do that,

756. R: Mm.

757. P: because, everything in the context

loss of identity  
reduction, lack of knowledge or  
skill -> loss of identity

758. conspires to make you just be a bit cruder,

759. R: Yeah.

negative - (spoil)  
medical context - constricts  
prioritize you end up

- conspire - powerful

Diagnosis scales to  
measure experience.  
L. 726-731

More focus on the  
relationship with no  
diagnosis  
L. 731-732

Therapy is more  
open to with no  
diagnosis L. 731-732

Therapy is more  
open to with no  
diagnosis L. 736-741

Therapy is interesting  
regardless of diagnosis  
L. 742-747

call his name  
L. 742-747

Counselling Psychologists  
identity L. 741-750

Counselling Psychologists  
pay attention to diagnosis  
and the present TR.  
L. 744-750

Risk of losing Counselling  
Psychologist identity  
L. 752-755

Context is relevant  
L. 752-755

Medical model is  
powerful L. 757-758

Reductionist L. 759

24

760. P: and, um, so, (sighs) yeah I mean I really,  
 761. I would like to know what you think in 5  
 762. years time because I tell you, it's, it's a , it's  
 763. a kind of, I hate the word journey but it's  
 764. been a process for me, (researcher says  
 765. mm) and I did arrive, in the NHS, vitriolic  
 766. about labels, really vitriolic about them,  
 767. (researcher says mm) but I can't say they're  
 768. not useful, it's just with caution.

developing position is a process

initially vitriolic about diagnosis (butler)

not sit in middle - they are useful, but should be used with caution.

Metaphor, need to acknowledge diagnosis, but who find out about individual experience of their diagnosis. 774. know what you think about your clothes,

769. R: Mmm, yeah.  
 770. P: With caution, otherwise you just, yo-is  
 771. it's the same as saying, "she's got a blue  
 772. skirt on, and a black cardigan." (researcher  
 773. says mm) What does that say about, you  
 774. know what you think about your clothes,

775. R: Yeah.

776. P: do you know what I mean?

777. R: Yeah.

778. P: It just describes something.

779. R: Yeah, yeah, thank you. Um. So just,  
 780. thinking about the, the questions, we've  
 781. covered is there anything that you, feel,  
 782. you'd like to add about what we've  
 783. discussed?

784. P: No except that I think, my, inability  
 785. perhaps to talk satisfactorily, and, er maybe  
 786. give you some really interesting, "this label  
 787. and this is the way, it was between the two  
 788. of us" is because, in, the event, I think the  
 789. real person does take over for me, so I'm  
 790. even finding (researcher says mm) it hard to  
 791. access, you know I spent 4 years working  
 792. with diagnosis, (laughs) it's really hard to

Inbetween position for diagnosis L. 767-768  
 finding... a position on diagnosis L. 763-768  
 is a process.

Diagnosis is descriptive  
 L. 771-772.  
 L. 773:  
 Acknowledge diagnosis  
 and explore individual  
 experience.  
 L. 776-778.

Use diagnosis with  
 caution - L. 771-  
 773

The individual is  
 paramount.  
 L. 784-789.

25

793. access, individuals, (researcher says yeah)  
 different ~~but~~  
 individuals in terms of  
 their diagnosis, because  
 they were individuals  
 separate from diagnosis.
794. because those individuals, um, are  
 795. individuals for me, do you know what  
 796. (researcher says yeah) I mean? So,  
 797. R: Yeah.

Diagnosis is less  
 significant than the  
 individual.  
 L-791-795.

- Don't remember people by their  
 diagnosis.

Diagnosis separate from  
 the person.  
 L-789-795.

Diagnosis is relevant, but  
 the person is paramount.

The person is more memorable  
 than the diagnosis.  
 L-798-799.

My position as a consulting  
 psychologist is one of  
 tension.

Diagnosis is neutral in  
 the mental.  
 L-801.

The individual is  
 paramount.  
 L-801-803

tension is constant.

The in-between position  
 creates tension.  
 L-808-811.

- even difficult to articulate  
 because of the tension.

The tension from an  
 in-between position is  
 constant.  
 L-813-814.

The tension - feels like a  
 grind - tough - unpleasant.  
 difficult reality  
 whole world, widespread  
 dominant

Consulting psychology  
 position is challenged.  
 L-818-820.

difficult to work and  
 talk with the tension.

Diagnosis dominates.  
 L-819-822.

813. P: there's constantly a tension and so, it's a  
 814. tension talking about it,
815. R: Yeah.
816. P: I can't just spout with, you know,  
 817. platitudes, or wisdom, or anything,

The tension creates  
 challenge in working and  
 communicating.  
 L-824-825

818. (researcher says yeah) because it's really  
 819. about doing the grind of working with, with  
 820. what is a reality, (researcher says yeah) in,  
 821. in the world, with, with mental health as it,  
 822. as it's called.
823. R: Yeah.

824. P: So it's actually just every bit as hard to  
 825. talk about it as to work with it (laughs).

**Appendix K - List of Emerging Themes for Barbara**

Diagnosis is descriptive, L. 5-7; L. 35-37; L. 771-772; L. 778  
Diagnosis categorises, L. 7-8  
Diagnosis provides access to treatment, L. 8-10  
Diagnosis is not concerned with individual experience, L. 10-12  
Medical model is intrusive, L. 12-14  
Reductionist, L. 12-14; L. 371; L. 390; L. 758  
Personality disorders hold meaning, L. 23-24  
Personality disorder is a broad concept, L. 25-26  
Personality disorder is ubiquitous, L. 26-28  
Personality disorder diagnosis elicits an internal struggle, L. 30  
Behaviour reduced to be measurable, L. 36-40  
Diagnosis contradicts personal experience, L. 41-46  
Diagnosis creates conflict, L. 44-46  
Hatred of psychiatric language, L. 50-53  
Psychiatric language is offensive, L. 53-54  
Psychiatric language is dehumanising, L. 60-61  
Labelling, L. 65; 160-161; L. 245-246; L. 327-328; L. 543-544; L. 677-679; L. 701  
Diagnosis can dictate response, L. 64-65  
Diagnosis can be damaging, L. 64-70  
Preconceived responses, L. 65-70  
Diagnosis is prevalent, L. 75-76  
The individual predominates the diagnosis, L. 78-81  
Diagnosis is meaningless, L. 76-81  
Diagnosis provides a sense of knowing, L. 88-94; 104-108; L. 308-310; L. 430-432; L. 641-642; L. 691  
Diagnosis provides guidance, L. 92-95; L. 694-695  
Diagnosis is containing, L. 97-102; L. 292-293; L. 692-695  
Diagnosis eliminates uncertainty, L. 107-108  
Feeling reassured by diagnosis, L. 102-106  
Loss of identity, L. 110-111  
Inhumane treatment, L. 113-114  
Considers individual in context, L. 116-120  
Individuals are complex, L. 123-127  
Feeling there's more to consider than a diagnosis, L. 129-131  
Working with someone with BPD feels intense, L. 135-136  
Complexity about a person is difficult to articulate, L. 133-134  
More to consider than diagnosis, L. 135-138  
Diagnosis is a help and a hindrance, L. 139-141  
Doubt in the existence of diagnosis, L. 143-144  
Categorisation, L. 145-146  
Diagnosis is a burden, L. 151-152; 159-160; L. 573-574  
Diagnosis is considered before meeting the person, L. 155-157  
Working through own response to diagnosis, L. 159-162  
Countertransference from diagnosis, L. 164-165  
Ambivalence about diagnosis, L. 170-171; L. 298; L. 380

Diagnosis is powerful, L. 171-172; L. 292-297; L. 306-307; L. 324-328; L. 538-539; L. 627-629; L. 700-701  
Aware of countertransference feelings, L. 1773-175  
Internal response to diagnosis, L. 178-179  
Experience of self is constant, L. 180-181  
Repetitions in internal response, L. 182-191  
Diagnosis is part of a complex picture, L. 202-203  
Complex relationship, L. 210-213  
Controlling own feelings, L. 210-211  
Power struggle, L. 215; L. 220-222  
Aware of own experience, L. 216-218  
Confusion in relationship, L. 220-221  
Loss of power, L. 222  
Loss of awareness, L. 220-221  
Awareness of feelings, L. 225-227  
Strength of own feeling parallels that of the client, L. 235-237  
Trying to maintain control, L. 238  
Awareness difficult to maintain, L. 238-239  
Repetition in experience, L. 240-243  
Diagnosis helps make sense of experience, L. 246-248  
Diagnosis determines treatment, L. 257-259; L. 627-629  
Dehumanising L. 260-261; L. 451-453  
Diagnoses given weightings, L. 264  
Society influences response to diagnoses, L. 264-266  
Society pays attention to some diagnoses, L. 26-5-266  
Diagnosis impacts on therapy, L. 274  
Diagnosis influences language used, L. 277-278  
Significance of setting, L. 276-278  
Reductionist, L. 279-280; L. 451-453  
Diagnosis narrows focus, L. 282-284  
Absence of diagnosis brings you closer to the individual, L. 287-289  
Use of own response to make sense of client experience, L. 288-291  
Diagnosis reduces autonomy, L. 292  
Closer to the client with no diagnosis, L. 304-305  
Diagnosis determines focus, L. 306-314; L. 375-378  
Closer to client experience with no diagnosis, L. 315-316  
Diagnosis makes experience of therapy indescribably different, L. 322-323  
When diagnosis is absent, sharp contrast to when it's not, L. 319-320  
Loss of autonomy, L. 324  
Diagnosing brings sense of finality, L. 324-325  
Naturally evolving therapeutic relationship with no diagnosis, L. 333  
Diagnosis is disempowering for clients, L. 335-339  
Diagnosis elicits assumptions and predictions, L. 338-340  
Practitioner experience is relevant to the context, L. 344-346  
Complexity, L. 345-346; L. 566-568; L. 577-578; L. 609-611; L. 687  
More challenging with no diagnosis, L. 350  
Diagnosis influences thinking, L. 349-353  
A client's whole experience is considered with no diagnosis, L. 356-361

