An assessment into the value of attending The Manchester Institute for Psychotherapy's Low Cost Therapy Clinic

Karen F Burke
M S Gestalt Psychotherapy

October 2012 - October 2013

Abstract

This short research project is a both a quantitative and qualitative study into two years practice 2011- 2012 and 2012- 2013 at The Manchester Institute for Psychotherapy's Low Cost Therapy Clinic.

The trainee therapists, who were each in their third year of their four-year training to become Transactional Analysis psychotherapists, collected the data, over the period of their supervised placement at The Low Cost Therapy Clinic.

Core forms as used in the National Health Service, were used from the beginning of the therapy to the end. From all of the data collected from clients and trainee therapists, the forms that were not completed in full, for the duration of the therapy, were discarded. This means that the data that was used, was able to be cross-referenced for every client and there were no 'gaps' in the data.

In the first year, 2011- 2012 there were 14 clients that attended the Low Cost Therapy Clinic and in the second year of research there were 12 clients.

From the first year 42.8% of the clients had fully completed forms, 6 in total. In the second year 2012-2013, 50% of the clients had fully completed forms, again totalling 6. This gave data from 12 clients over a two-year period.

This research is to consider if the service provided to the clients was of value to them. The value is measured by the Core form 10, completed weekly by each client regarding their experience of the previous week, between therapy sessions and the Core form Side 2, Helpful Aspects of Therapy, which is completed at the final session.

As the data is both numeric, completion of multiple choice tick boxes and a written account of their experience, I chose to use both quantitative and phenomenological qualitative research methods.

In the quantitative component I have used graphs to illustrate the findings from the CORE 10 screening forms that the clients completed each week of their therapy and from their final session on the Helpful Aspects of Therapy form.

In the qualitative part I took the written statements from the original Helpful Aspects of Therapy form and drew out statements and entered them into documents of the transcripts. Those that had a similar or comparable meaning were eliminated. I then found meanings of the remaining statements, drawing from the initial description. This was to create and discover what the hidden context was within the phenomenon. A new document was then produced for each of the three written responses and I then used these documents to produce a preliminary exhaustive statement for each of the responses. Then I organised clusters of themes from the meanings. These were then referred back to the original texts to validate them.

I continued to use the phenomenological method to produce three statements. From these documents I made the concluding exhaustive statement in the conclusion.

In the conclusion are the bullet points from the findings of the quantitative research. Finally there is a discussion where the contradictory findings are discussed and the findings that I personally, had found interesting or surprising.

Acknowledgements

Thanks are particularly due to the clients who attended The Manchester Institute for Psychotherapy Low Cost Therapy Clinic during the academic years, 2011-2012 and 2012 -2013 and their trainee therapists for collecting the data, each week. Without their dedication and tenacity to complete the forms each week, this study would not have been possible. To Bob Cooke, the owner and Principal Training Director and his wife, my colleague and friend, Stephanie Cooke for their support of the clinic and my study. It was Bob's vision to provide a facility that would give the community an access route to therapy, for those people whose financial situation would not have allowed them ordinarily to experience psychotherapy. Stephanie, my co-coordinator of the Low Cost Therapy Clinic who met with each of the student therapists monthly to supervise and support their work, as well as our twice-yearly meeting with trainees. Thank you both for your continued support and good humour. To May Senior-Johnson who kindly took time and energy to proof read and make suggestions for improvement, thank you I appreciate you and your generosity. Finally, to Annette and Donna from the administration department, who organise and support both the Low Cost Therapy Clinic and The Manchester Institute for Psychotherapy – both organisations would grind to a halt without your hard work.

To every one concerned thank you

Karen Burke October 2013

Table of Contents

List of Appendices

Introduction

This research project covers September 2011 to July 2013, when the third year trainees at The Manchester Institute for Psychotherapy, (MIP) had a supervised placement at The Low Therapy Clinic, (LCTC) for the duration of their third year training (October-May).

The LCTC has been running since September 2009, therefore this study took place during the third and fourth year of the placement being established.

The LCTC was the vision of Bob Cooke, the clinical director of MIP to give the students a supervised placement and provide a low cost therapy clinic to the general public. Throughout the three years the researcher, Karen F Burke has been involved with the LCTC since it's inception, by writing the student handbook (2009,2012) and co-ordinating the students, with her colleague, Stephanie Cooke.

The purpose of this research is to consider the effectiveness of the LCTC and to see how the service could be improved. Previous research has been written on efficacy of psychotherapy these include, Fonagy and Target (1994), Roth and Fonagy (2004), however these consider efficacy of psychotherapy and do not link it to one service. McCarthy, Walker and Kain, (1998) provided research into the efficacy of the Relate Services and more recently McKeown et al. (2002) considered the value of service received by service users at ACCORD, the Catholic Marriage Care Service.

Both of the above studies found similar results, that the majority of clients (two thirds in both cases) experienced the counselling/therapy as positive, and an improvement to their relationships followed. The Relate organisation study used questionnaires at the beginning and at the end of the therapy, follow up questionnaires were completed six and twelve months after the clients ended therapy.

In considering the experience of the clients who have attended the Low Cost Therapy Clinic in this study I hoped that the value of the service and any improvements that could be made to the service would become obvious through the results of the qualitative and the quantitative research.

I believe there will be further internal research done by other organisations, however very few are published externally and are used to validate their services, internally and to potential service users.

Ethical considerations

The clinical practitioners that run the LCTC are all qualified and registered UKCP psychotherapists and abide by the code ethical principles and code of professional conduct. (2009) The exception to this is the members of the administration staff, who handle the forms at the end of the clinical, supervised placement. The administrator that has access to these forms was previously employed in a law firm and understands that confidentiality is required. This has been explained to her at the beginning of her employment and is part of her employment contract.

The assessor and their student therapist tell the client that their completed forms maybe used for research and supervision, this is also written into the three-way contract, the client, the student therapist and the MIP. (See Appendix One) As suggested by Hart and Bond, (1995, p199)

'we would recommend that the respondent should have a signed copy of the form as a record'.

All parties, including the client has their own copies of recording and the three-way contract.

The students are bound by the practice of the LCC and the MIP (Appendix Two). The LCTC consider the safety of the student therapists and the client throughout the process. Students are able to discuss any immediate practice concerns with the clinical director, the LCTC co-ordinators or their supervisor at any time, in person or by telephone. The LCTC work takes place at the MIP building and they practice when there are personnel available. There is a group meeting prior to practice and one mid way through their placement. There is regular case consultation and supervision, provided by a qualified supervisor. The forms to be completed and details of practice are clearly written in the LCTC handbook and every student is issued a handbook.

At the end of his or her second year of Transactional Analysis Psychotherapy training, students are assessed by their tutor in conjunction with the Clinical Director, to ensure they are ready to practice, from a professional, emotional, ethical and academic viewpoint. (Appendix Three)

The students have received tuition regarding confidentiality and ethical considerations prior to them seeing clients. Their parallel obligations during the course, includes them being in personal therapy for the duration of the training.

Students receive a 'Clinical Endorsement of Competency from the Manchester Institute for Psychotherapy for Readiness to Practice', to enable them to practice as 'Trainee Psychotherapists in Advanced Training'. This protects both the trainee therapists and the clients. The clients that attend the LCTC are considered clients of the LCTC, not the trainee therapists and accounts for the significant supervision they receive during the placement.

The potential clients apply to the LCTC. The services are advertised on the MIP website, http://www.mcpt.co.uk/page.php?pg=187 (21 October 2012). They receive an appointment by the administrator to meet the Clinical Director for a clinical thirty-minute assessment. They are given an outline of the services and they recognise to

access the clinic, they must have an income lower the £12,000 pa (during 2011-2013).

The clinical director, knowing the students and matching the client's needs, allocates the client a student practitioner.

A file is made up for the client and the student is informed of their placement by the Institute's administration department. The student and the administrator hold the key for the filing cabinet where client details are held. The files are kept in accordance to the Data Protection Act (1998). So confidentiality is maintained for all paper records. The term of placement is the academic year, September/October to the following May and the therapy takes place weekly. There are considerations for holidays and necessary breaks.

The student therapist fills out the three-way contract, the recording contract (Appendix Four) and the information sheet (Appendix Five).

On further forms used, the client's identity is not disclosed. Initials of the student therapist and the client are used and the forms are not used in conjunction with the information form, so that cross-referencing cannot take place.

Clients of the LCTC are not distinguished from other clients at the MIP. They are seen in individual rooms that are regularly used by qualified psychotherapists and also therapists in advanced psychotherapy training, who are in private practice.

In this research I have not had access to the client's personal, identifying information, only the completed therapy forms (see methodology and appendix). This ensures that there is no opportunity for any unintentional disclosure to take place. As the researcher I abide by the code of ethical principles and code of professional conduct of the UKCP (2009) as a member of this organisation.

I followed the ethical considerations as discussed by Jenkins, et al (2002, p56) and others, Cresswell, (1998, p132), Moustakas, (1994, p109) and McLeod, (2001, p15 & p92). It is McLeod (2003, p175) that reminded me of the,

'social responsibility of the researcher'.

As I have been involved with the organisation (LCTC) and work at the MIP I am aware of how I may want this research to 'prove' that the clinic is of value to the community and that it provides a valuable service. In order to hold my own wants, I have bracketed my own hopes and beliefs and designed a vigorous research.

I considered the benefits to various individuals and communities, also the disadvantages if any, including the potential of an emotional cost or inconvenience to participants. As there was no identifying information and that I would include all forms received, I believe that I had identified the boundaries for this project.

I also discussed the ethical considerations of this research project in outline with other qualified practitioners, including my own supervisor.

Limitations

I am aware of the limitations of the forms used, the CORE (Clinical Outcomes in Routine Evaluations) system, (http://www.core-systems) and that clients may choose to try and 'please' their student therapist by writing an improvement they did not genuinely feel. Of course, the converse may be true, that the client may be angry, or have another negative feeling towards their therapist and write adverse comments. I have to accept that what the client writes is truthful and it is evidence of their progress. I understand that there may be nuances that cannot be noted on a weekly 'tick box' system, however the space available on the CORE goal attainment forms, would give the client an opportunity to write how they felt and give their evaluation of how they are at the beginning and end of their therapy.

Therapy is often noted to be discrete, client's can forget how they were feeling, upon entering therapy and often the gentle re-framing that occurs during therapy or counselling is done at such a tempo that client's do not note the differences. It is also ordinary that there may be ruptures during therapy, Stern, (2004, p157) times when the environment challenges the client and it seems as though there is a 'backward' step. Experienced practitioners understand this is part of the therapeutic journey and process and see it as an opportunity for clients to test their new skills, awareness and strengths they have gained during therapy.

I am aware that I am also constricted by time frames. As a busy practitioner I may wish to devote the same time and energies that I would have put into other research projects and recognise that although I want this document to be rigorous, it may have parts missing, due to my own blind spots or lack of time devoted to it, as I wish to present it within two months of receiving the final data. For this reason there is no literature review within the research project however sources are referenced throughout the document.

Methodology

The British Association for Counselling and Psychotherapy (BACP), write, (2012)

'The types of research investigating the effects of therapy are often divided into 2 categories: efficacy *research which studies therapy under strictly controlled experimental conditions, comparing the difference between control and intervention groups, and e*ffectiveness *research which investigates therapy in routine settings using pre- and post- measures, but without a control group*.'

With this information I recognised that this research would be an 'effectiveness research' as we used pre and post measures, without a control group.

The forms used were the CORE Assessment V2 form, (Appendix Six) which would give a starting point to identify what issues the clients were bringing to therapy, their relationships, if they had used psychological services previously and if they were at risk, of self harm, including being suicidal, harm to others or harm to property.

The student therapist, whilst discussing the client's situation on the initial therapy session completes this form. At the same session the client completes the CORE Goal Attainment form, side one (Appendix Seven).

During the weekly therapy, before sessions, the client completes the CORE 10 Screening form, (Appendix Eight) which indicates how they are progressing, if at all.

On the final session, with the client, the student therapist completes the CORE End of Therapy form (Appendix Nine) and the client completes the CORE Goal Attainment form, side two, Helpful Aspects of Therapy (Appendix Ten).

I attended a workshop, facilitated by Mindfields College, 'How to incorporate Outcome Measures Into Your Practice', in November 2009 so I could learn more about CORE forms and the way to use them, effectively within my practice. I took this learning to the LCTC, decided that our client base and student therapists would be able to invest in the forms, in turn this would give us data, to consider.

I saw the forms as being able to give both qualitative and quantitative research. When I researched if this was possible, McLeod, (1996), (2001), (2003), Cresswell, (1998) Moustakas, (1994), Davies, (2007) and Bell, (2008) agreed this was possible, according to the data available.

Davies, (2007, p34) and Laws, (2003, p281) discusses triangulation. This is when the same data is crosschecked by using a second or third different methodology. Laws points out that this is not 'tidy', that 'mismatches and conflicts occur'.

'You need to critically examine the meaning of any mismatches to make sense of them'.
Laws, (2003, p281)

I was initially concerned, as I knew that there was only a small sample of data. This project only covered two years. In the first year of the research there were 8 student therapists, in year two there were 7. In total, the study had 14 client participants in year 1 and 12 in the second year of the research, giving 26 potential opportunities to collect data. Some clients did not attend sessions, particularly the last session to fill out side two of the goal attainment forms. I knew from previous experience that often with small limited data, qualitative research often suited the research. I felt that having the questionnaires, also gave an opportunity to use quantitative methods.

I recognised there was limited data and the decision to run the research over two years which would give further data, gain more experiences from new clients and student therapists and also provide the opportunity, to compare the data from the two years. With this in mind, I made the decision that I would use a qualitative method for the CORE 10 Screening forms (Appendix Eight) and the Helpful Aspects of Therapy forms (Appendix Ten) that were completed at the end of therapy. Both of these forms had a multiple choice tick box questionnaire.

I would use quantitative research methods, with the side two of the Goal Attainment form, Helpful Aspects of Therapy (Appendix Ten) completed at the final session by the client, I was interested in using qualitative 'action research', after reading,

'*To arrive at recommendations for good practice that will tackle a problem or enhance the organization and individuals through changes to the rules and procedures within which they operate.'*
Denscombe, (2002, p27)

I made this decision as it matched the LCTC, as it is a dynamic organisation that has evolved through its four years of being in operation. There have been small changes throughout each year that have enhanced either the client's or the student therapist's experience. At no time have any of these changes impacted upon the other party in a negative way.

When I considered the impact of using two different research designs I found that it was possible to integrate the two methods, of both quantitative and qualitative research within one project. Curry, Nembhard and Bradley say,

'Mixed methods, in which quantitative and qualitative methods are combined, are increasingly recognized as valuable, because they can capitalize on the respective strengths of each approach. Pairing quantitative and qualitative components of a larger study can achieve various aims, including corroborating findings, generating more complete data, and using results from 1 method to enhance insights attained with the complementary method. Approaches to mixed-methods studies differ on the basis of the sequence in which the components occur and the emphasis given to each. The qualitative and quantitative components may be performed concurrently or sequentially, and emphasis may be placed on either component or equal weight given to both.'

Whilst this research project is not large, it only covers a two year period with twelve client participants it may be enhanced by using both methods, concurrently and I am hoping that I can give 'equal weight' to both parts of the research.

There are core concepts of validity, reliability and ‘generalisability’ that are essential to quantitative research. These fit with three other markers used in qualitative research as well.

For qualitative research, the principles are credibility, dependability and transferability. To ensure credibility I need to make sure that the findings explain the phenomenon of my area of interest, how it matches with what is already known and consideration to alternative explanations and being honest in my portrayal of the client’s experience.

Dependability is managing and referring to the external changes that happen within the data collection and if necessary, change the research design to appreciate those findings.

To ensure transferability it is looking to see if the themes or protocols can be transferred to another setting, therefore specific detailed information must be given, to allow this to happen.

What I needed to consider was I capable of using a qualitative research method that gave analysis that was explicit, systematic and if another researcher used the same data collection sample, they would arrive at a very similar outcome. My experience in research had been mainly qualitatively based, so I recognised it would be a new, different experience and I wanted to use both methods, as the data provided evidence for both designs. I was intrigued if, as previously stated there maybe conflicting evidence found, using the alternative methods.

The data for 2011-13 was collected by the students, weekly on their placement, at the end of their placement the CORE forms were given to the administrator. The CORE forms were removed from the identifying information and I received a file with the CORE forms.

Each client had his or her own forms, which were kept together in a folder. This ensured that the data was not mixed up. This was the beginning of the research for me, when I received this file, in October 2012, which held 14 different client cases of CORE forms, during the first year of the research.

I initially numbered each of the 14 files, with a green pen (not used on any of the originals) from one to 14, using a different number for each case, on all of the completed CORE forms. I did this so if I chose to look at groups of forms, for example all of the assessment forms together at a later date I would know which case they belonged to, if I wanted to look at individual files I could gather all of their case files together.

I initially made a matrix that gave an overview of the data assembled (see Appendix Twelve). From that matrix I could make a decision on what data there was and where there were gaps.

Once the matrix was completed and the information compiled, this gave an overview of the data and collated information that I could use for this small study using quantitative research methods. The written information from side 2 of the goal attainment form would be used for a qualitative research study.

I based this decision on reading many books and articles on research both now and when I had previously researched, I found this quote from Curry, Nembhard and Bradley,

'Qualitative research is a form of scientific inquiry that spans different disciplines, fields, and subject matter and comprises many varied approaches. Qualitative methods can be used to understand complex social processes, to capture essential aspects of a phenomenon from the perspective of study participants, and to uncover beliefs, values, and motivations that underlie individual health behaviors.'

During 2012-2013, the third year training group working at the LCTC collected further data using the same methods, as the previous students had. They followed the same procedure and the 7 student therapists had 12 files from the LCTC. This gave 26 cases to be considered for this research. A second matrix (Appendix Thirteen) was collated with the data collected from the second year of this research during October 2012- May 2013.

I chose to keep the information for each year separate from the other, so I could compare the data against each year, if necessary. The '2/' prefixing the client number denotes the client files from second year of the research. This ensures that they are obviously marked so that the two years findings can be collated, whilst remaining separate.

I initially looked at the information received, using the matrix from each year. If there were CORE forms that were not completed in full, then I decided to not use any data from that particular client, as I want this research to be rigorous and for the full information to be available if the data collected was scrutinised.

When I did this, there were 6 files of information from year one, 42.8% of the number of potential client participants and 6, 50% from year two, giving a total of 12 files to be scrutinised for this research project.

CORE 10 Methodology

From the CORE manual I copied the dimensions that are used on the CORE screening form10: (Appendix Eight)

The measure covers three dimensions:
1. *subjective well-being* (0 items),
2. *problems/symptoms* (6 items),
3. *life functioning* (3 items).

These should be compatible with the phase-model of change, which suggests a sequential impact on (remoralising) subjective well being early in therapy, progressing to (remediating) symptoms, and then to (rehabilitating) aspects of life functioning for many therapies (Howard, Lueger *et al*, 1993). In addition, it contains:

4. *risk/harm* (1 item).
These items should be used as clinical indicators of the patient being 'at risk' to themselves or others.

Features of the measure include high and low intensity items to increase sensitivity and 10% of the items are 'positively' framed.

Symptoms – anxiety	I have felt tense, anxious or nervous	Low	2
Functioning - close rel.	I have felt I have someone to turn to for support when needed	Low	3
Functioning - general	I have felt able to cope when things go wrong Pos	High	7
Functioning-Social Rel	Talking to people has felt too much for me	High	10
Symptoms-Anxiety	I have felt panic or terror	High	15
Risk/Harm	I have made plans to end my life	High	16

to self

Symptoms Physical	I have had difficulty getting to or staying asleep	Low	18
Symptoms Depression	I have felt despairing or hopeless	High	23
Symptoms Depression	I have felt unhappy	Low	27
Symptoms Trauma	Unwanted images or memories have been distressing me	High	28

The clients had the choice of ticking boxes labelled, Not at all, only occasionally, sometimes, often and most of the time. These were given a value of 0 through to 4. The scores are added up, divided by the number of questions completed to get the mean score and then multiplied by 10 to get the clinical score.

The clinical score is valued by the clinical score using the CORE Outcome Measure Scores form, which is a progress-tracking chart, (Appendix Eleven) as;

Under 4 – Healthy, with a risk cut off

Under 10 and above 4 - Low level with overall cut off.

Under 15 and above 10 – Mild.

Under 20 and above 15 – Moderate.

Under 25 and above 20 – Moderate severe.

Under 40 and above 25 – Severe

Therefore, this gives an overview of how the client is feeling each session, gives an indicator immediately to the student therapist and can be monitored through the therapy process as an indicator of risk, depression, social functioning and trauma, the client maybe experiencing.

I worked through each CORE Screening 10 forms and found the clinical score for each session, in the individual 12 files using the CORE Outcome Measurement Score form.

I transferred the scores that each client gave, onto an individual graph. The graphs for each individual client in the two-year study are in the findings section, with a short synopsis.