Work is more complex with no diagnosis, L. 360-361  
Diagnosis dampens creativity, L. 361-363  
Diagnosis adds to complexity, L. 264-365; L. 573-574  
Diagnosis elicits assumptions, L. 380  
Diagnosis simplifies, L. 380-384; L. 619  
Diagnosis as quick fix, L. 386-389  
Transparency about diagnosis, L. 414-415  
Awareness of experience is important, L. 418-419  
Diagnosis forms part of understanding client experience, L. 421-423  
Transparency about own process, L. 425-426  
Diagnosis is reassuring, L. 430-431  
Diagnosis externalises problem, L. 433-435  
Talk explicitly about thoughts on diagnosis to maintain awareness, L. 439-441  
Being aware of own responses is part of a counselling psychologist's identity, L. 467-468  
Awareness makes counselling psychologists distinct, L. 469-470  
Self-awareness facilitates being open about thoughts and feelings, L. 477-480  
Transparency about own experience leads to balance of power, L. 479-483  
Awareness brings a sense of control, L. 486-487  
Transparency about own position brings you closer to client experience, L. 505-508  
Awareness of own experience differs between diagnoses, L. 521  
Diagnosis can only describe, L. L. 545  
Some diagnoses bring more complexities than others, L. 549-551  
Some presentations oppose the therapy process, L. 554-556  
Response to behaviour vs response to diagnosis is difficult to differentiate, L. 562-568  
Difficult to isolate diagnosis as a variable, L. 566-568; L. 577-579  
Diagnosis is informative, L. 570-571  
Reflective capacity, L. 587; L. 652-653  
Awareness is not always conscious, L. 587-590; L. 652-653  
Diagnosis directs attention, L. 615  
Finer processes get missed with diagnosis, L. 617-619  
Aversion to some diagnoses, L. 628-629  
Assumptions about diagnosis effect behaviour, L. 631-633  
Possibilities are endless with no diagnosis, L. 635-636  
Diagnosis brings a sense of certainty, L. 638  
More room for reflection with no diagnosis, L. 654-657  
Diagnosis shuts down curiosity and reflection, L. 657-659  
Settings using diagnosis can be pressured, L. 666-667  
Diagnosis can be invalid, L. 667-668  
Risk of losing counselling psychologist identity, L. 672-675; L. 752-755; L. 758  
Diagnosis provides information, L. 688-689  
Use diagnosis with caution, L.695  
Overuse of diagnosis misses the person, L. 695-697; L. 712-715  
Diagnosis is dominant language, L. 700-703  
Easiest to conform to using diagnosis, L. 706-711  
Diagnosis provides a short-cut, L. 712  
Therapy is endlessly different with no diagnosis, L. 723

Diagnosis seeks to measure experience, L. 726-730  
More focus on the relationship with no diagnosis, L. 731-732  
Therapy is more spontaneous with no diagnosis, L. 731-732  
Therapy is more tentative with no diagnosis, L. 736-741  
Therapy is interesting regardless of a diagnosis, L. 742-747  
Counselling psychologist identity, L. 749-750  
Counselling psychologists pay attention to diagnosis and the person, L. 744-750  
Context is relevant, L. 752-755; L. 757-758  
Medical model is powerful, L. 757-758  
In between position on diagnosis, L. 767-768  
Finding a position on diagnosis is a process, L. 763-768  
Acknowledge diagnosis and explore individual experience, L. 770-774  
The individual is paramount, L. 788-789; L. 801-803  
Diagnosis is less significant than the individual, L. 791-795  
Diagnosis is separate from the person, L. 789-795  
The person is more memorable than the diagnosis, L. 798-799  
Diagnosis is useful in the moment, L. 801  
The in between position creates tension, L. 808-811  
The tension from an in between position is constant, L. 813-814  
Counselling psychology position is challenged, L. 818-829  
Diagnosis dominates, L. 819-822  
The tension creates challenges in working and communication, L. 824-825  
Difference between a paint pallet with 6 bold colours and one with 150 shades of grey, they're both really interesting, L. 742-747

## **Appendix L - Barbara: Clustering Themes Stage One**

### **Diagnosis is limited**

Diagnosis is descriptive, L. 5-7; L. 35-37; L. 771-772; L. 778; L. 545  
Diagnosis categorises, L. 7-8  
Reductionist, L. 12-14; L. 371; L. 390; L. 758; L. 279-280; L. 451-453  
Behaviour reduced to be measurable, L. 36-40  
Labelling, L. 65; 160-161; L. 245-246; L. 327-328; L. 543-544; L. 677-679; L. 701  
Categorisation, L. 145-146  
Diagnosis simplifies, L. 380-384; L. 619

### **Diagnosis is not concerned with individual experience**

Diagnosis is separate from the person, L. 789-795  
Diagnosis externalises problem, L. 433-435  
Diagnosis is not concerned with individual experience, L. 10-12  
Diagnosis contradicts personal experience, L. 41-46  
Psychiatric language is dehumanising, L. 60-61  
Inhumane treatment, L. 113-114  
Dehumanising L. 260-261; L. 451-453  
Diagnosis is disempowering for clients, L. 335-339  
Overuse of diagnosis misses the person, L. 695-697; L. 712-715  
Use diagnosis with caution, L.695

### **Diagnosis provides**

Diagnosis provides a sense of knowing, L. 88-94; 104-108; L. 308-310; L. 430-432; L. 641-642; L. 691  
Diagnosis provides guidance, L. 92-95; L. 694-695  
Diagnosis is containing, L. 97-102; L. 292-293; L. 692-695  
Diagnosis eliminates uncertainty, L. 107-108  
Feeling reassured by diagnosis, L. 102-106  
Diagnosis provides access to treatment, L. 8-10  
Diagnosis provides information, L. 688-689  
Diagnosis is reassuring, L. 430-431  
Diagnosis brings a sense of certainty, L. 638  
Diagnosis is informative, L. 570-571  
Diagnosis seeks to measure experience, L. 726-730  
Diagnosis is useful in the moment, L. 801

### **Diagnosis is intrusive**

Medical model is intrusive, L. 12-14  
Hatred of psychiatric language, L. 50-53  
Psychiatric language is offensive, L. 53-54  
Diagnosis can be damaging, L. 64-70  
Doubt in the existence of diagnosis, L. 143-144  
Diagnosis is a burden, L. 151-152; 159-160; L. 573-574  
Diagnosis can be invalid, L. 667-668  
Diagnosis impacts on therapy, L. 274

**Diagnosis holds a lot of power**

Diagnosis is dominant language, L. 700-703  
Easiest to conform to using diagnosis, L. 706-711  
Diagnosis can dictate response, L. 64-65  
Diagnosis is prevalent, L. 75-76  
Diagnosis is powerful, L. 171-172; L. 292-297; L. 306-307; L. 324-328; L. 538-539; L. 627-629; L. 700-701  
Society influences response to diagnoses, L. 264-266  
Society pays attention to some diagnoses, L. 265-266  
Diagnosis influences language used, L. 277-278  
Medical model is powerful, L. 757-758  
Diagnosis dominates, L. 819-822  
Diagnosing brings sense of finality, L. 324-325  
Personality disorder is ubiquitous, L. 26-28  
Diagnosis determines treatment, L. 257-259; L. 627-629

**Threat to professional identity**

Loss of identity, L. 110-111  
Loss of power, L. 222  
Diagnosis reduces autonomy, L. 292  
Loss of autonomy, L. 324  
Risk of losing counselling psychologist identity, L. 672-675; L. 752-755; L. 758  
Counselling psychologist identity, L. 749-750  
Counselling psychology position is challenged, L. 818-829

**Individual is more than diagnosis**

The individual is paramount, L. 788-789; L. 801-803  
Diagnosis is less significant than the individual, L. 791-795  
The person is more memorable than the diagnosis, L. 798-799  
The individual predominates the diagnosis, L. 78-81

**Complexity**

Some diagnoses bring more complexities than others, L. 549-551  
Response to behaviour vs response to diagnosis is difficult to differentiate, L. 562-568  
Difficult to isolate diagnosis as a variable, L. 566-568; L. 577-579  
Individuals are complex, L. 123-127  
Feeling there's more to consider than a diagnosis, L. 129-131  
Complexity about a person is difficult to articulate, L. 133-134  
More to consider than diagnosis, L. 135-138  
Diagnosis is part of a complex picture, L. 202-203  
Complex relationship, L. 210-213  
Practitioner experience is relevant to the context, L. 344-346  
Complexity, L. 345-346; L. 566-568; L. 577-578; L. 609-611; L. 687  
Work is more complex with no diagnosis, L. 360-361  
Diagnosis adds to complexity, L. 264-365; L. 573-574  
Considers individual in context, L. 116-120  
Context is relevant, L. 752-755; L. 757-758

Significance of setting, L. 276-278

### **Ambivalence**

Diagnosis is a help and a hindrance, L. 139-141

Ambivalence about diagnosis, L. 170-171; L. 298; L. 380

Therapy is interesting regardless of a diagnosis, L. 742-747

### **Valuing diagnosis and experience creates tension**

Diagnosis forms part of understanding client experience, L. 421-423

Diagnosis helps make sense of experience, L. 246-248

Counselling psychologists pay attention to diagnosis and the person, L. 744-750

In between position on diagnosis, L. 767-768

Finding a position on diagnosis is a process, L. 763-768

Acknowledge diagnosis and explore individual experience, L. 770-774

The in between position creates tension, L. 808-811

The tension from an in between position is constant, L. 813-814

The tension creates challenges in working and communication, L. 824-825

### **Recognising own responses**

Working with someone with BPD feels intense, L. 135-136

Countertransference from diagnosis, L. 164-165

Internal response to diagnosis, L. 178-179

Experience of self is constant, L. 180-181

Repetitions in internal response, L. 182-191

Repetition in experience, L. 240-243

Strength of own feeling parallels that of the client, L. 235-237

Personality disorders hold meaning, L. 23-24

### **Responses to diagnosis are limiting**

Diagnosis shuts down curiosity and reflection, L. 657-659

Aversion to some diagnoses, L. 628-629

Diagnosis is considered before meeting the person, L. 155-157

Preconceived responses, L. 65-70

Diagnosis narrows focus, L. 282-284

Diagnosis determines focus, L. 306-314; L. 375-378

Diagnosis elicits assumptions and predictions, L. 338-340

Diagnosis influences thinking, L. 349-353

Diagnosis dampens creativity, L. 361-363

Diagnosis elicits assumptions, L. 380

Diagnosis directs attention, L. 615

Assumptions about diagnosis effect behaviour, L. 631-633

### **Awareness of own responses**

Working through own response to diagnosis, L. 159-162

Awareness makes counselling psychologists distinct, L. 469-470

Aware of countertransference feelings, L. 1773-175

Controlling own feelings, L. 210-211

Aware of own experience, L. 216-218

Awareness of feelings, L. 225-227  
Trying to maintain control, L.238  
Use of own response to make sense of client experience, L. 288-291  
Talk explicitly about thoughts on diagnosis to maintain awareness, L. 439-441  
Being aware of own responses is part of a counselling psychologist's identity, L. 467-468  
Self-awareness facilitates being open about thoughts and feelings, L. 477-480  
Transparency about own experience leads to balance of power, L. 479-483  
Awareness brings a sense of control, L. 486-487  
Transparency about own position brings you closer to client experience, L. 505-508  
Awareness of own experience differs between diagnoses, L. 521  
Awareness of experience is important, L. 418-419  
Transparency about own process, L. 425-426  
Reflective capacity, L. 587; L. 652-653  
Awareness is not always conscious, L. 587-590; L. 652-653  
Awareness difficult to maintain, L. 238-239  
Transparency about diagnosis, L. 414-415  
Loss of awareness, L. 220-221

**Therapy is uninhibited without diagnosis**

Absence of diagnosis brings you closer to the individual, L. 287-289; L. 304-305; L. 315-316  
A client's whole experience is considered with no diagnosis, L. 356-361  
Diagnosis makes experience of therapy indescribably different, L. 322-323  
When diagnosis is absent, sharp contrast to when it's not, L. 319-320  
Naturally evolving therapeutic relationship with no diagnosis, L. 333  
More challenging with no diagnosis, L. 350  
Finer processes get missed with diagnosis, L. 617-619  
More room for reflection with no diagnosis, L. 654-657  
Therapy is endlessly different with no diagnosis, L. 723  
More focus on the relationship with no diagnosis, L. 731-732  
Therapy is more spontaneous with no diagnosis, L. 731-732  
Therapy is more tentative with no diagnosis, L/ 736-741  
Possibilities are endless with no diagnosis, L. 635-636

**Discarded themes**

Diagnosis as quick fix, L. 386-389  
Diagnosis provides a short-cut, L. 712  
Some presentations oppose the therapy process, L. 554-556  
Personality disorder is a broad concept, L. 25-26  
Settings using diagnosis can be pressured, L. 666-667  
Diagnosis can only describe, L. L. 545 – incorporated with diagnosis is descriptive  
Closer to the client with no diagnosis, L. 304-305 AND  
Closer to client experience with no diagnosis, L. 315-316 - incorporated into:  
Absence of diagnosis brings you closer to the individual, L. 287-289  
Personality disorder diagnosis elicits an internal struggle, L. 30

Diagnosis creates conflict, L. 44-46  
Power struggle, L. 215; L. 220-222  
Confusion in relationship, L. 220-221  
Therapy is interesting regardless of a diagnosis, L. 742-747  
Diagnosis is meaningless, L. 76-81  
Diagnoses given weightings, L. 264

### **Appendix M - Barbara: Clustering Themes Stage Two**

#### **Diagnosis simplifies, L. 380-384; L. 619**

Diagnosis is descriptive, L. 5-7; L. 35-37; L. 771-772; L. 778; L. 545

Diagnosis categorises, L. 7-8

Reductionist, L. 12-14; L. 371; L. 390; L. 758; L. 279-280; L. 451-453

Behaviour reduced to be measurable, L. 36-40

Labelling, L. 65; 160-161; L. 245-246; L. 327-328; L. 543-544; L. 677-679; L. 701

Categorisation, L. 145-146

Doubt in the existence of diagnosis, L. 143-144

Diagnosis is a burden, L. 151-152; 159-160; L. 573-574

Diagnosis can be invalid, L. 667-668

#### **Use diagnosis with caution, L.695; L. 767-770**

Diagnosis is separate from the person, L. 789-795

Diagnosis externalises problem, L. 433-435

Diagnosis is not concerned with individual experience, L. 10-12

Diagnosis contradicts personal experience, L. 41-46

Dehumanising L. 260-261; L. 451-453; L. 60-61; L. 113-114

Diagnosis is disempowering for clients, L. 335-339

Overuse of diagnosis misses the person, L. 695-697; L. 712-715

The individual is paramount, L. 788-789; L. 801-803; L. 791-795; L. 798-799; L. 78-81

#### **Containment vs. complexity**

Diagnosis provides a sense of knowing, L. 88-94; 104-108; L. 308-310; L. 430-432; L. 641-642; L. 691

Diagnosis provides, L. 92-95; L. 694-695; L. 8-10; L. 688-689

Diagnosis is containing, L. 97-102; L. 292-293; L. 692-695

Diagnosis eliminates uncertainty, L. 107-108; L. 638

Diagnosis is reassuring, L. 430-431; L. 102-106

Some diagnoses bring more complexities than others, L. 549-551

Difficult to isolate diagnosis as a variable, L. 566-568; L. 577-579; L. 562-568

Complexity, L. 345-346; L. 566-568; L. 577-578; L. 609-611; L. 687; L. 360-361; L. 264-365; L. 573-574; L. 123-127; L. 129-131; L. 133-134; L. 135-138; L. 202-203; L. 210-213

Context is relevant, L. 752-755; L. 757-758; L. 276-278; L. 116-120; L. 344-346

#### **Risk of losing counselling psychologist identity, L. 672-675; L. 752-755; L. 758; L. 110-111**

Medical model is intrusive, L. 12-14

Diagnosis can be damaging, L. 64-70

Diagnosis is dominant language, L. 700-703

Easiest to conform to using diagnosis, L. 706-711

Diagnosis can dictate response, L. 64-65

Diagnosis is powerful, L. 171-172; L. 292-297; L. 306-307; L. 324-328; L. 538-539; L. 627-629; L. 700-701; L. 757-758; L. 75-76; L. 819-822; L. 257-259; L. 627-629