With the information I had gained from the matrix for each year and the graphs for the individual clients I asked the questions

- Did the number of sessions attended seem to have an impact on the outcome?
- Did any clients end therapy in a ‘higher’ category, than they began?
- Did any clients stay within the same meridian that they began in, throughout therapy?
- Did any clients start and end therapy in the same meridian?
- If clients ended in a ‘lower’ band than they started was it a gradual drop or were there ‘spikes and valleys’ through the therapeutic process?
- How many clients travelled through 3 or more meridians during therapy?
- How many clients travelled through one or two meridians during therapy?
- Of the clients who travelled through one or two meridians, did they end in a lower meridian at the end of therapy?
- Overall did the clients, who completed, score themselves lower than they did at the initial session?

Helpful Aspects of Therapy form Methodology

The Helpful Aspect of Therapy form (Appendix Ten) has six questions for the client to respond to. The first is a tick box response, to be completed on side one of the form, which for use within this qualitative enquiry I will not be using. I will be using all the responses on Appendix Ten for this part of the research and not referring back to the side one document.

The responses used are from the twelve clients that have been previously identified who are the participants in both parts (the qualitative and the quantitative) of this two-year study. In the second box the client has written their experiences of what has been positive about their therapy that will be considered, along with how helpful the experience has been, using a tick box to mark if the therapy will be useful in the future. Part three of the form looks at unresolved issues and has both a written report and a tick box to be completed.

The fourth box is a multiple-choice response to the satisfaction with the service. The fifth, if the service would be recommended to a friend and finally additional comments in part 6.

With the tick box responses I will make a graph for each part, to enable an overview of the responses from each of the clients to the individual questions. This will be part of the quantitative findings, with the Core 10 graphs.

Using the qualitative method of phenomenology I will be immersing myself in the written responses, by initially typing them out, only using the original coding to identify the client. This retains confidentiality for the client and the student practitioner, if they were to read the research, as the researcher and as previously discussed I did not have identifying information for each of the individual clients of the LCTC. In having codes for each respondent also helps to be able to compare the findings of the CORE 10 Screening form and The Helpful Aspects of Therapy form.

With the typed copies I then looked for central themes or implicit meanings and integrated into a single text.

> *'A Composite Description of the meaning and essences of the experience, representing the group as a whole.'* Moustakas (1994, p121).

During this process I endeavoured to bracket off assumptions, *'phenomenological reduction',* (McLeod, 2001, p41) whilst remaining open to the unfolding phenomena.

One way of doing this was to ensure that I placed no more meaning to one person's experience than I did, another's, the principle of horizontality as discussed by Moustakas (1994). I had to enquire into each unit, and explore if they were part of the phenomena, removing those that were not and in doing so, immersing myself into the participants' reality of their situation. It was at this stage I had the personal difficulty in staying with this, the slowing down and the total focussing and honing in on every detail that was given, to give a full and rich experience. It was at this stage that I would feel confused at times, and want to relate one experience to either my own or another participants before it was time to engage upon making one meaning, or revealing the essence.

The bracketing off within research practice is called '*epoche'* McLeod, (2001, p.51). As in humanistic psychotherapy practice, phenomenological research mirrors the practice of critical reflectivity, McLeod, (2001, p199) in recognising that my presence and attitude must in some form shape or alter the study.

I took the responses from the boxes in part 2, and transfered them onto a graph, to record the client participant experience. I gave each response a value of 2. Coloured pillars showed the different choices of the boxes offered on the form.

I followed the same procedure for the tick boxes 2 questions in part 3 and for the one question in part 4 and part 5 giving 5 graphs in total. This data would be part of the qualitative research in this exploratory study.

In the boxes in part 2, part 3 and part 6 which asked for a written response from each client, I faithfully copied out each one onto a 'word' document. I had 3 documents that each had every client's answer to one question on the same page. Each passage that had been copied was labelled with the client's ID number that has been used throughout this research.

These documents are Transcript of Responses to Q2 (Appendix Fourteen), Transcript of Responses to Q3 (Appendix Fifteen) and Transcript of Responses to Q6 (Appendix Sixteen).

I took the paragraphs from the three documents and drew out statements highlighted or changed the colour of the font to show themes throughout the responses. The themes were then put into clusters. There is no significance to the order of entry. Those that had a similar or comparable meaning were eliminated. I then found meanings of the remaining statements, drawing from the initial description. This was to create and discover what the hidden context was within the phenomenon. These were then referred back to the original texts to validate them. This highlighted, either accounts that were not in the original, or what had been missed from the initial transcripts. It was here that discrepancies became apparent, this might be because of their contradictory manner, or be unrelated to another. This I believed was due to the existential principle, which is honoured in Gestalt psychotherapy. It was real and valid to the participant and upheld the Gestalt theory that there are paradoxes to all things, the need to integrate all polarities and the existential struggle to find the zero ground.

The views and comments of all twelve participants have been examined for these themes. I condensed the statements, using original words whilst not changing their context and placed them into clusters of recurring words from different clients. I am aware that I had to chose, which cluster the statements, had to be placed. If there was any doubt, I considered the reference that the participants had used them by referring back to the original, full response. For example if the key word is self esteem, this is in relation to the core self so it was placed in the 'core self' cluster. This was to ensure that the initial phenomenon was not lost.

The most themes were found in the first set of data, retrieved from Appendix Fourteen. The highlighted form of this is found in Appendix Seventeen. Whilst preparing Appendix Twenty, Preliminary Exhaustive Statement 1, I saw that some comments could fit into several themes. I also realised there were too many themes

and I needed to make the theme ‘broader’. In doing this I recognised the original highlighting although it made the statements still stand out from the text, was no longer colour coding the themes. I ensured that I still used all of the statements into the preliminary statement, to keep the study rigorous.

Following that experience I found that as I collated the information from Appendix Eighteen, to the Preliminary Exhaustive Statement 2, Appendix Twenty One, the same situation happened and I appreciated that as I had sat and really considered the data that it needed to be reframed in the following statements and that I did not need to worry that the original document had been highlighted in a particular way, as the essence emerged as long as all of the relevant data was included it was ok to change my method to suit the study.

I prepared the Preliminary Exhaustive Statement 3, Appendix Twenty Two in the same manner.

From this information I formulated the comprehensive statements, this portrayal of the phenomenon is an explicit depiction as possible, to find ‘The Exhaustive Statement’ for each of the three written questions, on the ‘Helpful Aspects of Therapy Form’ from the client participants.

Findings

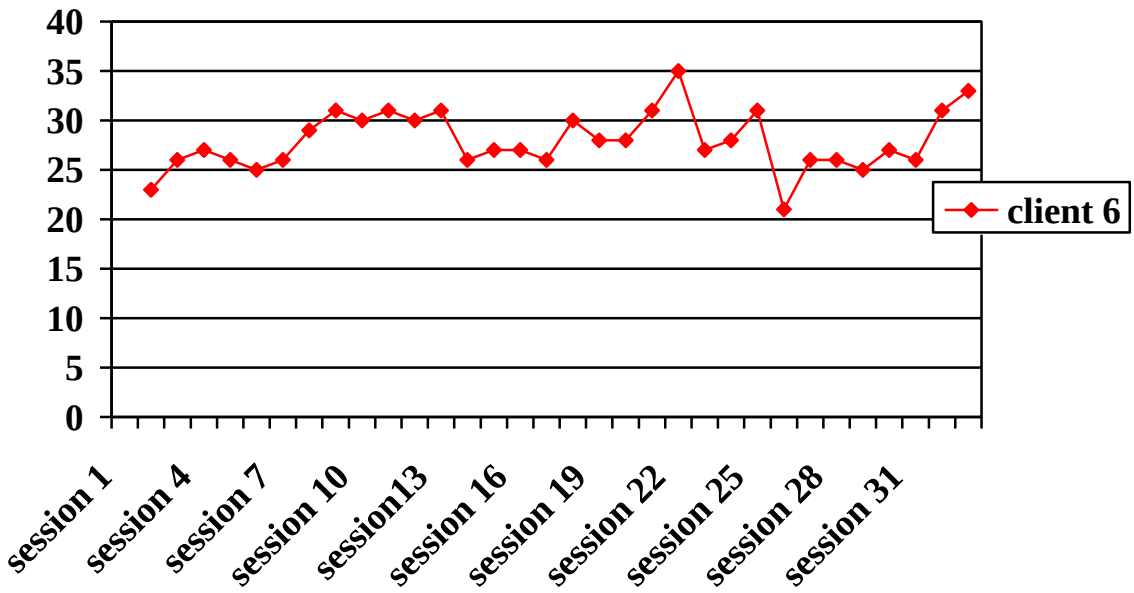
The CORE 10 forms

Using the matrix from the first year (Appendix Twelve), I gained the following information. There were 14 clients who used the LCTC during the academic year 2011-12. Of the 14 clients, 10 were female and 4 were male. The age range spanned from 23-58. The student practitioners did not note the client's ethnic heritage or sexual orientation.

Two of the clients attended the first session and then chose not to continue with therapy.

Three clients ended abruptly without an ending session. Two clients never completed the CORE Goal Assessment form at the beginning of the therapy. These two clients also never completed the CORE Screening 10 forms throughout attending the LCTC. One client who attended a dozen sessions did not complete the Assessment or the Beginning of Therapy form, although the end of therapy form was. This left 6 clients that completed the forms at the beginning, throughout the therapy and the ending forms.

The research findings for the first year are based on these 6 clients' forms. They and their student therapist have completed all of the forms throughout the period of their therapy at the LCTC.



For this graph and the following graphs, in this section, the horizontal axis shows the session number and the vertical axis depicts the score that each client made weekly, prior to their session on the CORE 10 Screening form.

This client, numbered 6 for this research is male and was 35 at the time of assessment for the LCTC. Both the student therapist and the client completed all the CORE forms.

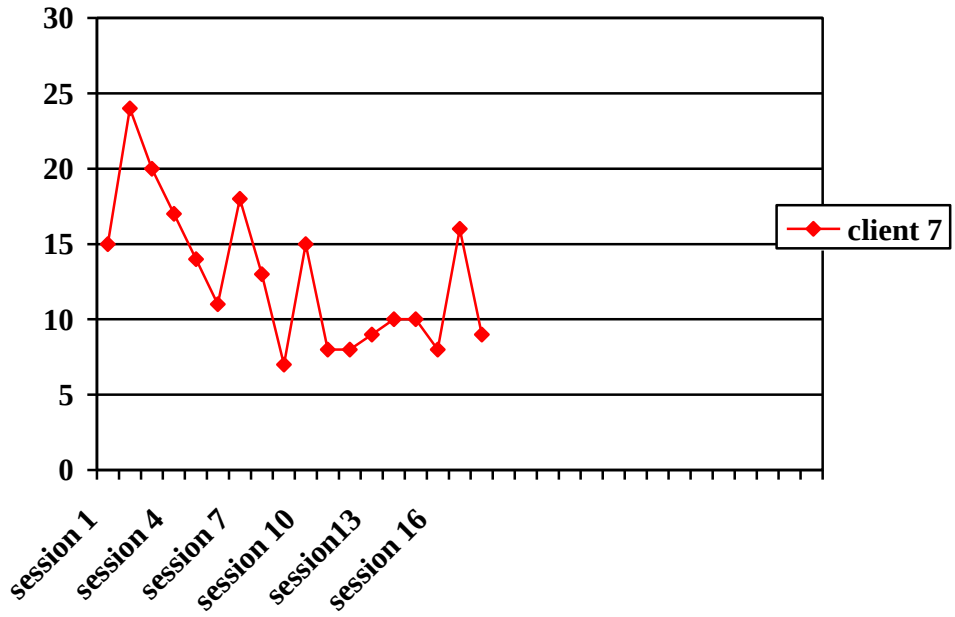
The client stayed in therapy for 35 sessions, which was the longest term of therapy recorded in this research.

Using the Core Outcome Measurement Scores Form, the client scored them selves at ‘moderate severe’ at the beginning of therapy, with a score of 23.

Client 6 only went into this meridian one more time, at session 26, when they measured a score of 21.

For the other sessions, and throughout the therapy, with the two exceptions noted above, client 6 measured them self between 25 and 35, putting them self in the category of ‘severe’.

So, using this quantitative method it would seem that there has been no discernable difference that therapy has made for client 6. They have remained within the ‘severe’ range for the majority of the term of therapy, only twice being in the ‘moderate severe’ range.



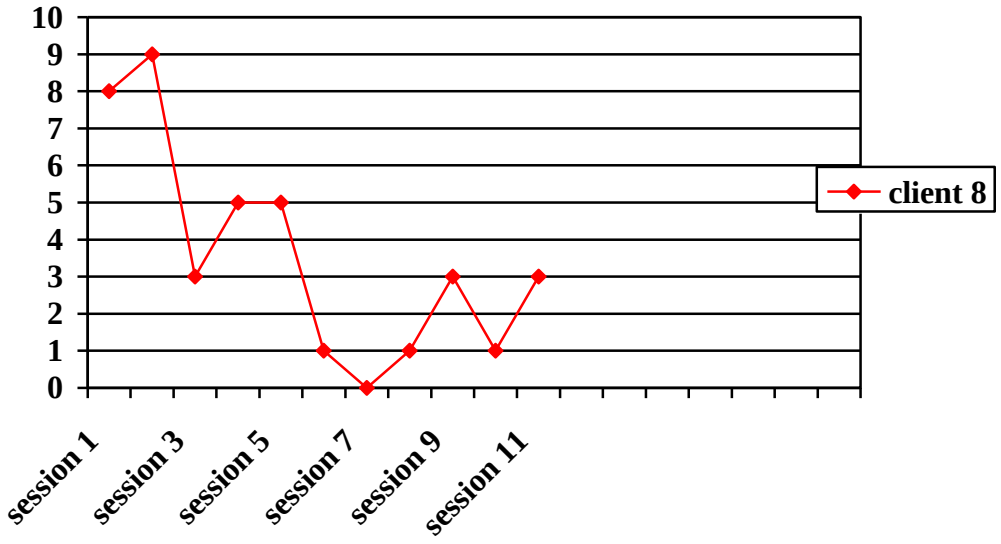
Client 7 is female and attended 17 sessions at the LCTC. At the time of the LCTC assessment she was 31.

The client scored herself at 15, which is on the cusp of the ‘mild’ into the ‘moderate’ meridian on the CORE Outcomes Measurement Chart at the beginning of therapy. At the second session, the client scored herself 24, and over the next four sessions the score fell steadily down into the ‘mild’ range. After a surge the sixth week to a score of 18, again the client recorded lower scores during the following two sessions, dropping to a score of 7. This score of 7 is within the class of ‘low level’.

There was again, a surge from this ‘low level’ score of 7, to 15, the exact score that the client reported during the initial session.

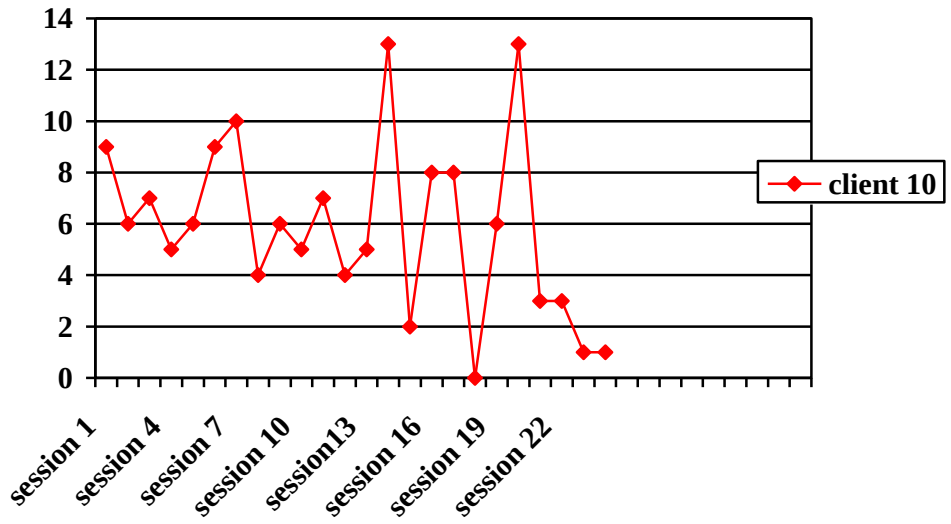
Over the following sessions, client 7 scored herself between ten and eight, therefore remaining in the ‘low level’ range, until the penultimate session when it changed to 16. The final score moved from the ‘moderate’ range to the ‘low level’ of 9.

The pattern that client 7 has shown a pattern that is often reported by therapists and scientists. (Anderson, 2011) (Bennett-Levy and Beedie, 2011) (Lutz etal, 2012) There will be peaks and troughs when the client works through the various levels of resistance and dichotomies, before settling at a manageable emotional place.



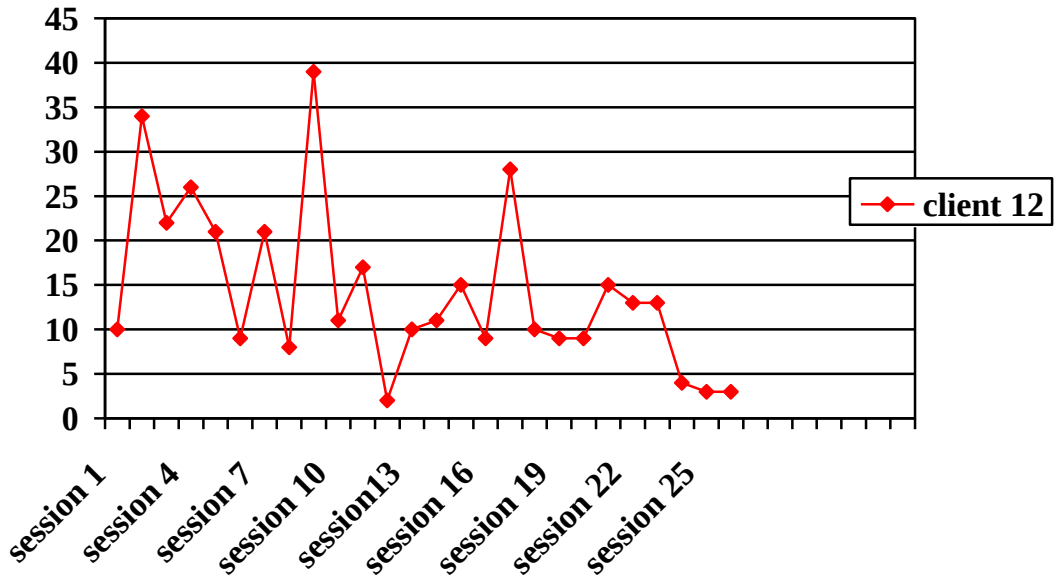
Client 8 aged 58 was the eldest of the clients attending the LCTC during 2011-2012 and is female. The client attended 12 sessions and as with all the clients considered in this project, completed the CORE 10 forms at the beginning, throughout and at the end of therapy.

In the dozen sessions attended, there was a significant drop in her measurement of discomfort from a low level average to a healthy emotional, no risk category. Of the first year client participants, this client attended the fewest sessions.



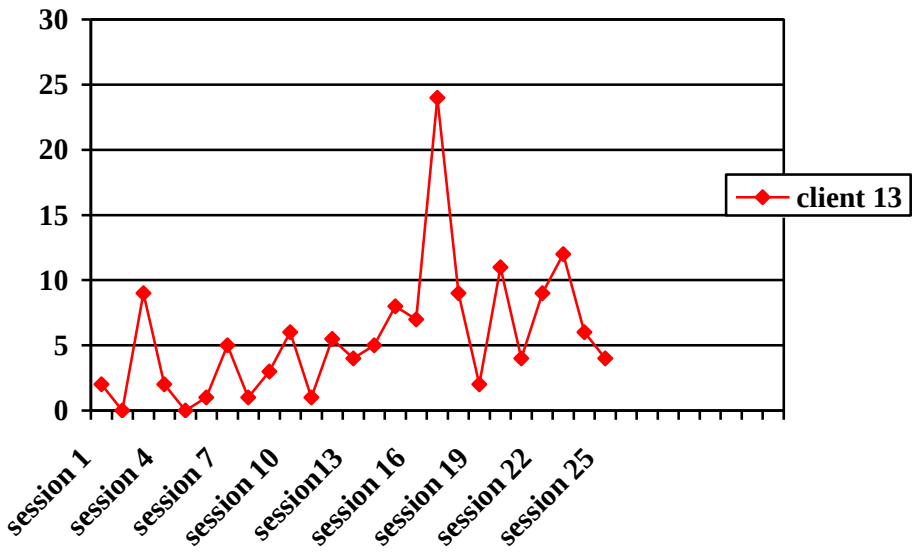
Client 10, from the first year of the research was female and aged 30 as she attended the LCTC. This was the youngest client participant who completed all of the CORE forms. In total she attended 24 sessions and began her therapeutic journey within the low level banding on the Core 10 forms. As the work progressed, she moved into the higher meridian of ‘mild’, as presenting issues were worked through.