Society influences response to diagnoses, L. 264-266

Society pays attention to some diagnoses, L. 265-266  
Diagnosing brings sense of finality, L. 324-325  
Loss of power, L. 222  
Diagnosis reduces autonomy, L. 292; L. 324

**Difference between a paint pallet with 6 bold colours and one with 150 shades of grey, they're both really interesting, L. 742-747**

Ambivalence about diagnosis, L. 170-171; L. 298; L. 380; L. 139-141  
Diagnosis forms part of understanding client experience, L. 421-423  
Diagnosis helps make sense of experience, L. 246-248  
Counselling psychologists pay attention to diagnosis and the person, L. 744-750  
In between position on diagnosis, L. 767-768  
Finding a position on diagnosis is a process, L. 763-768  
Acknowledge diagnosis and explore individual experience, L. 770-774  
Tension L. 808-811; L. 813-814; L. 824-825

**Awareness makes counselling psychologists distinct, L. 469-470; L. 467-468**

Working through own response to diagnosis, L. 159-162  
Awareness and control, L. 210-211; L. 486-487; L. 238  
Aware of own experience, L. 216-218; L. 225-227; L. 1773-175  
Awareness of own experience differs between diagnoses, L. 521  
Awareness of experience is important, L. 418-419  
Awareness is not always conscious, L. 587-590; L. 652-653  
Use of own response to make sense of client experience, L. 288-291  
Talk explicitly about thoughts on diagnosis to maintain awareness, L. 439-441  
Self-awareness facilitates being open about thoughts and feelings, L. 477-480  
Transparency and balance of power, L. 479-483; L. 505-508; L. 425-426; L. 414-415  
Reflective capacity, L. 587; L. 652-653  
Awareness difficult to maintain, L. 238-239; L. 220-221  
Countertransference from diagnosis, L. 164-165  
Internal response to diagnosis, L. 178-179  
Experience of self is constant, L. 180-181  
Repetitions in internal response, L. 182-191  
Repetition in experience, L. 240-243  
Strength of own feeling parallels that of the client, L. 235-237

**Diagnosis makes experience of therapy indescribably different, L. 322-323; L. 319-320**

Absence of diagnosis brings you closer to the individual, L. 287-289; L. 304-305; L. 315-316  
A client's whole experience is considered with no diagnosis, L. 356-361  
Naturally evolving therapeutic relationship with no diagnosis, L. 333  
More challenging with no diagnosis, L. 350  
Finer processes get missed with diagnosis, L. 617-619  
More room for reflection with no diagnosis, L. 654-657  
Therapy is endlessly different with no diagnosis, L. 723  
More focus on the relationship with no diagnosis, L. 731-732  
Therapy is more spontaneous with no diagnosis, L. 731-732

Therapy is more tentative with no diagnosis, L/ 736-741  
Possibilities are endless with no diagnosis, L. 635-636  
Diagnosis impacts on therapy, L. 274  
Diagnosis shuts down curiosity and reflection, L. 657-659  
Aversion to some diagnoses, L. 628-629  
Diagnosis is considered before meeting the person, L. 155-157  
Preconceived responses, L. 65-70  
Diagnosis narrows focus, L. 282-284  
Diagnosis determines focus, L. 306-314; L. 375-378  
Diagnosis elicits assumptions and predictions, L. 338-340; L. 380  
Diagnosis influences thinking, L. 349-353  
Diagnosis dampens creativity, L. 361-363  
Diagnosis directs attention, L. 615  
Assumptions about diagnosis effect behaviour, L. 631-633

### **Discarded themes**

Diagnosis as quick fix, L. 386-389  
Diagnosis provides a short-cut, L. 712  
Some presentations oppose the therapy process, L. 554-556  
Personality disorder is a broad concept, L. 25-26  
Settings using diagnosis can be pressured, L. 666-667  
Diagnosis can only describe, L. L. 545 – incorporated with diagnosis is descriptive  
Closer to the client with no diagnosis, L. 304-305 AND  
Closer to client experience with no diagnosis, L. 315-316 - incorporated into:  
Absence of diagnosis brings you closer to the individual, L. 287-289  
Personality disorder diagnosis elicits an internal struggle, L. 30  
Diagnosis creates conflict, L. 44-46  
Power struggle, L. 215; L. 220-222  
Confusion in relationship, L. 220-221  
Therapy is interesting regardless of a diagnosis, L. 742-747  
Diagnosis is meaningless, L. 76-81  
Diagnoses given weightings, L. 264

### **Discarded from “diagnosis provides” because do not fit the new theme: “contained vs unbounded.”**

Diagnosis is informative, L. 570-571  
Diagnosis seeks to measure experience, L. 726-730  
Diagnosis is useful in the moment, L. 801

### **Discarded from “diagnosis holds a lot of power” because too weak.**

Diagnosis influences language used, L. 277-278

### **Discarded from “power struggles” because does not fit.**

Counselling psychologist identity, L. 749-750  
Counselling psychology position is challenged, L. 818-829 – too weak  
Hatred of psychiatric language, L. 50-53; L. 53-54  
Personality disorder is ubiquitous, L. 26-28

**Discarded from “Middle ground position on diagnosis” because does not fit.**  
Therapy is interesting regardless of a diagnosis, L. 742-747

**Discarded from “awareness of own responses” because not a great fit.**  
Working with someone with BPD feels intense, L. 135-136  
Personality disorders hold meaning, L. 23-24

### **Appendix N - Barbara: Clustering Themes Stage Three**

#### **Diagnosis simplifies, L. 380-384; L. 619**

Diagnosis is descriptive, L. 5-7; L. 35-37; L. 771-772; L. 778; L. 545  
 Diagnosis categorises, L. 7-8; L. 145-146; L. 65; 160-161; L. 245-246; L. 327-328;  
 L. 543-544; L. 677-679; L. 701  
 Reductionist, L. 12-14; L. 371; L. 390; L. 758; L. 279-280; L. 451-453; L. 36-40  
 Doubt in the existence of diagnosis, L. 143-144; L. 667-668

#### **Use diagnosis with caution, L.695; L. 767-770**

Diagnosis is separate from the person, L. 789-795; L. 433-435  
 Diagnosis is not concerned with individual experience, L. 10-12; L. 41-46; L. 695-  
 697; L. 712-715  
 Dehumanising L. 260-261; L. 451-453; L. 60-61; L. 113-114  
 Diagnosis is disempowering for clients, L. 335-339  
 The individual is paramount, L. 788-789; L. 801-803; L. 791-795; L. 798-799; L. 78-  
 81  
 Diagnosis can be damaging, L. 64-70

#### **Containment vs. complexity**

Diagnosis provides, L. 92-95; L. 694-695; L. 8-10; L. 688-689 L. 88-94; 104-108; L.  
 308-310; L. 430-432; L. 641-642; L. 691  
 Diagnosis is containing, L. 97-102; L. 292-293; L. 692-695; L. 430-431; L. 102-106  
 Diagnosis eliminates uncertainty, L. 107-108; L. 638  
 Some diagnoses bring more complexities than others, L. 549-551  
 Difficult to isolate diagnosis as a variable, L. 566-568; L. 577-579; L. 562-568; L.  
 752-755; L. 757-758; L. 276-278; L. 116-120; L. 344-346  
 Complexity, L. 345-346; L. 566-568; L. 577-578; L. 609-611; L. 687; L. 360-361; L.  
 264-365; L. 573-574; L. 123-127; L. 129-131; L. 133-134; L. 135-138; L. 202-203;  
 L. 210-213

#### **Diagnosis is powerful and can reduce autonomy**

Risk of losing counselling psychologist identity, L. 672-675; L. 752-755; L. 758; L.  
 110-111  
 Loss of power, L. 222  
 Diagnosis reduces autonomy, L. 292; L. 324  
 Diagnosis is dominant language, L. 700-703  
 Easiest to conform to using diagnosis, L. 706-711  
 Diagnosis can dictate response, L. 64-65  
 Diagnosis is powerful, L. 171-172; L. 292-297; L. 306-307; L. 324-328; L. 538-539;  
 L. 627-629; L. 700-701; L. 757-758; L. 75-76; L. 819-822; L. 257-259; L. 627-629  
 Society influences response to diagnoses, L. 264-266  
 Diagnosing brings sense of finality, L. 324-325

#### **Difference between a paint pallet with 6 bold colours and one with 150 shades of grey, they're both really interesting, L. 742-747**

Ambivalence about diagnosis, L. 170-171; L. 298; L. 380; L. 139-141  
 Diagnosis forms part of understanding client experience, L. 421-423; L. 246-248

Counselling psychologists pay attention to diagnosis and the person, L. 744-750; L. 770-774

In between position on diagnosis, L. 767-768

Finding a position on diagnosis is a process, L. 763-768

Tension L. 808-811; L. 813-814; L. 824-825

### **Awareness of experience and transparency**

Awareness makes counselling psychologists distinct, L. 469-470; L. 467-468

Awareness and control, L. 210-211; L. 486-487; L. 238

Aware of own experience, L. 216-218; L. 225-227; L. 1773-175; L. 521; L. 418-419

Awareness is not always conscious, L. 587-590; L. 652-653

Use of own response to make sense of client experience, L. 288-291; L. 164-165; L. 235-237

Talk explicitly about thoughts on diagnosis to maintain awareness, L. 439-441

Transparency and balance of power, L. 479-483; L. 505-508; L. 425-426; L. 414-415

Reflective capacity, L. 587; L. 652-653

Awareness difficult to maintain, L. 238-239; L. 220-221

Internal response to diagnosis, L. 178-179; L. 182-191; L. 240-243

### **Indescribable differences between therapy with and therapy without a diagnosis**

Diagnosis makes experience of therapy indescribably different, L. 322-323; L. 319-320; L. 723; L. 274

Absence of diagnosis brings you closer to the individual, L. 287-289; L. 304-305; L. 315-316; L. 356-36; L. 333

Finer processes get missed with diagnosis, L. 617-619

Therapy is more spontaneous with no diagnosis, L. 731-732

Therapy is more tentative with no diagnosis, L. 736-741

Diagnosis shuts down curiosity and reflection, L. 657-659

Reacting to diagnosis, L. 628-629; L. 155-157; L. 65-70; L. 338-340; L. 380; L. 349-353; L. 631-633

Diagnosis directs attention, L. 615; L. 282-284; L. 306-314; L. 375-378

Diagnosis dampens creativity, L. 361-363

### **Discarded themes**

Diagnosis as quick fix, L. 386-389

Diagnosis provides a short-cut, L. 712

Some presentations oppose the therapy process, L. 554-556

Personality disorder is a broad concept, L. 25-26

Settings using diagnosis can be pressured, L. 666-667

Diagnosis can only describe, L. L. 545 – incorporated with diagnosis is descriptive

Closer to the client with no diagnosis, L. 304-305 AND

Closer to client experience with no diagnosis, L. 315-316 - incorporated into:

Absence of diagnosis brings you closer to the individual, L. 287-289

Personality disorder diagnosis elicits an internal struggle, L. 30

Diagnosis creates conflict, L. 44-46

Power struggle, L. 215; L. 220-222

Confusion in relationship, L. 220-221

Therapy is interesting regardless of a diagnosis, L. 742-747

Diagnosis is meaningless, L. 76-81

Diagnoses given weightings, L. 264

**Discarded from “diagnosis provides” because do not fit the new theme:  
“contained vs unbounded.”**

Diagnosis is informative, L. 570-571

Diagnosis seeks to measure experience, L. 726-730

Diagnosis is useful in the moment, L. 801

**Discarded from “diagnosis holds a lot of power” because too weak.**

Diagnosis influences language used, L. 277-278

**Discarded from “power struggles” because does not fit.**

Counselling psychologist identity, L. 749-750

Counselling psychology position is challenged, L. 818-829 – too weak

Hatred of psychiatric language, L. 50-53; L. 53-54

Personality disorder is ubiquitous, L. 26-28

**Discarded from “Middle ground position on diagnosis” because does not fit.**

Therapy is interesting regardless of a diagnosis, L. 742-747

**Discarded from “awareness of own responses” because not a great fit.**

Working with someone with BPD feels intense, L. 135-136

Personality disorders hold meaning, L. 23-24

Diagnosis is a burden, L. 151-152; 159-160; L. 573-574

Society pays attention to some diagnoses, L. 265-266

Medical model is intrusive, L. 12-14

Working through own response to diagnosis, L. 159-162

Self-awareness facilitates being open about thoughts and feelings, L. 477-480

Experience of self is constant, L. 180-181

More focus on the relationship with no diagnosis, L. 731-732

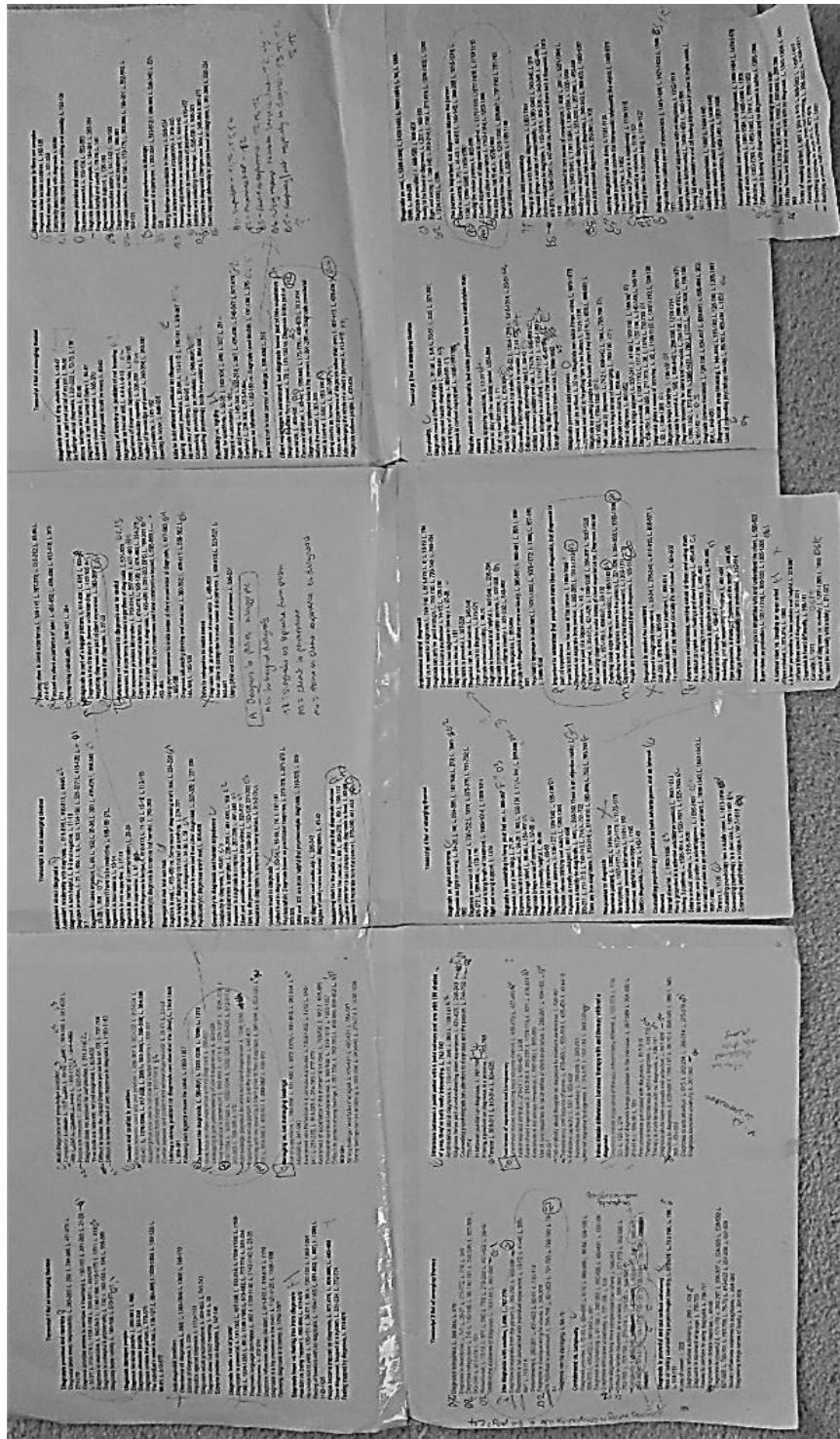
More room for reflection with no diagnosis, L. 654-657

Possibilities are endless with no diagnosis, L. 635-636

More challenging with no diagnosis, L. 350

## Appendix O - Clustering Themes Across Participants

This is an image to represent how themes were clustered across participants. The images on the following six pages break this picture up into readable segments.