There was a second spike, towards the end of the work that has been identified previously and at the final session the client had moved into the ‘healthy’, no risk category.



Client 12 was the penultimate client participant in the first year of the study. She was 35 when she attended the LCTC. Of the clients that completed all of the CORE forms, she attended 26 sessions, therefore had the second longest attendance at the LCTC during 2011-12.

Although this client began the first session just within the low level grouping, there were three occasions when it rose into the severe category. At each spike it returned to the low level and eventually settled into healthy meridian at the last three sessions.



Client 13 is male and was 33 during the 2011- 2012 study. He attended 25 sessions at the LCTC. As with the previous five client participants in the first year of the study all the CORE forms were completed.

This client moved within the healthy and the low level for the majority of their time whilst in therapy. There was a sharp movement into the moderate severe band for one session only and he then returned into the meridians that he had previously been in.

In the second year of collecting data (2012-13) the third year students followed the same procedures as the previous year's student psychotherapists had, whilst they were in their supervised placement at the LCTC.

The matrix that collated the information from the second year of this study is in Appendix Thirteen.

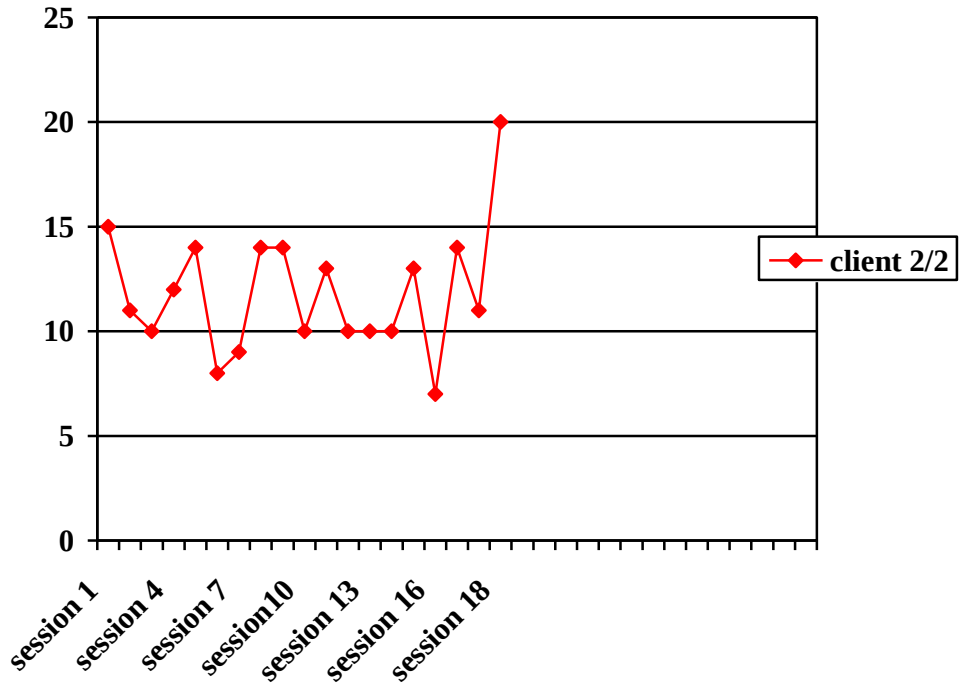
There were 12 clients who used the LCTC during the academic year 2012-13. Of the 12 clients, 10 were female and 2 were male. The age range of the clients spanned from 16-58. As in the 2011-2012 studies, the student practitioners did not note the client's ethnic heritage or sexual orientation.

All 12 clients completed the assessment form and the CORE10 forms, when they attended the LCTC.

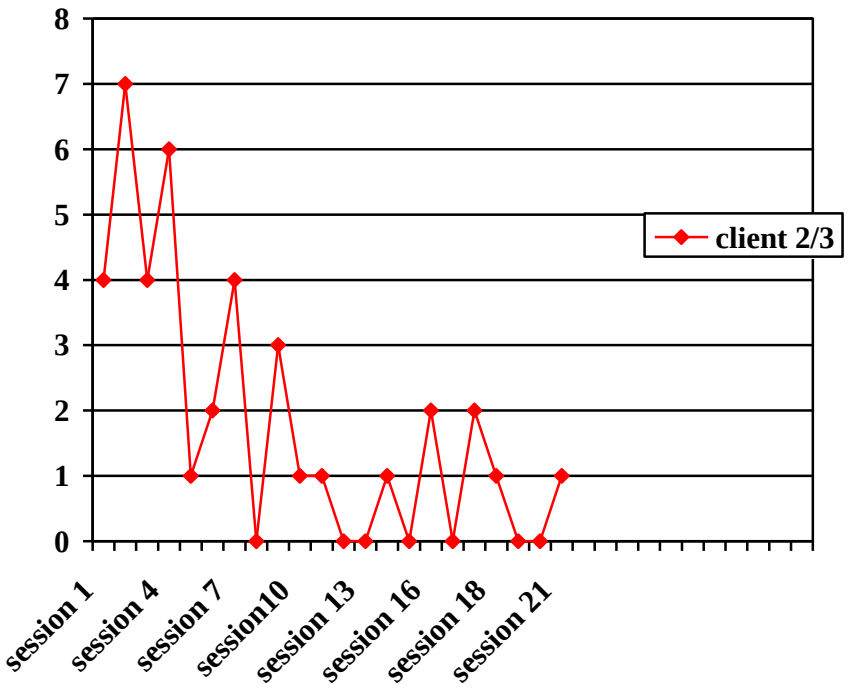
Two of the clients attended the first five sessions and chose not to continue with therapy.

Another four clients also ended abruptly without an ending session. This left 6 clients that completed the forms at the beginning, throughout the therapy and the ending forms.

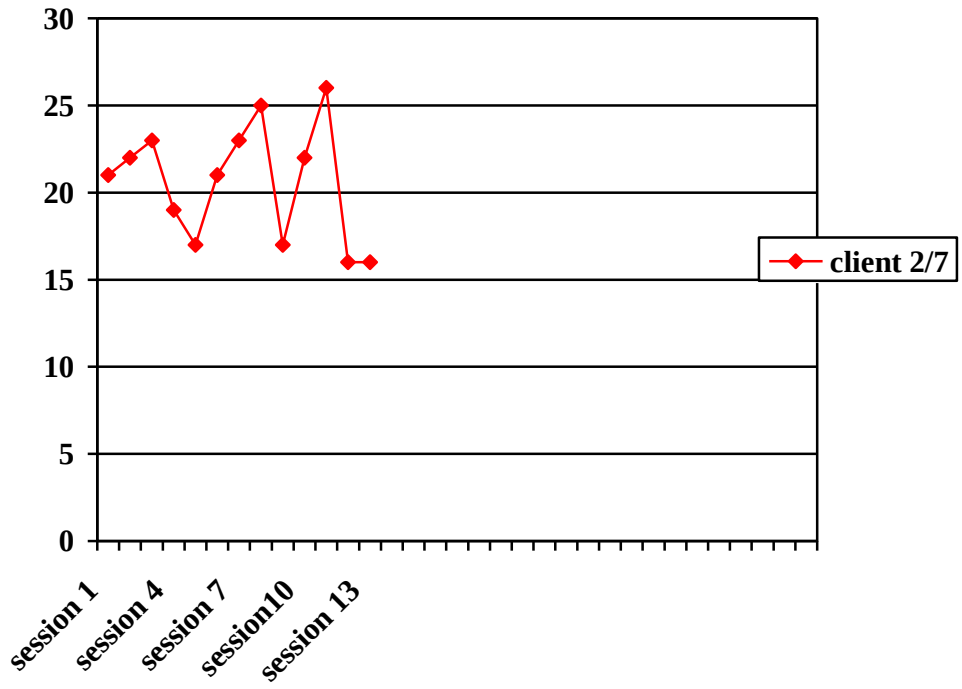
The research findings for the second year are based on these 6 clients' forms.



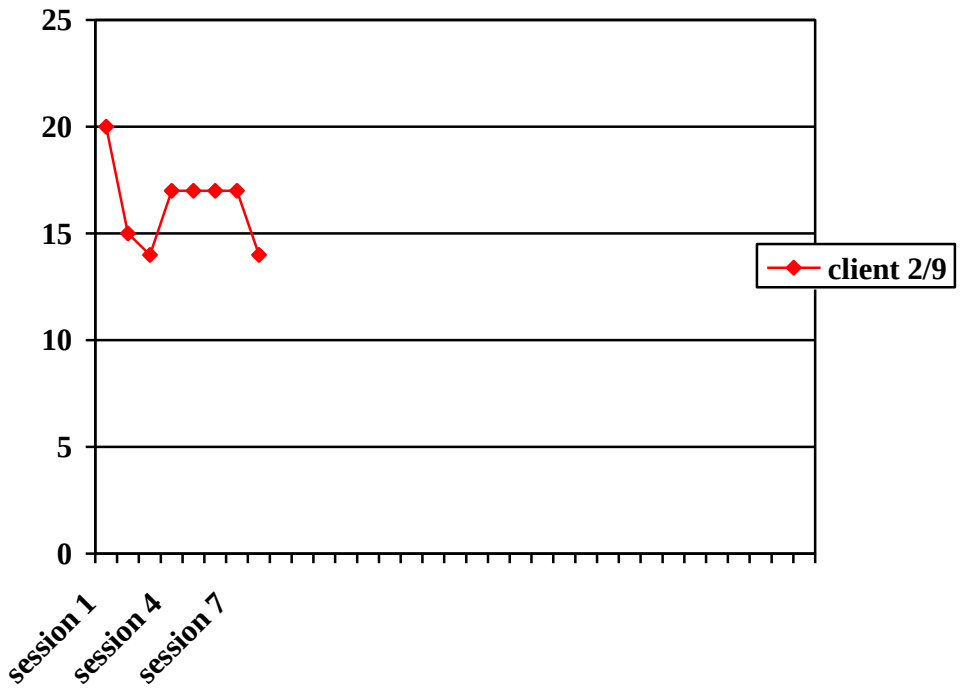
This client is male and was 29 years of age when he attended the LCTC for 18 sessions. Throughout the period of seeing a student practitioner he generally stayed within the 'mild' category although for three sessions he went down into the low level meridian. What is obvious in this graph is the significant jump into the area between moderate and moderate severe on his final visit.



This female client is aged 24 at the time of research during the academic year of 2012-13. She attended 21 sessions and unlike many other people whose findings are discussed she shows a steady movement down from the low level meridian into the healthy category. There are seven points where she scored herself as zero, being well within the healthy category.



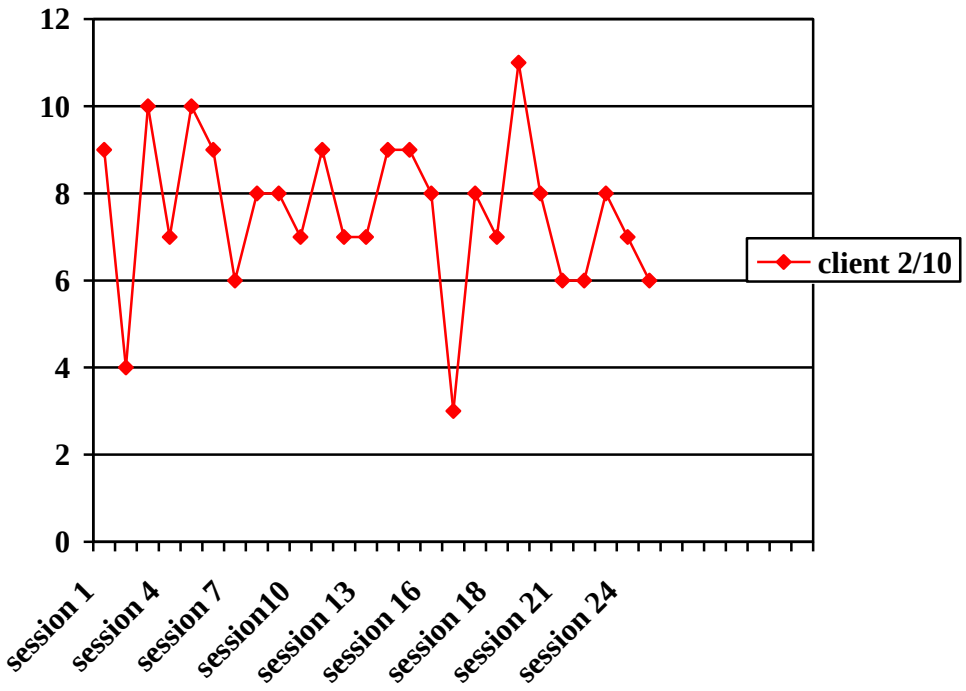
Client 2/7 is female and was aged 30 during the study. This client scored herself as being within the moderate severe meridian at her first session then wavered between that category and moderate during her 13 sessions with one exceptional week when she marked herself as severe. She ended with being in the moderate band.



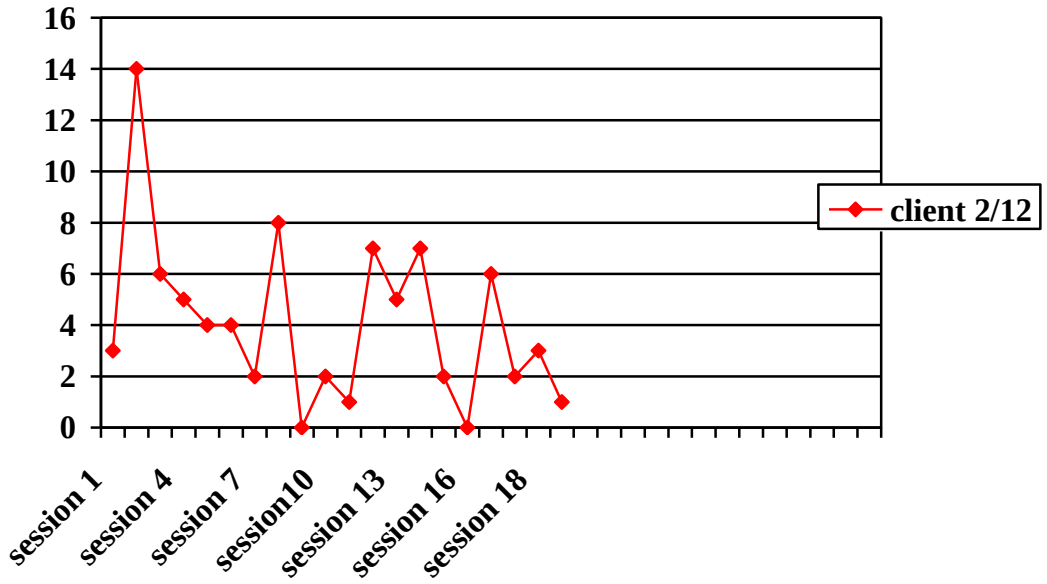
This female client aged 22 attended 8 sessions and completed all of the CORE forms throughout the process.

She initially scored herself on the cusp of moderate severe and throughout the following sessions dropped down into mild category, in four sessions remaining at a steady place mid way in the moderate band. At the final session she was in the mild meridian.

This client attended the fewest number of sessions during the second year of the study 2012-2013 and the fewest sessions in the whole two year study.



This 58 year old female was the eldest client at the LCTC during 2012-13. With the exception of one session when she moved upwards into the mild category, she began in the low level category and moved between this and the healthy band, throughout her 25 sessions. This client had the longest period of sessions at the LCTC during 2012-13.



This final client of the 6 that provided data during 2012-13, is female and was aged 32 when she attended the LCTC. She attended 19 sessions and with the exception of her second session, when she scored herself as being in the upper part of the moderate band, stayed in the mild band for three sessions and was in the healthy section for the majority of the time.

Without the student therapist's or the client participent's account to add understanding what can we learn from these findings on the CORE 10 reports?

I refer back to the questions I asked in the methodology

- Did the number of sessions attended seem to have an impact on the outcome?
- Did any clients end therapy in a 'higher' category, than they began?
- Did any clients stay within the same meridian that they began in, throughout therapy?
- Did any clients start and end therapy in the same meridian?
- If clients ended in a 'lower' band than they started was it a gradual drop or were there 'spikes and valleys' through the therapeutic process?
- How many clients travelled through 3 or more meridians during therapy?
- How many clients travelled through one or two meridians during therapy?
- Of the clients who travelled through one or two meridians, did they end in a lower meridian at the end of therapy?
- Overall did the clients, who completed, score themselves lower than they did at the initial session?

26 clients over a period of two years attending the LCTC potentially had the opportunity to provide data. There were were 14 clients in the first year, (2011-12) and 12 in the second year, (2012-13).

From these 26 clients there were 12 in total where all of the CORE forms were completed throughout the therapy, 6 from both years. The reason why the other client's data was incomplete were-

Only one client, 9 did not complete the CORE Assessment form.

Clients, 1, 3, 4, 9, did not complete the CORE Goal Attainment form at the initial session.

Clients 1, and 11 did not complete the CORE 10 Screening forms regularly.

11 different clients 1, 2, 5, 11, 14, 2/1, 2/4, 2/5, 2/6, 2/8 and 2/11 ended prematurely, without notice and did not complete the CORE End of Therapy form and the CORE Side Two Goal Attainment forms. The number of sessions they attended were between nil and 34. Of the eleven clients that did not give notice, ten had less than 12 sessions. The eleventh client, 2/8 attended 15 sessions.

Only one client, 2/9 attended less than ten sessions, completed therapy and all the forms. The 12 clients that did complete had between 8 and 35 sessions.

Three clients that completed, 6, 13 and 2/2 ended in a higher meridian than the one they initially scored.

No client throughout the two year study remained in only one band, from assessment to finish.

Clients that ended in a lower meridian than they started at assessment that had a general gradual drop were 8, 2/3 and 2/9. The other nine clients had varying

spikes and valleys moving from meridian to meridian throughout therapy at the LCTC.

Two clients, 12 and 13 travelled through three meridians when they were in the therapeutic process.

Seven clients, 7, 8, 10, 2/3, 2/7, 2/9 and 2/10 moved through one or two other meridians, then scored themselves in a lower meridian at the end of therapy than the meridian they scored themselves in at the assessment.

One client, 6 stayed in two meridians throughout the therapy and ended in a higher meridian than he originally assessed himself at, during the assessment.

Only one client 2/2 who had generally remained within the mild meridian, moving down into the low level during therapy, spiked at the final session to the top of the moderate section.

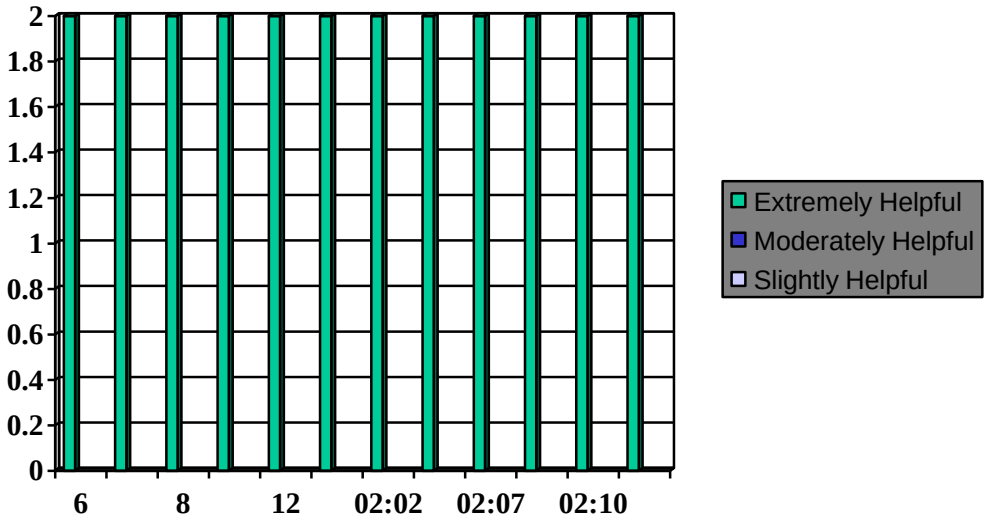
Two clients, 13 and 2/12 began and ended in the same meridian although they moved to another meridian throughout the therapeutic journey.

Overall, the nine clients that scored themselves at a lower score at the end of therapy were, 7, 8, 10, 12, 2/3, 2/7, 2/9, 2/10 and 2/12.

The Helpful Aspects of Therapy form.

Response to Box 2, Multiple choice question on CORE Helpful Aspects of Therapy form

‘How helpful do you feel the experience, out come or insight will be to you in the future?’