**Transcript 1 list of emerging themes**

**Diagnosis provides and restricts**  
 Diagnosis takes away responsibility, L. 283-285; L. 292; L. 294-296; L. 471-472; L. 274-276  
 Diagnosis provides access to services & treatment, L. 150-151; L. 201-203; L. 21-23;  
 Diagnosis is restrictive, L. 772-774; L. 1188-1189; L. 320-321; L. 683-686  
 Diagnosis is unhelpful & problematic, L. 130; L. 152-153; L. 194; L. 568-569  
 Diagnosis lacks validity, L. 166-168; L. 570-571

**Diagnosis damages people**

Diagnosis tarnishes people, L. 650-651; L. 695  
 Diagnosis alienates people, L. 333-335  
 Diagnosis inhibits the person, L. 370-375  
 The individual's voice is lost, L. 136-137; L. 664-666; L. 1023-1025; L. 122-123; L. 86-91; L. 572-575

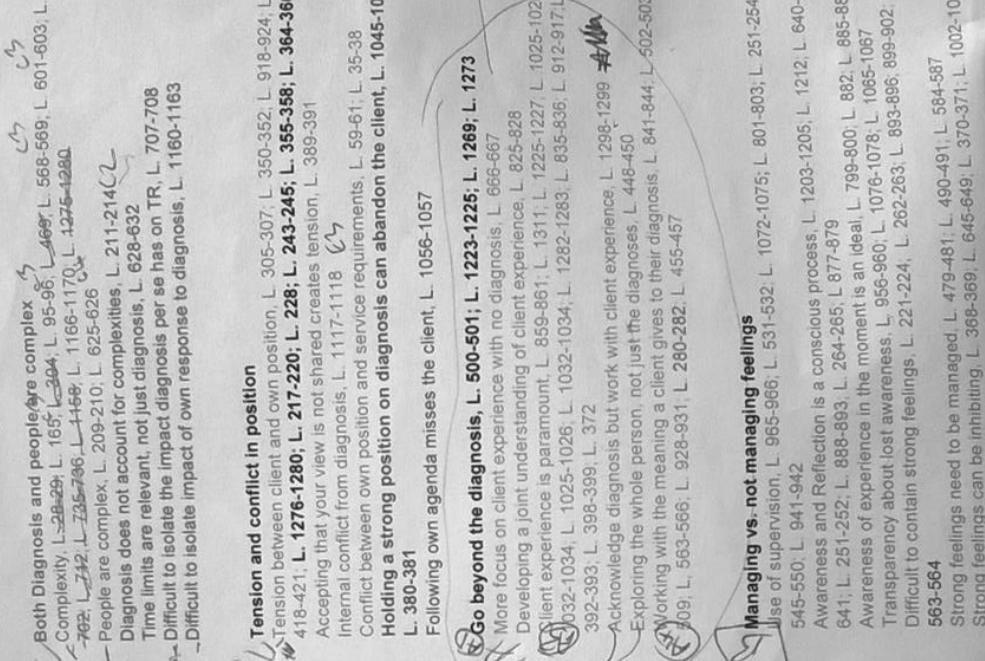
**Anti-diagnosis position**

Dismisive of diagnosis, L. 560; L. 1303-1304; L. 1309; L. 168-170  
 Distrust of diagnosis, L. 225  
 Prejudice against diagnosis, L. 1113-1118  
 Diagnosis elicits preconceptions, L. 654-655; L. 741-743  
 Diagnosis does not hold meaning, L. 3-4; L. 30  
 Extreme position on diagnosis, L. 147-148

**Diagnosis holds a lot of power**  
 Diagnosis is powerful, L. 151-152; L. 197-198; L. 313-314; L. 1128-1130; L. 1188-1189; L. 1234-1235; L. 59; L. 1185-1186; L. 679-682; L. 772-774; L. 231-234  
 Diagnostic language dominates, L. 662; L. 1128-1130; L. 1142-1143; L. 25-26  
 Powerlessness, L. 312-314  
 Diagnosis influences therapy duration, L. 811-812; L. 816-819; L. 1170  
 Diagnosis is a big presence in the room, L. 1121-1125; L. 1166-1168  
 Opposing diagnosis is isolating, L. 1254-1257

**Diagnosis traps vs. feeling free from diagnosis**

Freedom vs. being trapped L. 692-694; L. 674-675  
 No choice but to yield, L. 150-151; L. 34-37; L. 59; L. 120-122; L. 1263-1264  
 Feeling of freedom with no diagnosis, L. 1164-1165; L. 651-652; L. 657; L. 1093; L. 1123-1125  
 People become trapped by diagnosis, L. 477-478; L. 505-506; L. 483-485  
 Once diagnosed, trapped in a system, L. 231-234; L. 772-774  
 Feeling trapped by diagnosis, L. 674-675



**Transcript 2 list of emerging themes**

**D** Diagnosis simplifies, L. 380-384; L. 619  
Diagnosis is descriptive, L. 5-7; L. 35-37; L. 771-772; L. 778; L. 545  
Diagnosis categories, L. 7-8; L. 145-146; L. 65; L. 160-161; L. 245-246; L. 327-328; L. 543-544; L. 677-679, L. 701

**O2** Reductionist, L. 12-14; L. 371; L. 390; L. 758; L. 279-280; L. 451-453; L. 36-40

**O2** Doubt in the existence of diagnosis, L. 143-144; L. 667-668 — G1

**Use diagnosis with caution, L. 695; L. 767-770**

Diagnosis is separate from the person, L. 789-795; L. 433-435 — G1

Diagnosis is not concerned with individual experience, L. 10-12; L. 41-46; L. 695-697; L. 712-715

Dehumanising L. 260-261; L. 451-453; L. 60-61; L. 113-114

Diagnosis is disempowering for clients, L. 335-339

The individual is paramount, L. 783-789; L. 801-803; L. 791-795; L. 798-799; L. 78-79

81 Diagnosis can be damaging, L. 64-70

**Containment vs. complexity**

Diagnosis provides, L. 92-95; L. 694-695; L. 8-10; L. 688-689; L. 88-94; 104-108; L. 308-310; L. 430-432; L. 641-642; L. 691

Diagnosis is containing, L. 97-102; L. 292-293; L. 692-695; L. 430-431; L. 102-106

Diagnosis eliminates uncertainty, L. 107-108; L. 638

Some diagnoses bring more complexities than others, L. 549-551

Difficult to isolate diagnosis as a variable, L. 566-568; L. 577-579; L. 562-568; L. 752-755; L. 757-758; L. 276-278; L. 116-120; L. 344-346 ↑