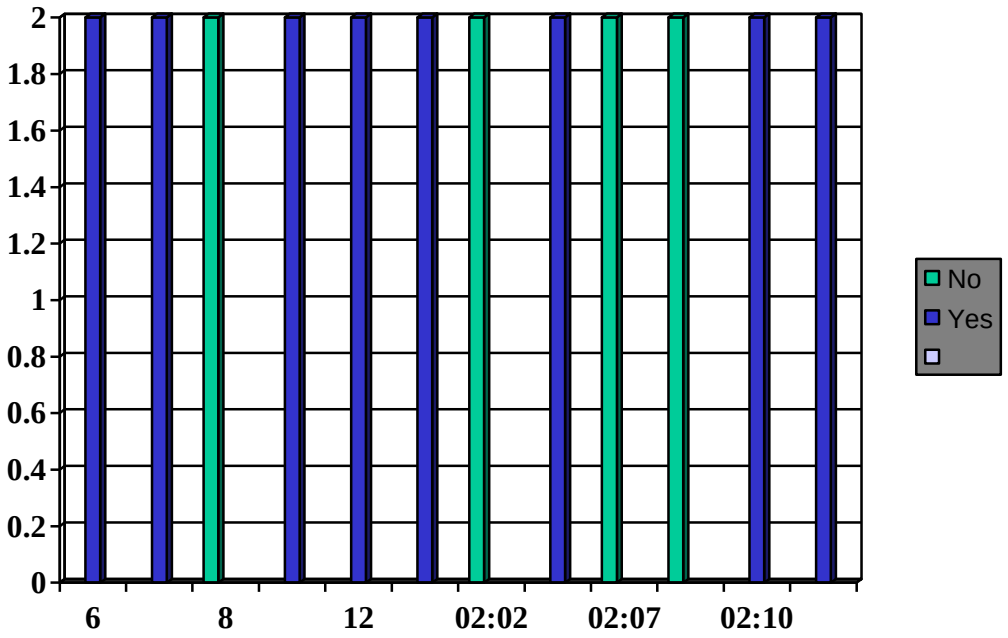


A value of 2 was given for each client particpant response as shown of the vertical axis. The client ID is given on the horizontal axis.

All clients said the LCTC had provided an extremely helpful service.

Response to Box 3, (i) Multiple choice question on the CORE Helpful Aspects of Therapy form

‘Looking back over your therapy, do you think that there is anything which remains unresolved or that you still feel uncomfortable about?’



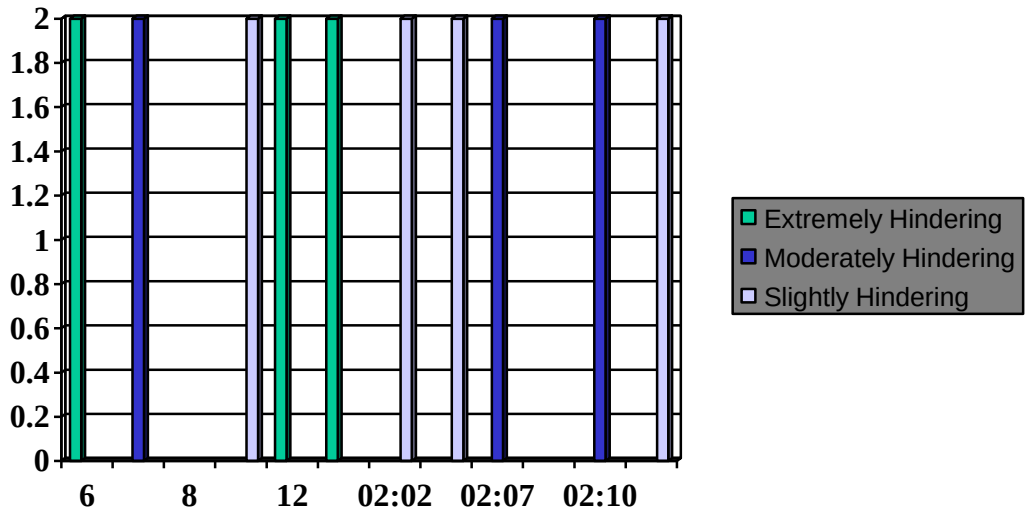
In response to the first multiple choice question in box 3, I plotted a value of 2 for each answer and colour coded the response, if it was yes or no on the vertical axis. The client ID is on the horizontal axis.

Client 8, 2/2, 2/7 and 2/9 answered ‘no’, they had no left over or unresolved from the LCTC experience of therapy.

The remaining 8 clients said they had something unresolved, or there was still something they felt uncomfortable about.

Response to Box 3, (ii) Multiple choice question on the CORE Helpful Aspects of Therapy form

‘Tick how hindering this maybe in the future’



I used the horizontal axis to plot the ID number for each client and gave their response a value of 2 on the vertical axis.

Two clients, number 8 and 2/9 did not respond as they said previously that they had no unresolved issues.

Therefore the graph above shows the responses of remaining ten client participants.

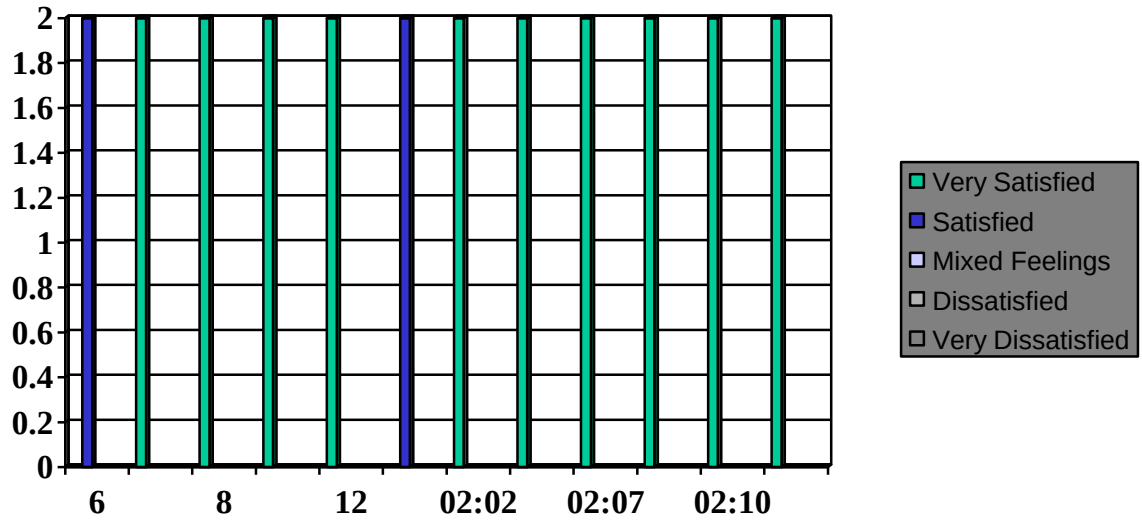
3 ticked the ‘extremely hindering’ box, clients 6, 12 and 13.

3 used the box, ‘moderately hindering’ they were clients 7, 2/7, 2/10.

The remaining 4 clients, 10, 2/2, 2/3 and 2/12 ticked the box, ‘slightly hindering’.

Response to Box 4, Multiple choice question on the CORE Helpful Aspects of Therapy form

‘Overall, how satisfied are you with the service received?’



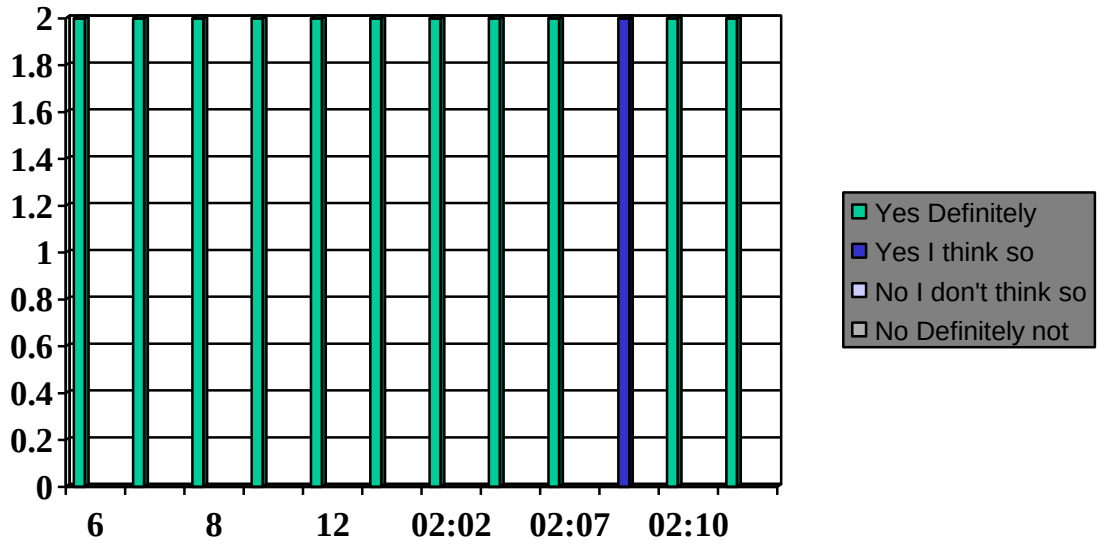
Again, to keep the format consistent, I used a value of 2 for each client participant’s response on the vertical axis. I used the horizontal axis to register each client.

All twelve respondents completed this multiple-choice question.

Ten clients, 7, 8, 10, 12, 2/2, 2/3, 2/7, 2/9, 2/10 and 2/12 noted they were ‘very satisfied’ with the service they received.

Two clients, 6 and 13 said they were satisfied.

Response to Box 5, Multiple-choice question on the CORE Helpful Aspects of Therapy form
'On the basis of your experience, would you recommend this service to a friend?'



For this final graph I used a value of 2, as had been used previously, for each response on the vertical axis and the individual clients on the horizontal axis.

Eleven clients, 6, 7, 8, 10, 12, 13, 2/2, 2/3, 2/7, 2/10 and 2/12 responded that they would definitely recommend this service to a friend.

One client, 2/9 said they thought they would recommend this service to a friend.

The Exhaustive Statement 1

In response to the question, ‘Could you please describe what has been positive about your therapy. This might be an outcome, insight or experience.’

I now realise that not everything is my fault, how what I experienced as a child has influenced my choices and the impact that my family have had upon me.
This has helped me to come to terms with my past and develop a different perspective on things that happen in my dad’s life.

I no longer feel guilty or ashamed and notice I don’t have to big everything up now, as I don’t have to be perfect, as I won’t always get it right. I can now be less hard on myself.

My self worth, self-confidence, self-esteem have improved, I know that I am not a bad person. So I feel better about myself as I know I am important.

I have an understanding of myself and know where my feelings come from and why I behave in certain ways. I’ve enjoyed learning different theories and knowing more about transactional analysis has improved my knowledge.

I am more positive about my relationships with other people. There have been changes in those relationships and I can talk more easily and be more honest. My relationship with my mum has improved massively.

Being in therapy has been difficult and it has given me time to explore my own interests and has given me structure.

Since I’ve been in therapy I’ve changed, my face doesn’t feel frozen .I’m now more aware of my feelings and emotions. Therapy has made changes to how I think. I can challenge myself more and can cope better as I act on new thoughts and behaviours now.

I now experience feelings at the time they happen and I have a grasp of what I need to do. Understanding my actions means I can change and influence situations. In trying to think more rationally and positively has helped me to deal with my anger and be positive about life.

The Exhaustive Statement 2

In response to the question in part 3 of the Helpful Aspects to Therapy, ‘If yes, what remains unresolved or what do you feel uncomfortable about?

I feel the experience has just been an introduction to changes; I want long-term therapy as I feel I have a long way to go. It is still ongoing and I haven’t really addressed it yet, as some issues began to be explored and they had to be left as the therapy was coming to an end. I felt it could have gone higher.

I have taken some big steps and there has been an improvement as I have good insight into my difficulties. I know how to live the solution, in coming a long way as I have the right tools to deal with situations. I’m launched into a new phase where my life is not as impacted to such an extent and my self-esteem has increased. I’m positive and able to manage bad days and lows, so I think I can avoid a repeat.

I have started to open the lid and feel that I’m not ready yet to continue.

My fears are that I may affect my child as I never know what may emerge and I am nervous what may swing me back into the old state. I have a fear of relapsing.

The Exhaustive Statement 3

The final written question, number 6 on the 'Helpful Aspects to Therapy Form', was, 'Have you any additional comments about the service you have received?'

My experience at being in therapy at the LCTC is that I really enjoyed it and I'm happy and pleased with the service. It has been rewarding and I have loved learning the theory, which has helped my understanding. There have been some laughs and I didn't have to try too hard to be understood, I feel very appreciative.

My therapist has been great, I was able to open up and trust her, as she understood my problems. More importantly she really did care, she didn't give in and could relate to me. My first therapist had abruptly dropped me and I had a following, great experience with my other therapist who was encouraging, empathetic. I was comfortable when I was emotional, as she is compassionate. She is a wonderful person and a cool therapist.

The Manchester Institute for Psychotherapy, where I attended the LCTC has a nice atmosphere and everyone I have met there have been approachable and nice. It is also comfortable. I'm unsure if the Institute knew I had changed my therapist.

I found the cost very good value, as I never would have been able to afford such extensive therapy.

Conclusion

The quantitative research conclusion

- In the first year of the research, 2011-2012 there were 8 student therapists
- In 2011-2012 there were 14 clients that attended the LCTC
- There were 10 female clients and 4 male clients in 2011-2012
- The age range of the clients during 2012-2012 was 23-58
- The average age of the clients during 2011-2012 was 34
- During 2011-2012 clients attended between 1-35 sessions
- The average number of sessions during 2011-2012 was 18
- During 2011-2012 there were 256 sessions at the LCTC
- 2 clients in 2011-2012 left after the assessment session
- 5 clients during 2011-2012 left therapy without an ending session
- 1 client during 2011-2012 never completed the beginning of therapy or assessment forms
- Therefore 6 clients from the first year were eligible for the study
- Those eligible 6 clients attended between 12 – 35 sessions

- In the second year of the research 2012- 2013 there were 7 student therapists
- There were 12 clients that attended the LCTC in 2012-2013
- There were 10 female clients and 2 male clients during the second year
- The age range of the clients during 2012-2013 was 16-58
- The average age of the clients during 2012-2013 was 30
- During the second year, 2012-2013 clients attended between 8 and 34 sessions
- The average number of sessions attended during 2012-2013 was 14
- In total during 2012-2013 there were 169 therapy sessions held at the LCTC
- In 2012-13, 2 clients had 5 sessions and left without an ending session
- 4 other clients left without an ending session
- 6 clients completed the therapy and provided information for the research

- Overall during the 2 year study there were 15 student therapists
- Overall during the 2 year study there were 26 clients
- From the 26 clients, full information was received from 12 clients, 6 from both years
- 42.8% of clients completed therapy and completed all CORE forms through the 1st year 2011-2012
- 50.0% of clients completed therapy and completed all the CORE forms through the 2nd year 2011-2013
- In total 46.1% of clients completed therapy through the 2 year study
- In total during 2011-2013 there were 425 therapy sessions
- During 2011-2013 the average number of sessions was 16

- In total 14 clients ended therapy during the 2 years without completing the whole suite of CORE forms
- Those clients who did not complete attended between 1-34 sessions
- 10 of the 14 clients had less than 12 sessions

- 3 clients that completed ended in a higher meridian than they began in
- No client remained in one meridian throughout their therapy
- 3 clients ended in a lower meridian than the one they started in
- 2 clients travelled through 3 meridians
- 7 clients travelled through 1 or 2 meridians and ended in the lowest meridian at the end of their therapy
- 1 client ended in the same meridian that they began in
- 2 clients moved through 1 meridian during their therapy and ended in the same meridian
- 9 clients scored themselves on their final CORE10 screening form lower than they began

- On the Helpful Aspects of Therapy form 100% clients said the experience, outcome or insight would be extremely helpful in the future
- On the Helpful Aspects of Therapy form, in response to the question, is there anything that remains unresolved or that you feel uncomfortable about? 8 clients, 66.6% said Yes and 4 clients, 33.3% said No
- On the Helpful Aspects of Therapy form 2 clients,16.6% did not respond to writing as they had no unresolved issues
- 2 clients who had no unresolved issues still chose to write in their experience
- Therefore there were 10 responses to the question in Box 3 in the Helpful Aspects of Therapy form
- When asked how hindering the unresolved issue or uncomfortable feeling was, 3 clients, 25% said it was extremely hindering, 3 clients, 25% said it was moderately hindering and 33.3%, 4 of the respondents said it was slightly hindering
- In box 4 on the Helpful Aspects of Therapy form, 83.3%, 10 clients said they were very satisfied with the service they had received
- In box 4 on the Helpful Aspects of Therapy form, 16.6%, 2 clients said they were satisfied with the service they had received
- In box 5 on the Helpful Aspects of Therapy form 1 client would think they would recommend the service to a friend, 8.4%
- In box 5 on the Helpful Aspects of Therapy form 91.6% of clients, 11 said they would definitely recommend the service to a friend
- One client had already recommended the service prior to the service for themselves ending

The qualitative research conclusion
The Conclusive Exhaustive Statement

Therapy at the LCTC has taught to me not only TA psychotherapeutic theories, it has given me a different way to think. I can now, in the moment feel what emotion I am experiencing and react in different way because I understand the impact that others and especially my early years had upon me.

I can now manage change and can cope better as I think more rationally and am more positive about life. My self esteem has improved as I now know I am not responsible for others and I am important.

My relationships with others have improved, particularly with my close family and I see an improvement with others, including my partner, my friends and at work.

I know I have the right tools to deal with situations however I am fearful, as I do not know what life will bring. I am aware of how I influence others and particularly with my child this is scary. I can manage bad days and lows, yet I want to return to therapy. Some issues haven't been addressed and I am sure if I had more therapy I may be ready to open the lid, later.
I really enjoyed therapy at the LCTC although it could be difficult. The people at the Manchester Institute were friendly and approachable and the building was comfortable. I don't know if they knew, I changed my therapist.

My therapist was empathetic and encouraging, I was understood and I could be open, as I trusted her. I felt cared for and I recognised how she could relate to me.

The fee was good value as I received extensive therapy at the LCTC.

Discussion

Personal Notes from the researcher

As suggested in the methodology there are some conflicting information that has come to light during this study, from using the two forms of research and even within the quantitative research.

One question that came up for me was that only 46.1% of clients completed therapy at the LCTC. This happens in private practice and from my own experience I would say that the figure is significantly lower than 46.1%.

I am also interested that once clients went past 15 sessions, generally 10 sessions they did not end abruptly without notice. It raised the question, for me is this when the therapeutic relationship had been formed?

It was heartening that 100% of clients believed the experience of therapy would be of value in the future.

The figure of 66.6% of clients that were experiencing fears that they had unresolved issues or that they felt uncomfortable surprised me, as I knew that there is definite cut off date, for the therapy at the LCTC to end. I would have presumed that the clients were aware of that date too, as well as the trainee therapists. I think that the students will need to remind clients that at the LCTC this is time limited and that new work is not to be 'opened', during the final sessions.

Clients can of course, apply the following academic year to continue in therapy with a different student practitioner from the new 3rd year.

The question that MIP, or the co-ordinators would not know that the therapist had changed was out of the question. The trainee therapists are carefully and closely supervised and the transition would have been monitored very carefully.

The most surprising results for me were from the CORE 10 screening forms when they converted onto the graph and seeing the progression through the meridians, during therapy. The journey did not correspond to the comments in the qualitative research. When the clients wrote about their experience they were far more positive than the 'tick box' response would indicate.

Although 4 clients said there were no unresolved issues, 2 of those clients still chose to write a statement regarding that question.

I am a believer in what the LCTC offers for clients and student therapists and was delighted to see that it is considered by all clients to be a satisfactory service and that 83.3% were very satisfied. No one was dissatisfied with the service received.

As an action research document, I hope that this study does raise questions and that it leads to enhance the LCTC and the service it provides for the clients and the student therapists.

I recognise this research may be blighted by my own shortcomings and I assure that all information given and recorded is true, to the best of my knowledge

I would welcome comments on this short research study and I can be contacted by email on

karenfburke@hotmail.co.uk

References:

Anderson, K (2011)
http://www.psychologytoday.com/blog/the-ethical-therapist/201106/two-more-good-reasons-end-psychotherapy
Retrieved 18th November 2012

BACP
http://www.bacp.co.uk/research/resources/
Retreived 21st October 2012

Barber P (2009) Becoming a practitioner researcher Middlesex University Press: London

Bell J (2008) Doing your research project Maidenhead : Open University Press

Bennett-Levy J and Beedie The Ups and Downs of cognitive Therapy Training Behavioural and Cognitive Psychotherapy Vol 35,01 January 2007, pp 61-75

Burke K F (2009, 2012) The Low Cost Therapy Handbook. Manchester : Manchester Institute for Psychotherapy

Cresswell, J. W. (1998) Qualitative Inquiry and Research Design, Choosing among five traditions. London : Sage Publications

Curry L A, Nembhard IM and Bradley E H
http://circ.ahajournals.org/content/119/10/1442.full
Retrieved 21st October 2013

Data Protection Act (1998) http://www.legislation.gov.uk/ukpga/1998/29/contents
Retrieved 21st October 2012

Davies M B (2007) Doing a successful research project Basingstoke : Palgrave Macmillan
Denscombe M (2002) Ground Rules for Good Research A ten point guide for Social Researchers. Buckingham : Open University Press

Fonagy P and Target M (1994). Who is Helped by Child Psychoanalysis? A Sample Study of Disruptive Children, from the Anna Freud Centre Retrospective Investigation Bulletin of the Anna Freud Centre **17:**291-315

Hart E and Bond M (1995) Action research for health and Social Care. Buckingham : Open University Press

Howard, K.I., R.J. Leuger, *et al.* (1993) A phase model of psychotherapy outcome: Causal mediation of change. Journal of Consulting and Clinical Psychology, 61, 678-685.

Jenkins, S. Price, C.J. and Straker, L. (2002) The Researching Therapist**.** London: Churchill Livingstone

Laws, S with Harper C and Marcus R (2003) Research for development. London : Sage

Lutz etal 2012
http://www.ncbi.nlm.nih.gov/pubmed/22708586
Retrieved 18th November 2012

McCarthy P, Walker J and Kain J W (1998) Telling It As It Is The Client Experience of Relate Counselling Newcastle Centre for Family Studies; Newcastle upon Tyne.

McKeown K, Lehane P, Rock R, Haase T and Pratschke J (2002) Unhappy Marriages: Does Counselling Help? ACCORD Catholic Marriage Care Service: Maynooth.

McLeod, J. (1996) The Humanistic Paradigm. in Woolfe, R. and Dryden, W. (eds) Handbook of Counselling Psychology. London: Sage Publications Ltd

McLeod, J. (2001) Qualitative Research in Counselling and Psychotherapy. London: Sage Publications Ltd.

McLeod, J. (2003) Doing Counselling Research. London: Sage Publications Ltd. (First published 1994, second Edition 2003)

Moustakas, C. (1994) Phenomenological Research Methods. London : Sage Publications Ltd

Roth A and Fonagy, P (2004) What Works for Whom? London: Guilford Press

Silverman, D. (2000) Doing Qualitative Research; A Practical Handbook. London, Sage Publications.

Stern, D. N. (2004) The Present Moment. New York: W.W. Norton & Company Ltd.

UKCP (2009)
http://www.psychotherapy.org.uk/hres/UKCP%20Ethical%20Principles%20and%20Code%20of%20Professional%20Conduct%20approved%20by%20BOT%20Sept%2009.pdf
Retrieved 21st October 2012

Appendix One

Three way contract at The Manchester Institute of Psychotherapy For the Low Cost Therapy Clinic

This is a three way contract for therapy between the client, the trainee in advanced psychotherapy training (known as the student) and the Manchester Institute of Psychotherapy (MIP)

MIP will:
Initially have the written confirmation of the student's tutor that the student is competent to practice
Ensure the student is in regular supervision, will monitor and evaluate the student's clinical practice
Advise the client if there are grounds for discontinuing the placement, eg. If the student leaves the training
Provide a suitable venue
Provide a secure filing system
Provide a minimum of one and no more than three clients for the maximum of one year

The Student will:
Attend MIP training; remain in regular therapy and supervision.
Attend meetings that are pertinent to the Low Cost Therapy Clinic
The student will ensure that they practice and abide to the MIP's Codes of Ethics and Professional Practice
The student is responsible for completing the client information form and filing notes on sessions
Report to MIP and their supervisor any issues that may impact upon their ability to practice
The student may not under any circumstances see the client after the period of twelve months or move the client to another practice without prior permission of MIP

The Client will
Inform MIP if their financial circumstances change
Pay the appropriate fee to MIP weekly
Inform MIP if they are unable to attend the session.
The fee is still payable if less than 48 hours notice is not given to MIP
At the end of the work a final session to be attended and paid for to ensure an appropriate and mutually satisfactory ending is made
One session to held weekly over the maximum period of one academic year.
The client cannot see the student at any other practice except MIP LCTC
Recordings/Questionnaires completed maybe used for supervision/research purposes and my identity will not be disclosed at any time.

Course Tutor..... , on behalf of MIP I believe that .....is competent to practice
Signature.....
Date .....
Client I, ...have read and understood the contract
Signature .....
Date .....

Student, I, ...have read and understand the contract, I will abide by the MIP Code of Ethics and Practice and the practice of MIP Low Cost Therapy Clinic
Signature .....
Date .....

It is the responsibility of the student to get this 2 page contract signed by each party, then for it to be photocopied, and one copy for MIP (to be kept in client file) and another for the client to be given within 4 weeks. At any time I understand my supervisor may check the files to ensure these and other paperwork are complete

Appendix Two

Ethics and Code of Professional Practice.

The Code of Ethics and Professional Practice will be open to periodic review by the Ethics and Professional Practice Advisory Committee of the Manchester Institute for Psychotherapy (hereafter MIP). Counsellors/Therapists are responsible for the observation of the principles inherent in the Code of Ethics and Professional Practice and are to use the Code as the basis of good practice rather than a set of minimal requirements. The Code of Ethics and Professional Practice may be revised periodically to ensure compatibility with the Code of Ethics and Professional Practice of the United Kingdom Council for Psychotherapy (hereafter UKCP).

1 JURISDICTION

1.1 The Code applies to all categories of membership of MIP - Trainee, Graduate, Associate Teaching Member, Teaching Member - in the management of their professional responsibilities to clients, colleagues within MIP and the wider professions of Counselling and Psychotherapy.

2 INTENTION

The Code of Ethics and Professional Practice is intended to:

2.1 Protect and inform members of the general public who are inquiring about, or receiving, the clinical services of Members of MIP.

2.2 Make clear and explicit the standards of professional practice of Members of MIP and promote good practice.

2.3 In the event of a breach of Ethics and Professional Practice the Complaints Procedure may be invoked and appropriate sanctions may include suspension or termination of membership.

2.4 MIP is required to report to the UKCP the names of Members whose membership has been suspended or terminated.

3 CLIENT-THERAPIST RELATIONSHIP

3.1 The client-therapist relationship is a professional relationship within which the welfare of the client is the Member's primary concern.

3.2 The dignity, worth and uniqueness of the client is to be respected at all times.

3.3 It is the Member's aim to promote increased awareness, encourage self support, and facilitate the self development and

autonomy of clients with a view to increasing the range of choices available to them, together with their ability/willingness to accept responsibility for the decisions they make.

3.3.1 Members are responsible for working in ways which enhance their client's sense of empowerment, their capacity to become self supporting, their ability to make creative choices and changes in response to their evolving needs, circumstances, values and beliefs.

3.3.2 Members should be respectful of their client's age, health, gender, sexuality, religion, ethnic group, social context and any other significant aspects of their life.

3.3.3 Members should provide regular opportunities to review the terms of the therapeutic contract and the progress of therapy.

3.3.4 Decisions regarding the termination of therapy are the joint responsibility of client and Member. Should a Member's professional assessment not accord with a client's decision to terminate, a Member should facilitate termination in a manner which is respectful of the client's autonomy. Termination of therapy or facilitation of a change of therapist should be managed with care and consideration for the client's dignity and well-being.

3.4 Members must recognise the importance of a good relationship for effective therapy and be cognisant of the power and influence this responsibility gives them. The Member must act in a manner consistent with this recognition and not exploit client financially, sexually or emotionally for their own personal advantage or their own needs.

3.4.1 Members should not take money under false pretences - knowingly retaining a client after therapy has ceased to be effective or increasing fees without prior negotiation with the client.

3.4.2 A physical, sexual relationship with a client is exploitative and unethical.

3.4.3 Sexual harassment in the form of deliberate or repeated comments, gestures, or physical contacts of a sexual nature that are, or could be, considered offensive by the client, are unethical.

3.5 Members need to be aware when other relationships or external commitments conflict with the interests of the client. When such a conflict of interest exists it is the Member's responsibility to declare it and be prepared to work through the issues with the client.

3.6 Members need to recognise that dual relationships - where the client is also an employee, close friend, relative, or partner - will likely impair their professional judgement and cause undue stress to clients and themselves.

4 CONFIDENTIALITY

4.1 Confidentiality is intrinsic to good practice. All exchanges between Members and client must be regarded as confidential. Where a Member has any doubts about the limits of confidentiality she/he should seek supervision.

4.2 A client should be informed at the outset of therapy (as part of the therapist-client contract) that in extreme circumstances where the client is a danger to themselves or others, a Member may break confidentiality and take appropriate action.

4.3 When a Member wishes to use specific information gained during work with a client - in a lecture or publication, the client's permission should be obtained and anonymity preserved. Clients should be informed that they have a right to withdraw consent at any time.

4.4 Members should provide a working environment which ensures privacy

4.5 Members should not make trivialising comments about clients.

4.6 Members must maintain confidentiality after the completion of therapy.

5 CLIENT SAFETY

5.1 Members must take all reasonable steps to protect clients from physical or psychological harm during therapy.

5.2 When a client develops a medical condition, Members should encourage the client to obtain advice from their doctor or other suitably qualified person. Members should obtain clients` permission before contacting other professionals, unless there are overriding ethical or legal considerations.

5.3 Members should consider what provisions may be made for clients to be informed in the event of the Members serious incapacity or death. Responsibilities will include management of confidential files and audio/video recordings.

6 INITIAL CONTRACTING

6.1 Contracts with clients, whether written or verbal, should be explicit regarding fees, payment schedule, holidays, cancellation of sessions by client or Member. The length of therapy, transfer of clients and termination's, are discussed with clients and mutual agreement sought. This should be done at the outset before any commitment is made to ongoing therapy. Subsequent changes to the contract must be negotiated and agreed with the client.

6.2 If requested by a client Members should provide information about their qualifications and experience.

6.3 If requested by a client Members should provide information about MIP Codes of Ethics and Professional Practice and MIP Complaints Procedure.

6.4 Members must inform clients if they become aware of any relevant conflict of interest at the initial interview or at any subsequent stage of therapy.

6.5 Members are responsible for setting and monitoring the boundaries between a professional relationship and a social one, and for making explicit such boundaries to the client.

7 COMPETENCE

7.1 Members accept clients commensurate with their training, skill and supervision arrangements.

7..2 Members should pay attention to the limits of their competence. Where a Member recognises they are reaching their limit then consultation with a colleague and/or supervisor is essential. It may be appropriate to refer the client to someone else.

7.3 Members have a responsibility to maintain their own effectiveness and ability to practice. Members should not work with clients when their capacity is impaired because of emotional problems, illness, alcohol or any other reason.

7.4 Members should protect their own physical safety when engaged in therapy.

7.5 Members should secure professional indemnity and public liability insurance to protect themselves in the event of legal action being taken against them or against the owners of premises in which they work.

7.6 Members should have appropriate therapeutic and supervisory support to maintain ethical and professional practice.

8 SUPERVISION

8.1 Supervision provides a challenging and supportive context for Members to share their work, enhance their effectiveness, and protect the client. Members should not practice without appropriate levels of supervision.

8.2 A Member's supervisor should not be their therapist.

8.3 Members together with their supervisors share responsibility for maintaining a focus on supervision which is purposeful and relevant to the Member's clinical practice.

9 CONTINUED DEVELOPMENT

9.1 Members have a particular responsibility to continue their personal and professional development through any or all of the following; personal therapy, regular supervision, further training, research, publication.

10 RECORDS

10.1 Members should keep adequate client records which must be kept safely under secure conditions.

10.2 As a minimum records should include client's:

- name, address and telephone number
- name and telephone number of general practitioner
- details of any current involvement with other members of the caring professions
- information regarding significant medical problems
- ongoing case recordings

10.3 Members must ensure that computer based records comply with the requirements of the Data Protection Act 1984.

11 ADVERTISING

11.1 Advertising should be confined to descriptive statements about the services available, and the qualifications of the person providing them. Advertising should not include testimonials, make comparative statements, or in any way imply that the services concerned are more effective than those provided by other schools of therapy or organisations. Members should refrain from claiming qualifications they

do not possess.

11.2 Trainee Members should not describe themselves as a psychotherapist.

11.3 Members should not describe themselves as affiliated to any organisation in such a manner that inaccurately and improperly implies or suggests authorisation or sponsorship by that organisation.

12 RESEARCH

12.1 Members are obliged to conduct any research in counselling and/or psychotherapy with ethical endeavour and to follow the MIP guidelines for ethical practice in research.

13 LEGAL PROCEEDINGS

13.1 Members should be reasonably conversant with the legal implications of their work as counsellors/psychotherapists and have access to legal advice.

13.2 A member of the Manchester Institute for Psychotherapy who is convicted in a Court of Law for any criminal offence, or is the subject of a successful civil action by a client should inform the Institute.

13.3 Members who become aware of a specific crime in the course of their clinical practice, whether current or past, should seek supervisory and legal advice immediately.

14 RESPONSIBILITIES TO THE COUNSELLING/PSYCHOTHERAPY PROFESSION

14.1 Members should not accept anyone as a client if they are already the client of another counsellor/psychotherapist.

14.2 It is considered good practice to acknowledge the source of a referral of a client.

14.3 Members should conduct themselves personally and professional in ways which promote the confidence of the general public in the professions of counselling and psychotherapy.

14.4 A Member who is concerned about the professional conduct of another Member, should discuss their concerns with this person. In the event that the matter cannot be resolved satisfactorily, then the

Complaints Procedure of MIP may be implemented.

To be read in conjunction with:

1.1 The ITA Code of Ethics and the Requirements and Recommendations for Professional Practice

This code is divided into four sections: Section 1 outlines the theoretical framework for the Code of Ethics, Section 2 the Ethical Code, Section 3 gives examples of the application of this framework, and Section 4 outlines the requirements and recommendations for professional practice.
The following abbreviations are used: TA – Transactional Analysis, ITA – Institute of Transactional Analysis, EATA – European Association for Transactional Analysis, ITAA – International Transactional Analysis Association, and BACP – British Association for Counselling &Psychotherapy.

These codes replace all previous ITA Codes of Ethics and Professional Practice and are dated
1st March 2008.
SECTION 1 – THE THEORETICAL FRAMEWORK FOR THE CODE OF ETHICS
General Introduction

This Code replaces all previous ITA Codes of Ethics and is congruent with the EATA Code of Ethics. Appreciation and acknowledgment to the BACP is expressed for the guidance provided by their Code.
This Code is intended to guide and inform both organisations and individual members of the ITA in the ethical practice of transactional analysis.
In this Code the word ‘practitioner’ relates to all members of the ITA who use transactional analysis as a model for understanding and change with individuals, couples, groups or organisations and also includes the roles of supervisor and trainer. The word ‘client’ denotes any recipient of professional services of members of the ITA.

Within the helping profession, ethical principles need to address many areas in order to influence ethical behaviour. These are:
* Clients
* Self as practitioner
* Trainees
* Colleagues
* Our environment and community
TA practitioners will consider the philosophy, ethical principles and personal qualities and reflect on what stance to take and how to behave in each of the mentioned areas. The practitioner will analyse any situation looking at the influence of ethical principles on the

practice and choose behaviours taking into account a wide variety of factors, e.g. client, self, environment, etc. A practitioner may wish to seek consultation with a qualified supervisor or qualified peer.

Limitations

It is recognised that any Code of Ethics will have limitations. For example, Berne's philosophy of TA was part of 1950's America and has an individualistic rather than community based focus. This focus also remains largely true for the early 21st century United Kingdom. If there were a shift of emphasis from a culture of individualism to one of community, then both this code and transactional analysis would need to change. It is therefore necessary that this code is considered within the context of benefit to the community as well as benefit to the individual.

The Relationship between Morality and Ethical Practice

*1 Morality – The evaluation of, or means of evaluating, human conduct especially a) a set of ideas of right or wrong; b) A set of customs of a given society, class or social group which regulate personal and social relationships and prescribe modes of behaviour to facilitate a groups existence or ensure its survival.

Ethics – The study of the general nature of morals and of the specific moral choices to be made by the individual in his relationship with others.

*1 Definitions from The Universal Dictionary, Reader's Digest 1987

Any ethical code has therefore to be based in both the cultural norms of a country about what are right and wrong behaviours as well as account the particular customs and norms of the TA profession. So the ethical code needs to be rooted in both professional and social norms about how to behave. In practice this is not as straightforward as it seems as it may be that what is morally right in one situation is not morally right in another. As this is the case it becomes apparent that any ethical code which comprises a set of rules cannot fully account every situation nor adequately determine whether or not a course of action is right or wrong. It is therefore necessary to base any ethical decision on whether or not it is variance with our professional philosophy and our personal (moral) values. This code therefore offers a construct which incorporates these features.

This approach moves the arena of ethical practice away from the application of a set of rules, which denotes what shall or shall not be done, to a consideration of the values and philosophical principles which guide us in transactional analysis. It also enables practitioners to address more directly those issues of practice and approach that 'fall between' any rule driven Code of Ethics. A further advantage is that cultural differences are more easily incorporated when considered in terms of philosophy and value.

There are, however, some standards and requirements that are generally accepted by everybody in the profession as ethical and appropriate and breaches of them are therefore considered to be clear requiring little ethical thought. Therefore a set of obligatory rules are listed below.

In Conclusion

Working ethically is a continuous demand on all practitioners in both their professional and private lives. Some ethical challenges are straightforward and are easily resolved. Other challenges are more difficult to determine when in seeking to act ethically, there seems to be competing obligations or principles. This code seeks to support the practitioner by identifying a variety of factors that influence ethical practice and to offer a variety of ways for the practitioner to consider various courses of action. No ethical code can ever cover every eventuality, nor can it lessen the difficulty of making a professional judgment in a changing and uncertain world. By accepting this code practitioners are committing themselves to the challenge of behaving ethically even when doing so requires courage in the face of moral dilemmas and difficult decisions.

SECTION 2 – THE CODE OF ETHICS

It is intended that this Code represent an attempt to encourage thinking that permits the coexistence of differing views on ethical practice by stating primary principles in ethical practice. It will do this by basing the Code on four central and principles universally held in transactional analysis which are also congruent with the norms of society within the United Kingdom:

* The philosophical base from which we practice.
* The principles, which support and affirm our practice.
* Personal moral qualities of the practitioner.
* Clearly explicit, generally accepted rules of behaviour.

Reporting Possible Violations and the Responsibility of the Practitioner

This Code addresses the ITA's commitment to openness and non-defensiveness. It is encouraged that concerned individuals raise their questions, concerns, suggestions or complaints with someone who can address them properly. In the case of an ITA member, in the first instance, it might be with their supervisor, trainer or qualified peer who is in the best position to address an area of concern. For members of the public this may be informally with a member of the ethics committee who can be contacted by telephone via 0845 0099101 or email ethics@ita.org.uk. However, if complainants are not comfortable speaking with their supervisor, trainer etc. or are not satisfied with their response, they are encouraged to speak
with someone on the Ethics Committee or Professional Practice Committee. Contact details can be found in the ITA website www.ita.org.uk or on the above phone number.

Reports of violations or suspected violations will be kept confidential to the extent possible, consistent with the need to conduct an adequate investigation and appropriately address the ethical and professional issues involved.

The philosophical base from which we practice

Our ethical practice must be grounded in our philosophy and the principles which support it. Practitioners will encounter situations that are not covered by Ethics and Code of Professional Practice.

The Code of Ethics and Professional Practice will be open to periodic review by the Ethics and Professional Practice Advisory Committee of the Manchester Institute for Psychotherapy (hereafter MIP). Counsellors/Therapists are responsible for the observation of the principles inherent in the Code of Ethics and Professional Practice and are to use the Code as the basis of good practice rather than a set of minimal requirements. The Code of Ethics and Professional Practice may be revised periodically to ensure compatibility with the Code of Ethics and Professional Practice of the United Kingdom Council for Psychotherapy (hereafter UKCP).

1 JURISDICTION

1.1 The Code applies to all categories of membership of MIP - Trainee, Graduate, Associate Teaching Member, Teaching Member - in the management of their professional responsibilities to clients, colleagues within MIP and the wider professions of Counselling and Psychotherapy.

2 INTENTION

The Code of Ethics and Professional Practice is intended to:

2.1 Protect and inform members of the general public who are inquiring about, or receiving, the clinical services of Members of MIP.

2.2 Make clear and explicit the standards of professional practice of Members of MIP and promote good practice.

2.3 In the event of a breach of Ethics and Professional Practice the Complaints Procedure may be invoked and appropriate sanctions may include suspension or termination of membership.

2.4 MIP is required to report to the UKCP the names of Members whose membership has been suspended or terminated.

3 CLIENT-THERAPIST RELATIONSHIP

3.1 The client-therapist relationship is a professional relationship within which the welfare of the client is the Member's primary concern.

3.2 The dignity, worth and uniqueness of the client is to be respected at all times.

3.3 It is the Member's aim to promote increased awareness, encourage self support, and facilitate the self development and autonomy of clients with a view to increasing the range of choices available to them, together with their ability/willingness to accept responsibility for the decisions they make.

3.3.1 Members are responsible for working in ways which enhance their client's sense of empowerment, their capacity to become self supporting, their ability to make creative choices and changes in response to their evolving needs, circumstances, values and beliefs.