Complexity, L. 645-645; L. 346-346; L. 609-611; L. 612-612; L. 620-620; L. 360-361; L. 624-365; L. 573-574; L. 123-127; L. 128-131; L. 133-134; L. 135-136; L. 215-216; L. 217-218; L. 219-220; L. 221-222; L. 223-224; L. 225-226; L. 227-228; L. 229-230; L. 231-232; L. 233-234; L. 235-236; L. 237-238; L. 239-240; L. 241-242; L. 243-244; L. 245-246; L. 247-248; L. 249-250; L. 251-252; L. 253-254; L. 255-256; L. 257-258; L. 259-260; L. 261-262; L. 263-264; L. 265-266; L. 267-268; L. 269-270; L. 271-272; L. 273-274; L. 275-276; L. 277-278; L. 279-280; L. 281-282; L. 283-284; L. 285-286; L. 287-288; L. 289-290; L. 291-292; L. 293-294; L. 295-296; L. 297-298; L. 299-300; L. 301-302; L. 303-304; L. 305-306; L. 307-308; L. 309-310; L. 311-312; L. 313-314; L. 315-316; L. 317-318; L. 319-320; L. 321-322; L. 323-324; L. 325-326; L. 327-328; L. 329-330; L. 331-332; L. 333-334; L. 335-336; L. 337-338; L. 339-340; L. 341-342; L. 343-344; L. 345-346; L. 347-348; L. 349-350; L. 351-352; L. 353-354; L. 355-356; L. 357-358; L. 359-360; L. 361-362; L. 363-364; L. 365-366; L. 367-368; L. 369-370; L. 371-372; L. 373-374; L. 375-376; L. 377-378; L. 379-380; L. 381-382; L. 383-384; L. 385-386; L. 387-388; L. 389-390; L. 391-392; L. 393-394; L. 395-396; L. 397-398; L. 399-400; L. 401-402; L. 403-404; L. 405-406; L. 407-408; L. 409-410; L. 411-412; L. 413-414; L. 415-416; L. 417-418; L. 419-420; L. 421-422; L. 423-424; L. 425-426; L. 427-428; L. 429-430; L. 431-432; L. 433-434; L. 435-436; L. 437-438; L. 439-440; L. 441-442; L. 443-444; L. 445-446; L. 447-448; L. 449-450; L. 451-452; L. 453-454; L. 455-456; L. 457-458; L. 459-460; L. 461-462; L. 463-464; L. 465-466; L. 467-468; L. 469-470; L. 471-472; L. 473-474; L. 475-476; L. 477-478; L. 479-480; L. 481-482; L. 483-484; L. 485-486; L. 487-488; L. 489-490; L. 491-492; L. 493-494; L. 495-496; L. 497-498; L. 499-500; L. 501-502; L. 503-504; L. 505-506; L. 507-508; L. 509-510; L. 511-512; L. 513-514; L. 515-516; L. 517-518; L. 519-520; L. 521-522; L. 523-524; L. 525-526; L. 527-528; L. 529-530; L. 531-532; L. 533-534; L. 535-536; L. 537-538; L. 539-540; L. 541-542; L. 543-544; L. 545-546; L. 547-548; L. 549-550; L. 551-552; L. 553-554; L. 555-556; L. 557-558; L. 559-560; L. 561-562; L. 563-564; L. 565-566; L. 567-568; L. 569-570; L. 571-572; L. 573-574; L. 575-576; L. 577-578; L. 579-580; L. 581-582; L. 583-584; L. 585-586; L. 587-588; L. 589-590; L. 591-592; L. 593-594; L. 595-596; L. 597-598; L. 599-600; L. 601-602; L. 603-604; L. 605-606; L. 607-608; L. 609-610; L. 611-612; L. 613-614; L. 615-616; L. 617-618; L. 619-620; L. 621-622; L. 623-624; L. 625-626; L. 627-628; L. 629-630; L. 631-632; L. 633-634; L. 635-636; L. 637-638; L. 639-640; L. 641-642; L. 643-644; L. 645-646; L. 647-648; L. 649-650; L. 651-652; L. 653-654; L. 655-656; L. 657-658; L. 659-660; L. 661-662; L. 663-664; L. 665-666; L. 667-668; L. 669-670; L. 671-672; L. 673-674; L. 675-676; L. 677-678; L. 679-680; L. 681-682; L. 683-684; L. 685-686; L. 687-688; L. 689-690; L. 691-692; L. 693-694; L. 695-696; L. 697-698; L. 699-700; L. 701-702; L. 703-704; L. 705-706; L. 707-708; L. 709-710; L. 711-712; L. 713-714; L. 715-716; L. 717-718; L. 719-720; L. 721-722; L. 723-724; L. 725-726; L. 727-728; L. 729-730; L. 731-732; L. 733-734; L. 735-736; L. 737-738; L. 739-740; L. 741-742; L. 743-744; L. 745-746; L. 747-748; L. 749-750; L. 751-752; L. 753-754; L. 755-756; L. 757-758; L. 759-760; L. 761-762; L. 763-764; L. 765-766; L. 767-768; L. 769-770; L. 771-772; L. 773-774; L. 775-776; L. 777-778; L. 779-780; L. 781-782; L. 783-784; L. 785-786; L. 787-788; L. 789-790; L. 791-792; L. 793-794; L. 795-796; L. 797-798; L. 799-800; L. 801-802; L. 803-804; L. 805-806; L. 807-808; L. 809-810; L. 811-812; L. 813-814; L. 815-816; L. 817-818; L. 819-820; L. 821-822; L. 823-824; L. 825-826; L. 827-828; L. 829-830; L. 831-832; L. 833-834; L. 835-836; L. 837-838; L. 839-840; L. 841-842; L. 843-844; L. 845-846; L. 847-848; L. 849-850; L. 851-852; L. 853-854; L. 855-856; L. 857-858; L. 859-860; L. 861-862; L. 863-864; L. 865-866; L. 867-868; L. 869-870; L. 871-872; L. 873-874; L. 875-876; L. 877-878; L. 879-880; L. 881-882; L. 883-884; L. 885-886; L. 887-888; L. 889-890; L. 891-892; L. 893-894; L. 895-896; L. 897-898; L. 899-900; L. 901-902; L. 903-904; L. 905-906; L. 907-908; L. 909-910; L. 911-912; L. 913-914; L. 915-916; L. 917-918; L. 919-920; L. 921-922; L. 923-924; L. 925-926; L. 927-928; L. 929-930; L. 931-932; L. 933-934; L. 935-936; L. 937-938; L. 939-940; L. 941-942; L. 943-944; L. 945-946; L. 947-948; L. 949-950; L. 951-952; L. 953-954; L. 955-956; L. 957-958; L. 959-960; L. 961-962; L. 963-964; L. 965-966; L. 967-968; L. 969-970; L. 971-972; L. 973-974; L. 975-976; L. 977-978; L. 979-979; L. 980-981; L. 982-983; L. 983-984; L. 984-985; L. 985-986; L. 986-987; L. 987-988; L. 988-989; L. 989-990; L. 990-991; L. 991-992; L. 992-993; L. 993-994; L. 994-995; L. 995-996; L. 996-997; L. 997-998; L. 998-999; L. 999-1000; L. 1000-1001; L. 1001-1002; L. 1002-1003; L. 1003-1004; L. 1004-1005; L. 1005-1006; L. 1006-1007; L. 1007-1008; L. 1008-1009; L. 1009-1010; L. 1010-1011; L. 1011-1012; L. 1012-1013; L. 1013-1014; L. 1014-1015; L. 1015-1016; L. 1016-1017; L. 1017-1018; L. 1018-1019; L. 1019-1020; L. 1020-1021; L. 1021-1022; L. 1022-1023; L. 1023-1024; L. 1024-1025; L. 1025-1026; L. 1026-1027; L. 1027-1028; L. 1028-1029; L. 1029-1030; L. 1030-1031; L. 1031-1032; L. 1032-1033; L. 1033-1034; L. 1034-1035; L. 1035-1036; L. 1036-1037; L. 1037-1038; L. 1038-1039; L. 1039-1040; L. 1040-1041; L. 1041-1042; L. 1042-1043; L. 1043-1044; L. 1044-1045; L. 1045-1046; L. 1046-1047; L. 1047-1048; L. 1048-1049; L. 1049-1050; L. 1050-1051; L. 1051-1052; L. 1052-1053; L. 1053-1054; L. 1054-1055; L. 1055-1056; L. 1056-1057; L. 1057-1058; L. 1058-1059; L. 1059-1060; L. 1060-1061; L. 1061-1062; L. 1062-1063; L. 1063-1064; L. 1064-1065; L. 1065-1066; L. 1066-1067; L. 1067-1068; L. 1068-1069; L. 1069-1070; L. 1070-1071; L. 1071-1072; L. 1072-1073; L. 1073-1074; L. 1074-1075; L. 1075-1076; L. 1076-1077; L. 1077-1078; L. 1078-1079; L. 1079-1080; L. 1080-1081; L. 1081-1082; L. 1082-1083; L. 1083-1084; L. 1084-1085; L. 1085-1086; L. 1086-1087; L. 1087-1088; L. 1088-1089; L. 1089-1090; L. 1090-1091; L. 1091-1092; L. 1092-1093; L. 1093-1094; L. 1094-1095; L. 1095-1096; L. 1096-1097; L. 1097-1098; L. 1098-1099; L. 1099-1100; L. 1100-1101; L. 1101-1102; L. 1102-1103; L. 1103-1104; L. 1104-1105; L. 1105-1106; L. 1106-1107; L. 1107-1108; L. 1108-1109; L. 1109-1110; L. 1110-1111; L. 1111-1112; L. 1112-1113; L. 1113-1114; L. 1114-1115; L. 1115-1116; L. 1116-1117; L. 1117-1118; L. 1118-1119; L. 1119-1120; L. 1120-1121; L. 1121-1122; L. 1122-1123; L. 1123-1124; L. 1124-1125; L. 1125-1126; L. 1126-1127; L. 1127-1128; L. 1128-1129; L. 1129-1130; L. 1130-1131; L. 1131-1132; L. 1132-1133; L. 1133-1134; L. 1134-1135; L. 1135-1136; L. 1136-1137; L. 1137-1138; L. 1138-1139; L. 1139-1140; L. 1140-1141; L. 1141-1142; L. 1142-1143; L. 1143-1144; L. 1144-1145; L. 1145-1146; L. 1146-1147; L. 1147-1148; 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## Transcript 3 list of emerging themes

## Ambivalent about diagnosis

Ambivalent relationship with diagnosis, L. 615-616; L. 610-613; L. 94-95 ↗  
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Diagnosis is both helpful, L. 8-9 and negative, L. 11-16

Diagnosis provides, L. 21; L. 634; L. 9; L. 102; L. 154-156; L. 331-337; L. 418-420; L. - 317

Diagnosis focuses attention, L. 96; L. 102; L. 25-26; L. 390; L. 418-423; L. 358-362; ↗

L. 27-28; L. 396 ↗

Diagnosis doesn't have to be restrictive, L. 188-189 ↗ L

Diagnosis is inconsistent, L. 13-14

Diagnosis is not supportive, L. 17-19

Diagnosis as method of communication, L. 23-24

Diagnosis is oppressive, L. 87

Psychiatric diagnosis is limited, L. 610-612; L. 11-12; L. 15-16; L. 112-113

Psychiatric analytic diagnosis is common but harmful, L. 262-263 -

Psychoanalytic diagnosis is common, L. 224-226 ↗

Diagnosis is real, L. 455-459 vs. Some ways of diagnosing aren't real, L. 224-226 ↗

Some ways of diagnosing do not tell us anything, L. 224-227

Truth to be found in diagnosis, L. 34-36; L. 58 ↗

Psychiatric diagnosis is more real than other diagnoses, L. 327-329; L. 227-229

Psychoanalytic diagnoses aren't real, L. 606-609

## Complexity in diagnosis and human experience

Complexity in diagnosis, L. 60-61 ↗

Human experience is complex, L. 205-208; L. 491-492; L. 188 ↗

Response to diagnosis is complex, L. 297-299; L. 491-492 ↗

Client and practitioner experience inter-twined, L. 523-527; ↗

How we diagnose is complicated, L. 259-261; L. 123-126; 221-222 ↗

Response to diagnosis is response to many factors, L. 311-313 ↗

## Variable trust in diagnosis

Limited trust in diagnosis, L. 53-54; L. 15-16; L. 74; L. 157-161

Psychoanalytic Diagnosis based on practitioner response, L. 273-278; L. 271-273; L.