3.3.2 Members should be respectful of their client's age, health, gender, sexuality, religion, ethnic group, social context and any other significant aspects of their life.

3.3.3 Members should provide regular opportunities to review the terms of the therapeutic contract and the progress of therapy.

3.3.4 Decisions regarding the termination of therapy are the joint responsibility of client and Member. Should a Member's professional assessment not accord with a client's decision to terminate, a Member should facilitate termination in a manner which is respectful of the client's autonomy. Termination of therapy or facilitation of a change of therapist should be managed with care and consideration for the client's dignity and well-being.

3.4 Members must recognise the importance of a good relationship for effective therapy and be cognisant of the power and influence this responsibility gives them. The Member must act in a manner consistent with this recognition and not exploit client financially, sexually or emotionally for their own personal advantage or their own needs.

3.4.1 Members should not take money under false pretences - knowingly retaining a client after therapy has ceased to be effective or increasing fees without prior negotiation with the client.

3.4.2 A physical, sexual relationship with a client is exploitative and unethical.

3.4.3 Sexual harassment in the form of deliberate or repeated comments, gestures, or physical contacts of a sexual nature that are, or could be, considered offensive by the client, are unethical.

3.5 Members need to be aware when other relationships or external commitments conflict with the interests of the client. When such a conflict of interest exists it is the Member's responsibility to declare it

and be prepared to work through the issues with the client.

3.6 Members need to recognise that dual relationships - where the client is also an employee, close friend, relative, or partner - will likely impair their professional judgement and cause undue stress to clients and themselves.

4 CONFIDENTIALITY

4.1 Confidentiality is intrinsic to good practice. All exchanges between Members and client must be regarded as confidential. Where a Member has any doubts about the limits of confidentiality she/he should seek supervision.

4.2 A client should be informed at the outset of therapy (as part of the therapist-client contract) that in extreme circumstances where the client is a danger to themselves or others, a Member may break confidentiality and take appropriate action.

4.3 When a Member wishes to use specific information gained during work with a client - in a lecture or publication, the client's permission should be obtained and anonymity preserved. Clients should be informed that they have a right to withdraw consent at any time.

4.6 Members should provide a working environment which ensures privacy

4.7 Members should not make trivialising comments about clients.

4.7 Members must maintain confidentiality after the completion of therapy.

5 CLIENT SAFETY

5.1 Members must take all reasonable steps to protect clients from physical or psychological harm during therapy.

5.2 When a client develops a medical condition, Members should encourage the client to obtain advice from their doctor or other suitably qualified person. Members should obtain clients` permission before contacting other professionals, unless there are overriding ethical or legal considerations.

5.3 Members should consider what provisions may be made for clients to be informed in the event of the Members serious incapacity or

death. Responsibilities will include management of confidential files and audio/video recordings.

6 INITIAL CONTRACTING

6.1 Contracts with clients, whether written or verbal, should be explicit regarding fees, payment schedule, holidays, cancellation of sessions by client or Member. The length of therapy, transfer of clients and termination's, are discussed with clients and mutual agreement sought. This should be done at the outset before any commitment is made to ongoing therapy. Subsequent changes to the contract must be negotiated and agreed with the client.

6.2 If requested by a client Members should provide information about their qualifications and experience.

6.3 If requested by a client Members should provide information about MIP Codes of Ethics and Professional Practice and MIP Complaints Procedure.

6.4 Members must inform clients if they become aware of any relevant conflict of interest at the initial interview or at any subsequent stage of therapy.

6.5 Members are responsible for setting and monitoring the boundaries between a professional relationship and a social one, and for making explicit such boundaries to the client.

7 COMPETENCE

7.1 Members accept clients commensurate with their training, skill and supervision arrangements.

7..2 Members should pay attention to the limits of their competence. Where a Member recognises they are reaching their limit then consultation with a colleague and/or supervisor is essential. It may be appropriate to refer the client to someone else.

7.3 Members have a responsibility to maintain their own effectiveness and ability to practice. Members should not work with clients when their capacity is impaired because of emotional problems, illness, alcohol or any other reason.

7.4 Members should protect their own physical safety when engaged in therapy.

7.5 Members should secure professional indemnity and public

liability insurance to protect themselves in the event of legal action being taken against them or against the owners of premises in which they work.

7.6 Members should have appropriate therapeutic and supervisory support to maintain ethical and professional practice.

8 SUPERVISION

8.1 Supervision provides a challenging and supportive context for Members to share their work, enhance their effectiveness, and protect the client. Members should not practice without appropriate levels of supervision.

8.2 A Member's supervisor should not be their therapist.

8.3 Members together with their supervisors share responsibility for maintaining a focus on supervision which is purposeful and relevant to the Member's clinical practice.

9 CONTINUED DEVELOPMENT

9.1 Members have a particular responsibility to continue their personal and professional development through any or all of the following; personal therapy, regular supervision, further training, research, publication.

10 RECORDS

10.1 Members should keep adequate client records which must be kept safely under secure conditions.

10.2 As a minimum records should include client's:

- name, address and telephone number
- name and telephone number of general practitioner
- details of any current involvement with other members of the caring professions
- information regarding significant medical problems
- ongoing case recordings

10.3 Members must ensure that computer based records comply with the requirements of the Data Protection Act 1984.

11 ADVERTISING

11.1 Advertising should be confined to descriptive statements about the services available, and the qualifications of the person providing them. Advertising should not include testimonials, make comparative statements, or in any way imply that the services concerned are more effective than those provided by other schools of therapy or organisations. Members should refrain from claiming qualifications they do not possess.

11.2 Trainee Members should not describe themselves as a psychotherapist.

11.3 Members should not describe themselves as affiliated to any organisation in such a manner that inaccurately and improperly implies or suggests authorisation or sponsorship by that organisation.

12 RESEARCH

12.1 Members are obliged to conduct any research in counselling and/or psychotherapy with ethical endeavour and to follow the MIP guidelines for ethical practice in research.

13 LEGAL PROCEEDINGS

13.1 Members should be reasonably conversant with the legal implications of their work as counsellors/psychotherapists and have access to legal advice.

13.2 A member of the Manchester Institute for Psychotherapy who is convicted in a Court of Law for any criminal offence, or is the subject of a successful civil action by a client should inform the Institute.

13.3 Members who become aware of a specific crime in the course of their clinical practice, whether current or past, should seek supervisory and legal advice immediately.

14 RESPONSIBILITIES TO THE COUNSELLING/PSYCHOTHERAPY PROFESSION

14.1 Members should not accept anyone as a client if they are already the client of another counsellor/psychotherapist.

14.2 It is considered good practice to acknowledge the source of a referral of a client.

14.3 Members should conduct themselves personally and

professional in ways which promote the confidence of the general public in the professions of counselling and psychotherapy.

14.4 A Member who is concerned about the professional conduct of another Member, should discuss their concerns with this person. In the event that the matter cannot be resolved satisfactorily, then the Complaints Procedure of MIP may be implemented.

To be read in conjunction with:

1.1 The ITA Code of Ethics and the Requirements and Recommendations for Professional Practice

This code is divided into four sections: Section 1 outlines the theoretical framework for the Code of Ethics, Section 2 the Ethical Code, Section 3 gives examples of the application of this framework, and Section 4 outlines the requirements and recommendations for professional practice.
The following abbreviations are used: TA – Transactional Analysis, ITA – Institute of Transactional Analysis, EATA – European Association for Transactional Analysis, ITAA – International Transactional Analysis Association, and BACP – British Association for Counselling &Psychotherapy.

These codes replace all previous ITA Codes of Ethics and Professional Practice and are dated
1st March 2008.
SECTION 1 – THE THEORETICAL FRAMEWORK FOR THE CODE OF ETHICS
General Introduction

This Code replaces all previous ITA Codes of Ethics and is congruent with the EATA Code of Ethics. Appreciation and acknowledgment to the BACP is expressed for the guidance provided by their Code.
This Code is intended to guide and inform both organisations and individual members of the ITA in the ethical practice of transactional analysis.
In this Code the word ‘practitioner’ relates to all members of the ITA who use transactional analysis as a model for understanding and change with individuals, couples, groups or organisations and also includes the roles of supervisor and trainer. The word ‘client’ denotes any recipient of professional services of members of the ITA.

Within the helping profession, ethical principles need to address many areas in order to influence ethical behaviour. These are:
* Clients
* Self as practitioner
* Trainees

* Colleagues
* Our environment and community

TA practitioners will consider the philosophy, ethical principles and personal qualities and reflect on what stance to take and how to behave in each of the mentioned areas. The practitioner will analyse any situation looking at the influence of ethical principles on the practice and choose behaviours taking into account a wide variety of factors, e.g. client, self, environment, etc. A practitioner may wish to seek consultation with a qualified supervisor or qualified peer.

Limitations

It is recognised that any Code of Ethics will have limitations. For example, Berne's philosophy of TA was part of 1950's America and has an individualistic rather than community based focus. This focus also remains largely true for the early 21st century United Kingdom. If there were a shift of emphasis from a culture of individualism to one of community, then both this code and transactional analysis would need to change. It is therefore necessary that this code is considered within the context of benefit to the community as well as benefit to the individual.

The Relationship between Morality and Ethical Practice

*1 Morality – The evaluation of, or means of evaluating, human conduct especially a) a set of ideas of right or wrong; b) A set of customs of a given society, class or social group which regulate personal and social relationships and prescribe modes of behaviour to facilitate a groups existence or ensure its survival.

Ethics – The study of the general nature of morals and of the specific moral choices to be made by the individual in his relationship with others.

*1 Definitions from The Universal Dictionary, Reader's Digest 1987

Any ethical code has therefore to be based in both the cultural norms of a country about what are right and wrong behaviours as well as account the particular customs and norms of the TA profession. So the ethical code needs to be rooted in both professional and social norms about how to behave. In practice this is not as straightforward as it seems as it may be that what is morally right in one situation is not morally right in another. As this is the case it becomes apparent that any ethical code which comprises a set of rules cannot fully account every situation nor adequately determine whether or not a course of action is right or wrong. It is therefore necessary to base any ethical decision on whether or not it is variance with our professional philosophy and our personal (moral) values. This code therefore offers a construct which incorporates these features.

This approach moves the arena of ethical practice away from the application of a set of rules, which denotes what shall or shall not be

done, to a consideration of the values and philosophical principles which guide us in transactional analysis. It also enables practitioners to address more directly those issues of practice and approach that ‘fall between’ any rule driven Code of Ethics. A further advantage is that cultural differences are more easily incorporated when considered in terms of philosophy and value.

There are, however, some standards and requirements that are generally accepted by everybody in the profession as ethical and appropriate and breaches of them are therefore considered to be clear requiring little ethical thought. Therefore a set of obligatory rules are listed below.

In Conclusion

Working ethically is a continuous demand on all practitioners in both their professional and private lives. Some ethical challenges are straightforward and are easily resolved. Other challenges are more difficult to determine when in seeking to act ethically, there seems to be competing obligations or principles. This code seeks to support the practitioner by identifying a variety of factors that influence ethical practice and to offer a variety of ways for the practitioner to consider various courses of action. No ethical code can ever cover every eventuality, nor can it lessen the difficulty of making a professional judgment in a changing and uncertain world. By accepting this code practitioners are committing themselves to the challenge of behaving ethically even when doing so requires courage in the face of moral dilemmas and difficult decisions.

SECTION 2 – THE CODE OF ETHICS

It is intended that this Code represent an attempt to encourage thinking that permits the coexistence of differing views on ethical practice by stating primary principles in ethical practice. It will do this by basing the Code on four central and principles universally held in transactional analysis which are also congruent with the norms of society within the United Kingdom:

* The philosophical base from which we practice.
* The principles, which support and affirm our practice.
* Personal moral qualities of the practitioner.
* Clearly explicit, generally accepted rules of behaviour.

Reporting Possible Violations and the Responsibility of the Practitioner

This Code addresses the ITA’s commitment to openness and non-defensiveness. It is encouraged that concerned individuals raise their questions, concerns, suggestions or complaints with someone who can address them properly. In the case of an ITA member, in the first instance, it might be with their supervisor, trainer or qualified peer who is in the best position to address an area of concern. For members of the public this may be informally with a member of the ethics committee who can be contacted by telephone via 0845 0099101 or email ethics@ita.org.uk. However, if complainants are not comfortable

speaking with their supervisor, trainer etc. or are not satisfied with their response, they are encouraged to speak
with someone on the Ethics Committee or Professional Practice Committee. Contact details can be found in the ITA website www.ita.org.uk or on the above phone number.

Reports of violations or suspected violations will be kept confidential to the extent possible, consistent with the need to conduct an adequate investigation and appropriately address the ethical and professional issues involved.
The philosophical base from which we practice
Our ethical practice must be grounded in our philosophy and the principles which support it. Practitioners will encounter situations that are not covered by specific codes or will be faced with having to decide between principles. In such circumstances any chosen course of action only becomes unethical if it can be shown that the practitioner
This is defined here as meaning that we all have the ability to consider our situation, consider options for action and we are responsible for those actions. In summary, in the ability to think all practitioners have the capacity to test and evaluate thoughts and actions. Acceptance of this philosophy ensures that the TA practitioner acknowledges that every adult is responsible for his or her own thought processes and is also responsible for the consequences of what she or he decides. However every TA practitioner recognises that congenital abnormalities, physical damage and traumatic early life experience can limit the capacity of an individual to make such decisions.

Any decision can be changed
This is defined here as meaning that when we make a decision, we can later change that decision. Acceptance of this philosophy ensures that the TA practitioner is open and accepting of the possibility of change to meet altering situations and needs. The Principles which support and affirm our practice. We have two primary principles, which support and underpin our philosophy:

* Open Communication
This requires that a practitioner will seek to maintain clear overt communication in their professional dealings with both clients and colleagues. It also means that where practitioners are aware of ulterior transactions they will seek to make them overt. importance of sharing knowledge and insights with the client which is a central feature of this principle. Open communication means that all practitioners are clear in all matters of communication including, for example; advertising, information given about services, rules of confidentiality and working practice and disclosing information that might compromise the professional relationship.

* The Contractual Method
This requires that all contracts are both clear and explicit as to the nature and purpose of the professional relationship and that both

parties to the contract have clear, functioning Adult thinking. The contractual method respects a client's right to be self-governing and encourages and emphasises the client's and practitioner's commitment to an active process in enabling change. It means that practitioners seek freely given and adequately informed consent from their clients. A further principle also guides our practice.

* Above All Do No Harm
This was a central principle for Eric Berne. It requires that in all dealings with clients the practitioner seeks to avoid causing harm. To maintain this Principle practitioners are required to sustain competence through ongoing professional development, supervision and personal therapy where necessary. All practitioners have a responsibility to confront, where appropriate, incompetence and unprofessional behaviour in colleagues, and co-operate in any organisational action against those who discredit the good name of transactional analysis. See also Obligatory Code 1 below.

Note on the Principles
Observances of the above principles are central in encouraging and respecting the trust that clients place in the practitioner. All ethical practice can be judged against whether or not any action honours that trust. Personal moral qualities Ethical practice and moral action are inextricably linked with personal qualities. While it would
be unrealistic to suppose that ethical practice is based solely on personal moral qualities, such qualities significantly support and assist authentic rather than adapted ethical behaviour. All TA practitioners are strongly encouraged to aim for such qualities. It is recognised, however, that in any ethical process consideration of such qualities needs to be limited to their demonstration in professional practice. Nevertheless if these qualities were not also demonstrated in an individual's personal life this indicate a lack of congruence and integration. Integrity; Demonstrated in openness, congruence and straightforwardness in dealings with others.
Courage; The ability to act for what is believed as right in the face of fear, risk and uncertainty. Respect; To show consideration and regard to others and to self and in the way that others perceive themselves.
Honesty; The capacity to demonstrate truthfulness, sincerity and trustworthiness in all interactions with others.
Compassion; The ability to experience concern and empathy for the suffering of another together with a desire to give support and help.
Humility; The ability to have a realistic understanding of one's own strengths and weaknesses.
Fairness; The ability to view events without bias or prejudice in order to inform decisions and take appropriate actions.

Obligatory Codes

1. ITA members shall not exploit their professional relationship with any person to whom the ITA member is providing services in the member's

field of specialisation. 'Exploit' means 'to take unfair or selfish advantage of the member's professional relationship with the recipient of services, in any matter including, but not limited to, sexual or financial matters.

2. Contracts with recipients of professional services shall be explicit regarding fees, payment schedule, holidays, and cancellation of sessions by client or practitioner, and frequency of sessions. The member shall make it clear whether the contract with the client is for therapy, training, supervision, consultancy or some other service.

3. Members of the ITA will operate and conduct services to recipient of professional services taking conscientious consideration of the laws of the country in which they reside and work.

4. All communication between the member and the client shall be regarded as confidential except as explicitly provided for in the contract or in compliance with relevant law.

5. In the event that a complaint should be made against a member, that member shall co-operate in resolving such a complaint and will comply in all respects with the requirements of the Procedures for Handling Ethics Charges, which are current at that time. Failure to do so will, in itself, be considered a breach of ethics.

SECTION 3 – PRACTICAL EXAMPLES

Use of the Code
In any given situation the TA practitioner will consider how the philosophy and principles of TA, together with personal values apply. They will explore the situation along with their inner motivations in order to determine what attitude to take and how to behave in a way that is congruent with this code. Such deliberations will be aimed at a reduction of harm and will actively support the possibility of growth for the client.

SECTION 4 – THE REQUIREMENTS AND RECOMMENDATIONS FOR
PROFESSIONAL PRACTICE
There has been much confusion about the status of a ‘code’ and this has led to confusion as to whether or not any breaking of a code of professional practice is, in fact, a breaking of an ethical code. For this reason the words ‘code’ and ‘guidelines’ have been replaced by ‘requirements’ and ‘recommendations’. Here requirements mean those regulations that are
essentials to belonging to the Institute of Transactional Analysis, the European Association of Transactional Analysis and, for psychotherapy

members, the United Kingdom Council for Psychotherapy. Recommendations are those things that are held to be appropriate in order to maintain a high level of professionalism in our work (best practice) but are not compulsory.

Clearly the omission or breaking of a requirement will necessitate an organisational response (e.g. suspension of being Registered with the ITA) and not an ethical one. The breaking of a recommendation may result in confrontation from a colleague. Examples of concern over professional practice includes such matters as false or misleading advertising, misuse of the logo, derogatory comments about another member, or a suspected breach of Professional Practice requirements or recommendations.
Such complaints are assumed to be the result of oversight or lack of information on the part of the offending party. The individual concerned is contacted and asked to take action to correct the situation. If the person refuses, then it becomes clear that the offending action(s) was intentional and it may become grounds for lodging an ethical charge against the individual. If this is the case then the matter is referred to the Ethics Committee for action. When there is not a clear violation, but rather a dispute between members, the matter may be referred to the Committee for information and advice. If it is considered appropriate, the Committee may also provide some level of mediation.
N.B. Failure to meet professional practice requirements or recommendations may also carry with it ethical implications.
Requirements
1. Insurance: Practising members will take out Professional Indemnity Insurance to provide cover in the event of a legal suit, or other claims that may be made against them (this cover may be provided by the member's employer). Members are advised to check their policy documents for clauses which may invalidate professional insurance e.g. disclosure of Professional Indemnity Insurance to a client. They are further advised to check that their insurance policy covers the full range of their professional activities, and that some provision for legal costs is included.

2. Qualifications: Members' statements concerning their professional qualifications and/or experience will be an accurate reflection of their status. Misrepresentation of qualifications may be illegal under the legal requirements for advertising and promotion that governs standards in
commercial advertising and may jeopardise a member's present and future standing with the ITA.

3. Supervision: All practicing members will ensure that they receive appropriate supervision of their work on a regular basis from some one who is suitably skilled and qualified in their chosen field. The recommendation is a minimum of eight times (minimum of an hour per

occasion) a year for Certified members.

4. Medical Backup: (specifically applies to Psychotherapy and Counselling members). When a practitioner is working with a client who has a potentially serious medical or psychiatric condition, the practitioner shall ensure that he/she seeks appropriate medical support and advice
for the continuation of treatment.

5. Duality of Roles: Members will avoid a duality of professional relationship in the following
areas:
• Therapist/counsellor and supervisor to one person
• Therapist and examiner to one person.
Practitioners are also expected to consider the appropriateness and ethicality of other types of dual relationships e.g. when a therapist is being supervised by their client's trainer. N.B. See also under Duality of roles in the recommendations for Professional Practice.

6. Continuing Professional Development: Certified members are required to follow a process of continuing professional development which meets their learning and development needs as well as reflecting their specific working environments and field of application and personal interests. Practitioners are required to maintain professional competence in all areas of their
work. Demonstration of CPD is an annual requirement and necessary in order to maintain membership and/or registration with the ITA and UKCP. (Refer to CPD Policy, as set out by the Training Standards Committee and the ITA Code of Ethics No.15). Additionally for UKCP Registrants (with more than five years Registration with UKCP) a 5 year group peer review of all CPD is required. All such groups will require at least one member who is of a different therapeutic modality to TA.

7. Equal Opportunities Policy: All practising members are required to adhere to the ITA policy of equal opportunity and ensure that, as far as is reasonably possible, their services are available to all members of society. Training members will inform trainees of all fields of application in TA. (Refer to Equal Opportunities policy as set out by the Membership Committee).

8. Recognition of Training Hours. Only Provisional or full Teaching Transactional Analysts can offer training leading up to recognition as a Transactional Analyst within the ITA, EATA, or ITAA. A registered 101 Trainer who is a CTA may offer TA101 training.

9. Maintaining Records: All members shall maintain records of sessions and these shall be kept confidential in a secure place. Except as agreed in the contract or in compliance with the law, information can be disclosed only with the client's' consent, unless the practitioner believes that there is convincing evidence of serious danger to the client or others if such information is withheld. Clients must be informed that practitioners may discuss their work with their supervisors. Supervisors and members of a supervision group shall treat material presented with the same care and confidentiality as provided for in the original contract. Particular care will be taken when presenting case material outside of the usual boundaries of supervision, e.g. for training or teaching purposes. In such cases where case material records are presented - whether printed, verbal, on tape, film, or video, or retrieved from electronic media - the client's consent in writing shall be obtained. Due consideration needs to be given as to the effect on the therapeutic relationship of asking the client’s permission to use such material.

10. Maintenance of Professional Membership: All members are required to pay membership dues promptly. Training members are committed to maintain membership of the ITA in order to fulfil membership obligations to EATA.

11. Valuing, Maintaining and Developing Skills and Competence as a Practitioner (Certified or in Training). Practitioners are committed to expanding their range of skills and to recognise their limitations. It is part of their professional responsibility to seek information and advice from colleagues and also to refer clients to other professional services if this may be of benefit to the client. Professional services shall not be started or continued if the practitioner believes her/him-self unqualified to meet the client’s needs. Psychotherapists and Counsellors have a particular responsibility to promote further study and research into psychotherapy theory and practice, as well as continue their personal development and the development of their own professional skills and understanding of psychotherapy. Practitioners shall continue in regular ongoing supervision, personal development, and continuing education and accept responsibility for seeking their own psychotherapy as necessary. Practitioners have a responsibility to themselves, their clients and their professional body, to maintain their own effectiveness, resilience and ability to work with clients. They are expected to monitor their own personal functioning and to seek help and/or withdraw from practicing, whether temporarily or permanently, when their personal resources are sufficiently depleted to require this.

Recommendations

Professional Etiquette: Practitioners accepting clients for psychotherapy or counselling who are already in a professional relationship as a client with another psychotherapist, counsellor, psychologist or psychiatrist, will normally only do so following consultation with the other professional. Such clients need to be

informed that normal practice requires that consultation take place with the professional responsible for their treatment prior to any proposed change or addition to their care. In doing so due account needs to be taken of the wishes and autonomy of the client.
* Practitioners will not accept as clients anyone with whom they may have a pre-existing and potentially prejudicial relationship. To do so may be considered unethical.
* For practitioners offering counselling or psychotherapy, they will not accept clients for therapeutic work who already have a counselling or psychotherapy contract with another practitioner unless it is specifically agreed with the all practitioners involved.
* Practitioners will not solicit trainees or clients from other practitioners. Solicit means to gain trainees by making insistent requests, pleas or bribing.
* Trainers will only agree to accept EATA training contracts with trainees who are under contract with another trainer following full consultation between all three parties.
* Practitioners will inform clients, and obtain their written permission, if they intend to use any material from the client for research or publication.
* Practitioners will maintain clear, 'above-board' contracts with their clients.

Duality of Roles: (See also under Duality of Roles in the Requirements above): It is a recommendation that practitioners will, as far as is practically possible avoid a duality of the following professional relationship. This means avoiding the following, except in geographical areas where to do so would create considerable difficulties.
• Therapist/counsellor and Trainer to one person

Fees: Psychotherapy and Counselling practitioners are responsible for charging fees which are commensurate with their qualifications and experience.

Protection: Practitioners need to make provision in their wills for an Executor of their professional estate in the event of their incapacity or death.

Records and the Security of Information:
a. Records about clients should be kept safely under locked conditions to ensure privacy, and in a form that can be inspected by the client should he/she request this.
b. Practitioners using computerised record-keeping need to be informed about requirements of the Data Protection Act and register if appropriate. (Refer to Data Protection guidelines issued by the

Committee).
c. Practitioners need to be aware that clients records can be required by the courts and so are advised to keep records and exam materials intact for a minimum period of eight years from the date of the last visit of the client, or if the client is a child until the client's 25th birthday or the 26th birthday if the client was 17 at the conclusion of the therapy.

EAPs and Professional Referral Schemes:
Any member responsible for running or managing a 'Therapeutic Service' such as an EAP or Professional Referral Scheme needs to ensure that it is well boundaried and incorporates the following guidelines:
a. Provision of an explicit, written outline of how this would work, including the remuneration involved. This would need to be given to the clients and counsellors/therapists/ administrators and everyone involved in the referral system, including referring authorities. Each contract needs to be explicit and agreed between the relevant parties
b. An EAP differs from a referral service in terms of the three-cornered contract. In the case of an EAP, the therapist is paid directly by that service. In the case of a referral service, therapist is paid directly by that service. In the case of a referral service, the therapist would usually pay a small fee to be a member and receive referrals.
c. It is recommended that an administrator be employed to run the system, whose sole role would be to administer the system, and would have no dual role in the system.
d. The counsellors/therapists receiving referrals need access to an independent supervisor.
Disputes between Trainers and Trainees:
Any disputes between a trainer and trainee will be dealt with through the complaints procedure.

Appendix Three

MIP LCTC Tutor's report

Date of report Tutor

The student..... has completed ……years of clinical training and has been endorsed to practice.

To gain the maximum advantage from the placement at MIP LCTC then the student would benefit from working with clients.....

This is because.....

The student's growing edge is.....

Tutor's signature ….....
Date.....

Student's signature.....
Date.....

Three copies of this report are to be photocopied by the student, the original is to be given to the assessor, then filed when client(s) are allocated, one copy for the supervisor, one copy for the tutor and one for the student's own records.

Appendix Four

LCTC Recording Contract

I, ……..…….have been asked to give my consent for recordings of my sessions with ……..... to be recorded.

I understand that this is ordinary for students to record sessions and that this is necessary for reflective practice, supervision, research practice and examinations.

I understand that I can withdraw my consent at any time and I have been assured if this is my choice, this will not impact upon the therapy. I have the choice to ask for all previous recordings to be erased at any time, the exception being if it is one calendar month before an examination, however the recording will be erased immediately after the completion of the examination.

The recordings will only be used for clinical supervision, research or examination purposes. They will not be heard by anyone who is not bound by a professional code of ethics and confidentiality.

I understand that identifying information, such as my name, names of others, places and other details will be changed to protect me.

I understand that the student will be responsible for the safety of the recordings, keeping them safe and secure. This includes the use of passwords if the recordings are kept on a memory stick, pc or laptop.

I understand that the recordings will be erased when the student has completed their training at the very latest.

I confirm that I have not been put under any pressure to consent to recording

I give my consent to the recording of my sessions

Appendix Five

LCTC Information Sheet

Full Name Date of Birth

Address (If new information the client must inform the student)

Next of kin/to be notified in an emergency

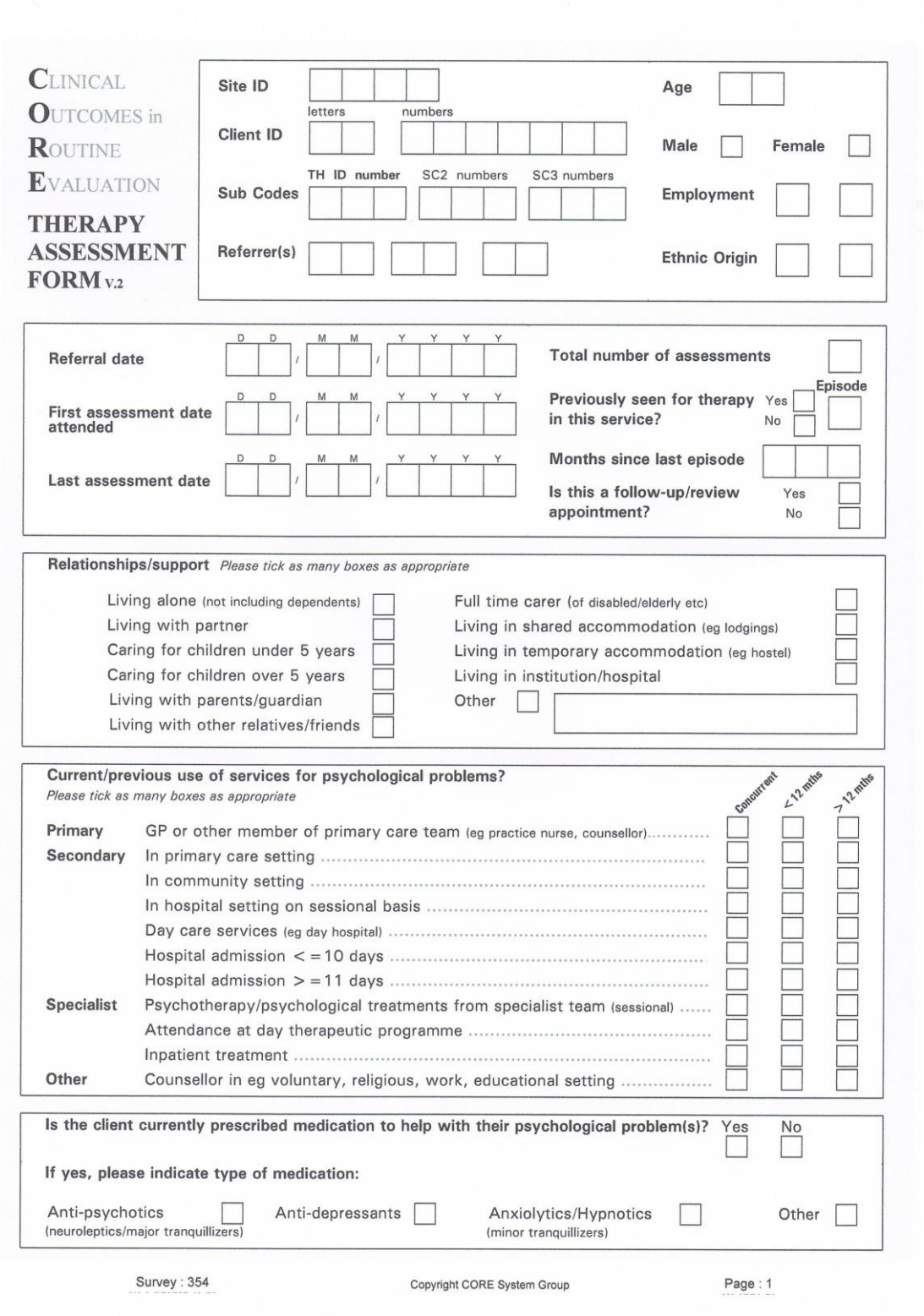
Doctor's name and address/phone number

`

Reason for attending

Outcome required/other information

Appendix Six



CLINICAL OUTCOMES in ROUTINE EVALUATION

THERAPY ASSESSMENT FORM v.2

Site ID (letters) (numbers) **Age**

Client ID **Male** **Female**

Sub Codes TH ID number SC2 numbers SC3 numbers **Employment**

Referrer(s) **Ethnic Origin**

Referral date D D / M M / Y Y Y Y **Total number of assessments**

First assessment date attended D D / M M / Y Y Y Y **Previously seen for therapy in this service?** Yes / No **Episode**

Last assessment date D D / M M / Y Y Y Y **Months since last episode**

Is this a follow-up/review appointment? Yes / No

Relationships/support *Please tick as many boxes as appropriate*

- Living alone (not including dependents)
- Living with partner
- Caring for children under 5 years
- Caring for children over 5 years
- Living with parents/guardian
- Living with other relatives/friends
- Full time carer (of disabled/elderly etc)
- Living in shared accommodation (eg lodgings)
- Living in temporary accommodation (eg hostel)
- Living in institution/hospital
- Other

Current/previous use of services for psychological problems?
Please tick as many boxes as appropriate

		Concurrent	< 12 mths	> 12 mths
Primary	GP or other member of primary care team (eg practice nurse, counsellor)			
Secondary	In primary care setting			
	In community setting			
	In hospital setting on sessional basis			
	Day care services (eg day hospital)			
	Hospital admission < = 10 days			
	Hospital admission > = 11 days			
Specialist	Psychotherapy/psychological treatments from specialist team (sessional)			
	Attendance at day therapeutic programme			
	Inpatient treatment			
Other	Counsellor in eg voluntary, religious, work, educational setting			

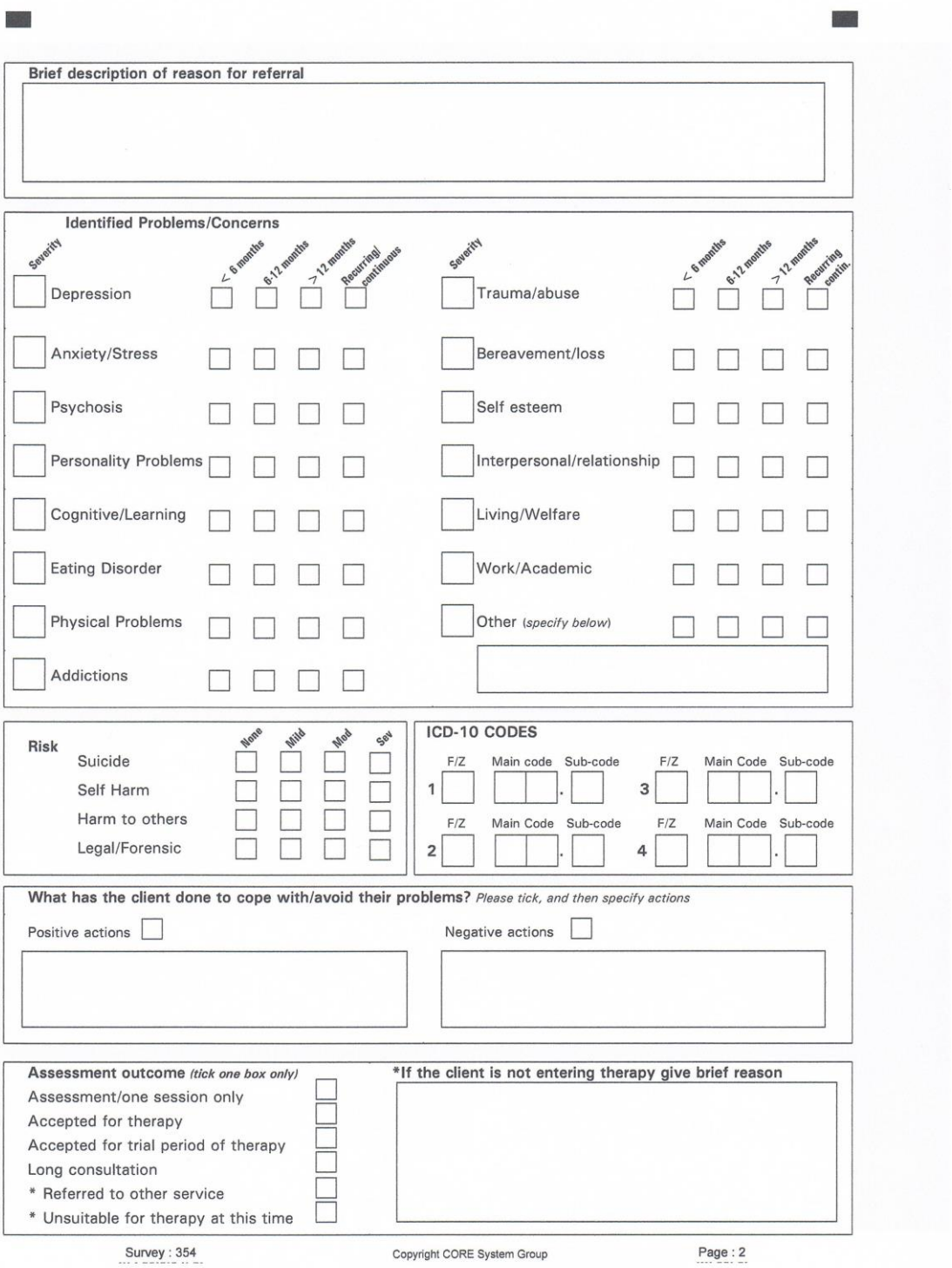
Is the client currently prescribed medication to help with their psychological problem(s)? Yes / No

If yes, please indicate type of medication:

Anti-psychotics (neuroleptics/major tranquillizers) / Anti-depressants / Anxiolytics/Hypnotics (minor tranquillizers) / Other

Survey : 354 Copyright CORE System Group Page : 1

Appendix Six Page 2



Brief description of reason for referral

Identified Problems/Concerns

Severity		< 6 months	6-12 months	> 12 months	Recurring/ continuous
☐	Depression	☐	☐	☐	☐
☐	Anxiety/Stress	☐	☐	☐	☐
☐	Psychosis	☐	☐	☐	☐
☐	Personality Problems	☐	☐	☐	☐
☐	Cognitive/Learning	☐	☐	☐	☐
☐	Eating Disorder	☐	☐	☐	☐
☐	Physical Problems	☐	☐	☐	☐
☐	Addictions	☐	☐	☐	☐

Severity		< 6 months	6-12 months	> 12 months	Recurring contin.
☐	Trauma/abuse	☐	☐	☐	☐
☐	Bereavement/loss	☐	☐	☐	☐
☐	Self esteem	☐	☐	☐	☐
☐	Interpersonal/relationship	☐	☐	☐	☐
☐	Living/Welfare	☐	☐	☐	☐
☐	Work/Academic	☐	☐	☐	☐
☐	Other *(specify below)*	☐	☐	☐	☐

Risk

	None	Mild	Mod	Sev
Suicide	☐	☐	☐	☐
Self Harm	☐	☐	☐	☐
Harm to others	☐	☐	☐	☐
Legal/Forensic	☐	☐	☐	☐

ICD-10 CODES

	F/Z	Main code	Sub-code		F/Z	Main Code	Sub-code
1	☐	☐☐ .	☐	3	☐	☐☐ .	☐
2	☐	☐☐ .	☐	4	☐	☐☐ .	☐

What has the client done to cope with/avoid their problems? *Please tick, and then specify actions*

Positive actions ☐ Negative actions ☐

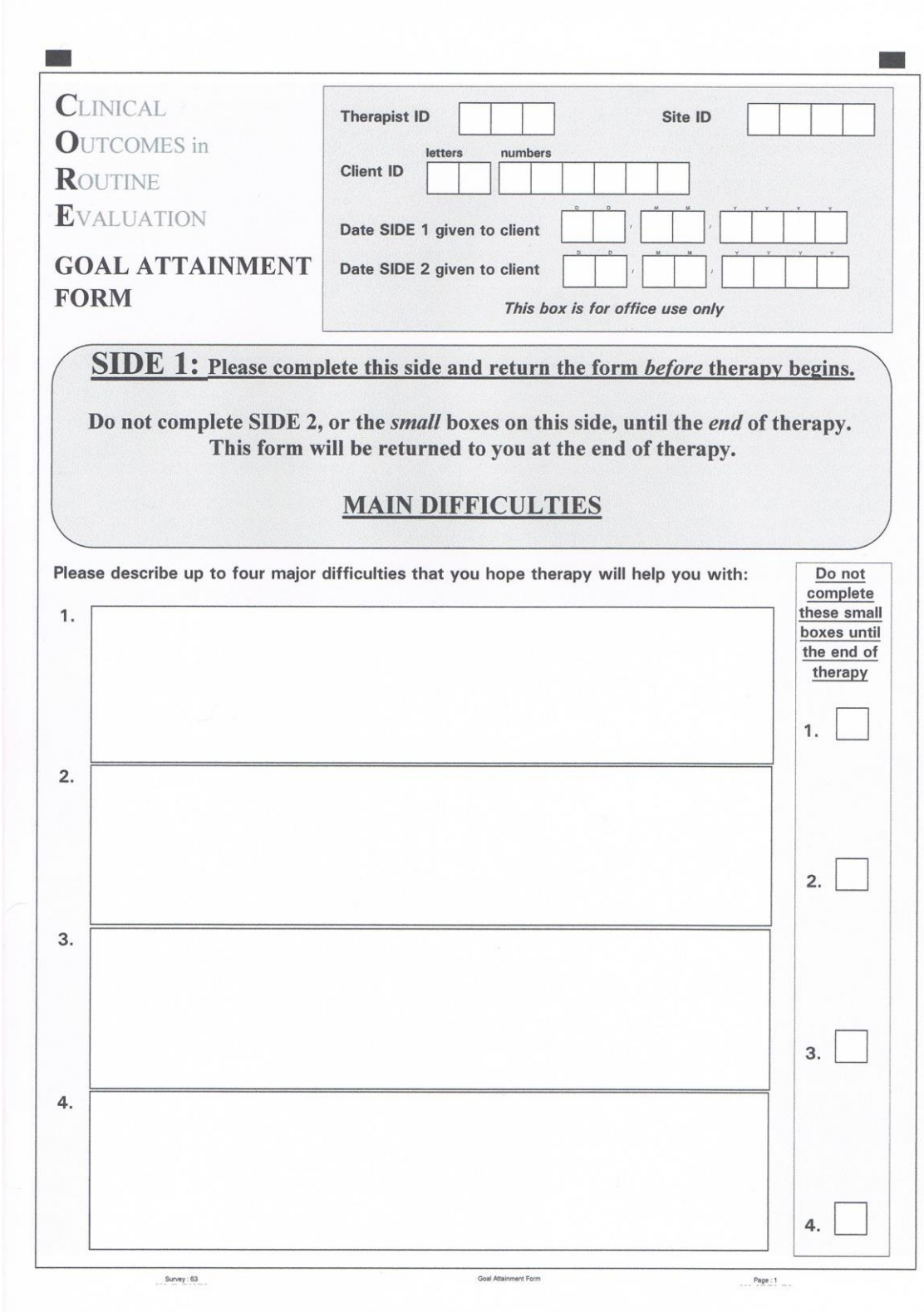
Assessment outcome *(tick one box only)*

- Assessment/one session only ☐
- Accepted for therapy ☐
- Accepted for trial period of therapy ☐
- Long consultation ☐
- * Referred to other service ☐
- * Unsuitable for therapy at this time ☐

***If the client is not entering therapy give brief reason**

Survey : 354 Copyright CORE System Group Page : 2

Appendix Seven



CLINICAL
OUTCOMES in
ROUTINE
EVALUATION

GOAL ATTAINMENT FORM

Therapist ID | Site ID

Client ID (letters | numbers)

Date SIDE 1 given to client (D D / M M / Y Y Y Y)

Date SIDE 2 given to client (D D / M M / Y Y Y Y)

This box is for office use only

SIDE 1: Please complete this side and return the form *before* therapy begins.