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DSM and ICD are more helpful than psychoanalytic diagnosis, L. 319-322; L. 323-

325

Any diagnosis used cautiously, L. 336-343

Degree of clarity varies between diagnoses, L. 41-43

## Remaining alert to the parts of people that diagnosis misses

Diagnosis misses the person, L. 99; L. 269-270; L. 89; L. 108-110

Individual experience can change while diagnosis is fixed, L. 82-86

Diagnosis is separate from the person L. 379-380; 441-443 ↗

Keeping close to client experience, L. 133-141; L. 367-370; L. 210-212; L. 93-95; L.

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Focused on client experience of label, L. 451-452; L. 436-438; L. 413-415; L. 372-374

Recognising individuality, L. 536-537; L. 284

Diagnosis is part of a bigger picture, L. 618-626; L. 631; L. 633 ↗

Diagnosis is the first step in deeper understanding, L. 102-105 ↗

Integrating diagnosis as part of client experience, L. 383-385 ↗

Consider more than diagnosis, L. 27-29

## Awareness of responses to diagnosis can be useful

Awareness of experience is constant regardless of diagnosis, L. 531-533 ↗

Own response provides information, L. 213-214; L. 557-559; L. 477-480 ↗

Experience as countertransference, L. 474-475; L. 198-199; L. 478-480; L. 214-215 ↗

Themes in own response to diagnosis, L. 493-499; L. 231-233; BPD, L. 198-201 ↗

Transparency about own responses can have constructive impact, L. 565-569; L. - 483-484

Using own experience to make sense of client experience of diagnosis, L. 577-583; ↗

L. 585-589

Diagnosis influencing thinking and behaviour, L. 390-392; L. 408-411; L. 559-562; L. ↗

144-145; L. 135-138

## Drive to categorise to make sense

Diagnoses help us make sense of experience, L. 499-503

Human drive to categories to make sense of experience, L. 509-513; L. 523-527; L.

540-541

Using DSM and ICD to make sense of experience, L. 528-531

A. Diagnosis is part of a wider pic

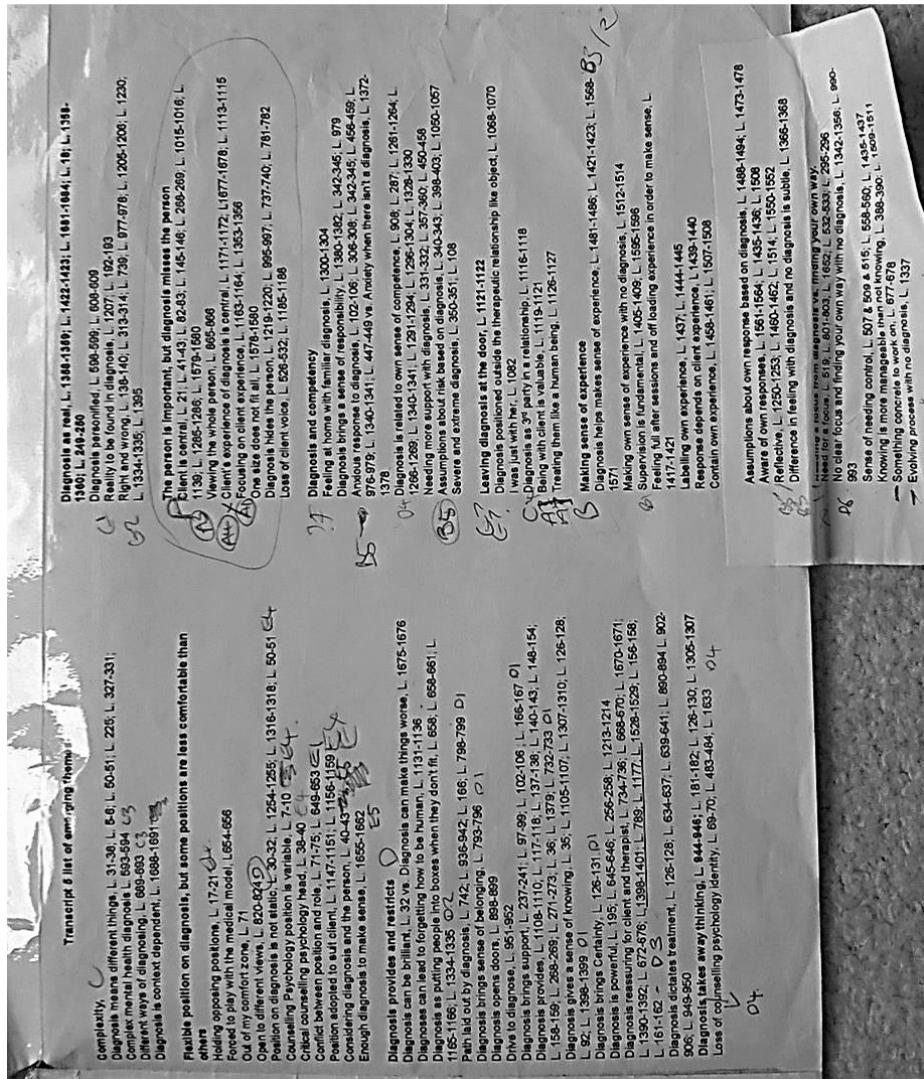
↗ 1 = beyond diagnosis

↗ 2 = diagnosis as separate from person

↗ 3 = client is paramount

↗ 4 = focus on client experience or diagnosis





**Transcript 6 list of emerging themes**

**Diagnoses and responses to them are complex**

- C Diagnosis varies across counties, L. 182-185
- C Different ways to diagnose, L. 231-233
- C Complexity associated with diagnosis, L. 54-59
- C Response to diagnosis depends on setting and modality, L. 152-156

**Diagnosis provides and restricts**

- D Diagnosis as powerful, L. 155-156; L. 552-553
- Diagnosis disempowers people, L. 194-201, L. 383-384
- Diagnosis helps and useful, L. 75-76; L. 140
- Diagnosis elicits support, L. 126-130
- Diagnosis specifies action, L. 141-142; L. 126-130
- Diagnosis indicates correct treatment, L. 386-387
- Diagnosis restricts, L. 155-156; L. 170-175; L. 383-386; L. 199-201, L. 552-553; L. 150-151

**Awareness of experiences in therapy**

- B Always aware of experience, L. 332-334; L. 510-512; L. 486-488; L. 338-340; L. 221-226
- B Strong feelings are inevitable in therapy, L. 532-534
- B Loss of awareness indicates incapability, L. 319-325
- B Processing experience as conscious act, L. 444-445
- G Use of supervision to make sense of experience, L. 476-477
- G Noticing and reflecting on feelings, L. 535-539; L. 500-501
- D Response to diagnosis changes over time, L. 348-354 & 361-377
- B Don't respond differently to people based on diagnosis, L. 391-398; L. 220-224

**Ability to hold different positions on diagnosis**

- E Holding different positions, L. 90-96; L. 112-115; L. 150-151; L. 379-387
- E No one way of working, L. 93-95
- E Counselling psychology as pluralistic, L. 549-552
- E Counselling psychology holds two positions, L. 554-556

**Flexibility vs. rigidity**

- E Need for specificity, L. 32-35; L. 102-104; L. 450; L. 327; L. 251
- E Tolerant of uncertainty, L. 18
- E Right and wrong, L. 145-148; L. 203-210; L. 387; L. 435-436; L. 546-547; L. 577-579
- E Certainty, L. 206-208; L. 513-514
- E Diagnosis as inflexible, L. 182-183 vs. Diagnosis used flexibly, L. 137-138; L. 376-377
- E Important not to lose control of feelings L. 535-539; L. 510

**Client experience is paramount, but diagnosis forms part of this experience**

- E Diagnosis separate from person, L. 70; L. 131-132 vs. Diagnosis forms part of person, L. 42-44
- E Focus on individual, L. 42-44
- E Diagnosis not considered before the person, L. 281-295 vs. Diagnosis considered before the person, L. 301-303
- E Client is central, L. 502; L. 159-160
- E Seeing clients as human, L. 397-398
- E Focus on client experience of diagnosis rather than own, L. 407-411, L. 423-425
- E Acknowledging the whole of a client's journey, L. 413-418
- E Diagnosis defines people, L. 420-424