Do not complete SIDE 2, or the *small* boxes on this side, until the *end* of therapy. This form will be returned to you at the end of therapy.

MAIN DIFFICULTIES

Please describe up to four major difficulties that you hope therapy will help you with:

1.

2.

3.

4.

Do not complete these small boxes until the end of therapy

1. ☐

2. ☐

3. ☐

4. ☐

Survey : 63 Goal Attainment Form Page : 1

Appendix Eight

CLINICAL OUTCOMES in ROUTINE EVALUATION

CORE-10 Screening Measure

Site ID

Client ID

letters only / numbers only

Sub codes

Therapist ID / numbers only (1) / numbers only (2)

Date form given D D / M M / Y Y Y Y

Stage Completed
S Screeening
R Referral
A Assessment
F First Therapy Session
P Pre-therapy (unspecified)
D During Therapy
L Last therapy session
X Follow up 1
Y Follow up 2

Episode Stage

Gender ☐ Male ☐ Female

Age

IMPORTANT - PLEASE READ THIS FIRST

This form has 10 statements about how you have been OVER THE LAST WEEK.
Please read each statement and think how often you felt that way last week.
Then tick the box which is closest to this.
Please use a dark pen (not pencil) and tick clearly within the boxes.

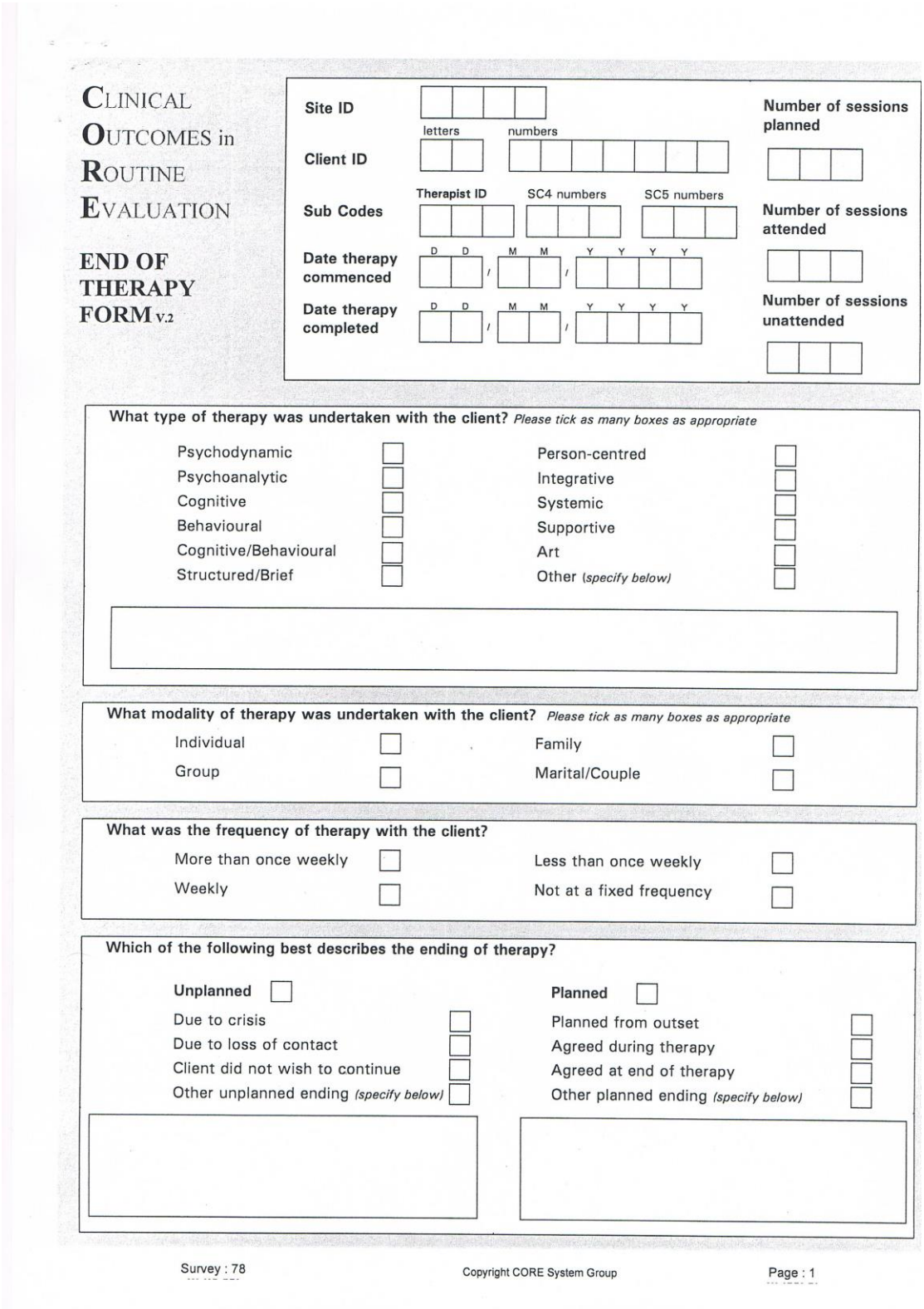
Over the last week...	Not at all	Only occasionally	Sometimes	Often	Most or all of the time
1 I have felt tense, anxious or nervous	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
2 I have felt I have someone to turn to for support when needed	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0
3 I have felt able to cope when things go wrong	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0
4 Talking to people has felt too much for me	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
5 I have felt panic or terror	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
6 I have made plans to end my life	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
7 I have had difficulty getting to sleep or staying asleep	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
8 I have felt despairing or hopeless	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
9 I have felt unhappy	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
10 Unwanted images or memories have been distressing me	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4

Total (Clinical Score*) ☐

* **Procedure:** Add together the item scores, then divide by the number of questions completed to get the mean score, then multiply by 10 to get the Clinical Score.
Quick method for the CORE-10 (if all items completed): Add together the item scores to get the Clinical Score.

Thank you for your time in completing this questionnaire

Appendix Nine



CLINICAL OUTCOMES in ROUTINE EVALUATION

END OF THERAPY FORM v.2

Site ID

Client ID (letters / numbers)

Sub Codes (Therapist ID / SC4 numbers / SC5 numbers)

Date therapy commenced (D D / M M / Y Y Y Y)

Date therapy completed (D D / M M / Y Y Y Y)

Number of sessions planned

Number of sessions attended

Number of sessions unattended

What type of therapy was undertaken with the client? *Please tick as many boxes as appropriate*

- Psychodynamic
- Psychoanalytic
- Cognitive
- Behavioural
- Cognitive/Behavioural
- Structured/Brief
- Person-centred
- Integrative
- Systemic
- Supportive
- Art
- Other *(specify below)*

What modality of therapy was undertaken with the client? *Please tick as many boxes as appropriate*

- Individual
- Group
- Family
- Marital/Couple

What was the frequency of therapy with the client?

- More than once weekly
- Weekly
- Less than once weekly
- Not at a fixed frequency

Which of the following best describes the ending of therapy?

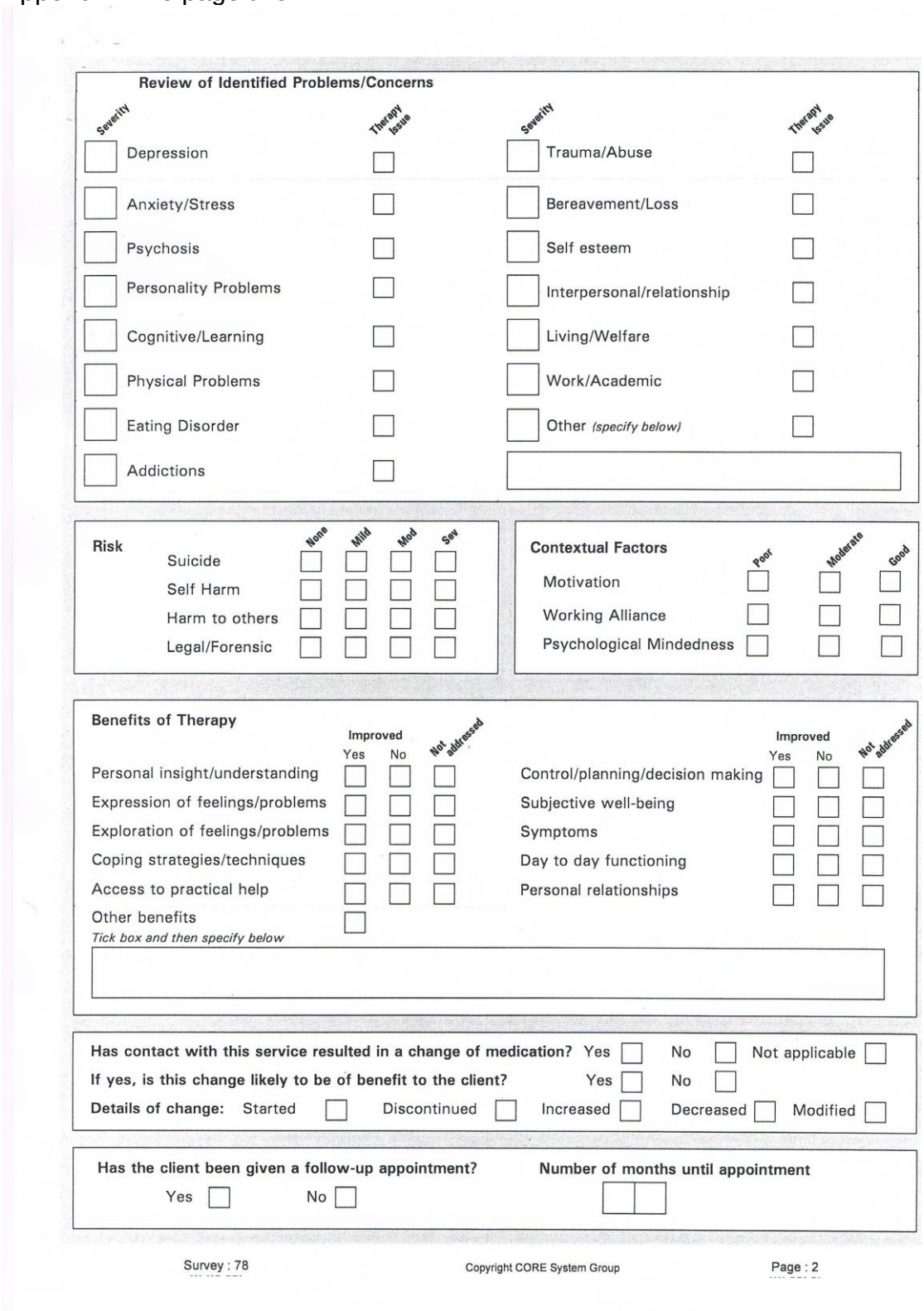
Unplanned
- Due to crisis
- Due to loss of contact
- Client did not wish to continue
- Other unplanned ending *(specify below)*

Planned
- Planned from outset
- Agreed during therapy
- Agreed at end of therapy
- Other planned ending *(specify below)*

Survey : 78

Page : 1

Appendix Nine page two



Review of Identified Problems/Concerns

Severity		Therapy Issue	Severity		Therapy Issue
☐	Depression	☐	☐	Trauma/Abuse	☐
☐	Anxiety/Stress	☐	☐	Bereavement/Loss	☐
☐	Psychosis	☐	☐	Self esteem	☐
☐	Personality Problems	☐	☐	Interpersonal/relationship	☐
☐	Cognitive/Learning	☐	☐	Living/Welfare	☐
☐	Physical Problems	☐	☐	Work/Academic	☐
☐	Eating Disorder	☐	☐	Other *(specify below)*	☐
☐	Addictions	☐			

Risk

	None	Mild	Mod	Sev
Suicide	☐	☐	☐	☐
Self Harm	☐	☐	☐	☐
Harm to others	☐	☐	☐	☐
Legal/Forensic	☐	☐	☐	☐

Contextual Factors

	Poor	Moderate	Good
Motivation	☐	☐	☐
Working Alliance	☐	☐	☐
Psychological Mindedness	☐	☐	☐

Benefits of Therapy

	Improved Yes	Improved No	Not addressed
Personal insight/understanding	☐	☐	☐
Expression of feelings/problems	☐	☐	☐
Exploration of feelings/problems	☐	☐	☐
Coping strategies/techniques	☐	☐	☐
Access to practical help	☐	☐	☐
Other benefits	☐		

Tick box and then specify below

	Improved Yes	Improved No	Not addressed
Control/planning/decision making	☐	☐	☐
Subjective well-being	☐	☐	☐
Symptoms	☐	☐	☐
Day to day functioning	☐	☐	☐
Personal relationships	☐	☐	☐

Has contact with this service resulted in a change of medication? Yes ☐ No ☐ Not applicable ☐

If yes, is this change likely to be of benefit to the client? Yes ☐ No ☐

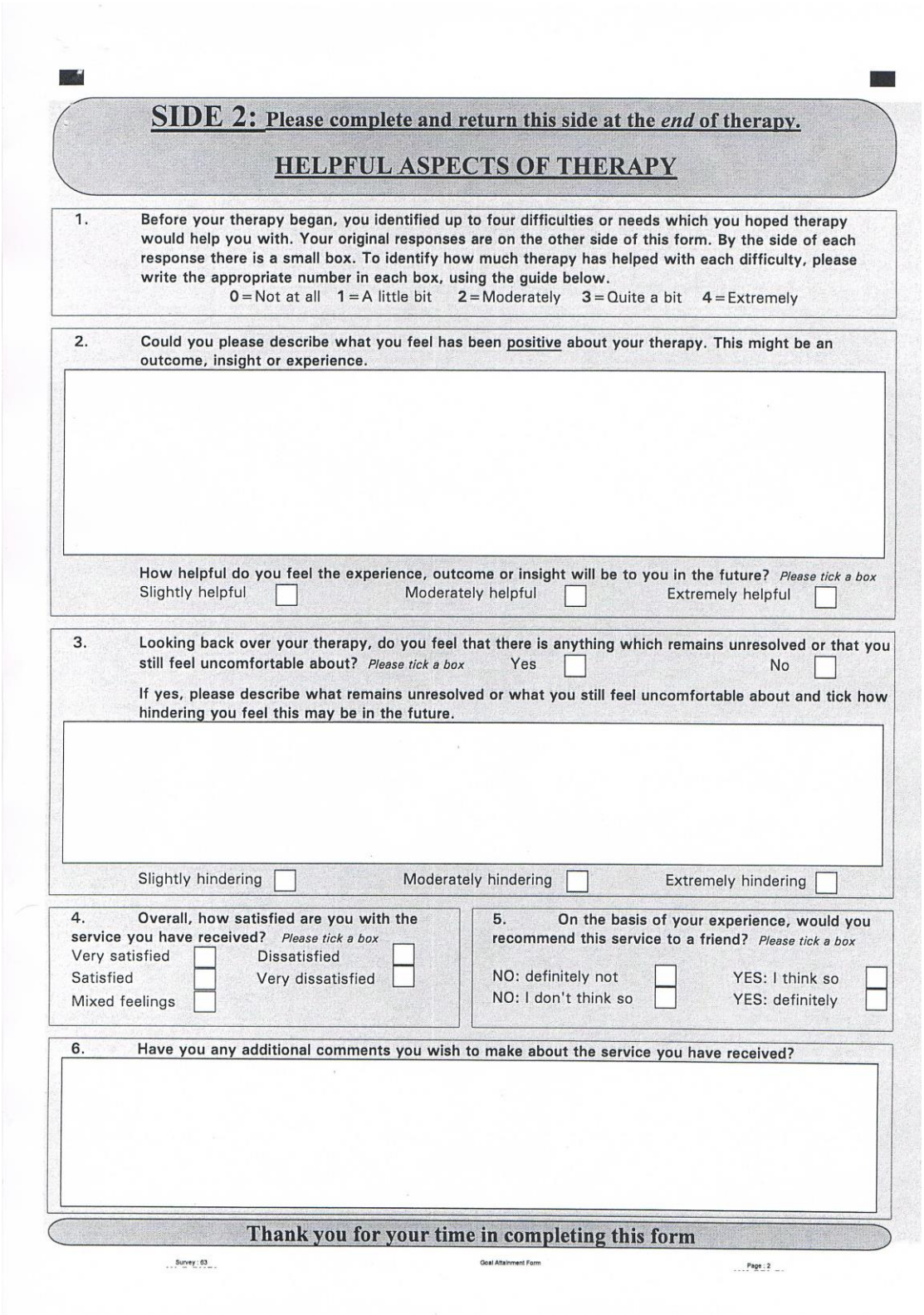
Details of change: Started ☐ Discontinued ☐ Increased ☐ Decreased ☐ Modified ☐

Has the client been given a follow-up appointment? Yes ☐ No ☐

Number of months until appointment ☐☐

Survey : 78 Copyright CORE System Group Page : 2

Appendix Ten



SIDE 2: Please complete and return this side at the *end* of therapy.

HELPFUL ASPECTS OF THERAPY

1. Before your therapy began, you identified up to four difficulties or needs which you hoped therapy would help you with. Your original responses are on the other side of this form. By the side of each response there is a small box. To identify how much therapy has helped with each difficulty, please write the appropriate number in each box, using the guide below.

0 = Not at all **1** = A little bit **2** = Moderately **3** = Quite a bit **4** = Extremely

2. Could you please describe what you feel has been positive about your therapy. This might be an outcome, insight or experience.

How helpful do you feel the experience, outcome or insight will be to you in the future? *Please tick a box*

Slightly helpful ☐ Moderately helpful ☐ Extremely helpful ☐

3. Looking back over your therapy, do you feel that there is anything which remains unresolved or that you still feel uncomfortable about? *Please tick a box* Yes ☐ No ☐

If yes, please describe what remains unresolved or what you still feel uncomfortable about and tick how hindering you feel this may be in the future.

Slightly hindering ☐ Moderately hindering ☐ Extremely hindering ☐

4. Overall, how satisfied are you with the service you have received? *Please tick a box*

Very satisfied ☐ Dissatisfied ☐
Satisfied ☐ Very dissatisfied ☐
Mixed feelings ☐

5. On the basis of your experience, would you recommend this service to a friend? *Please tick a box*

NO: definitely not ☐ YES: I think so ☐
NO: I don't think so ☐ YES: definitely ☐

6. Have you any additional comments you wish to make about the service you have received?

Thank you for your time in completing this form

Survey : 63 Goal Attainment Form Page : 2

Appendix Eleven

Paper Chart for CORE Outcome Measure Scores

Note: This form is for the personal use of the practitioner with the patient and is to be retained in the notes.

Average Score x 10

40
35
30
25
20
15
10
5
0

Severe
Moderate Severe
Moderate
Mild
Low Level
Healthy

Date
Clinician
CORE Q
Treatments

Patient
Practitioner

WW - Watchful Waiting
SP - Supportive Sessions (eg as given by a GP)
EX - Exercise
BB - Bibliotherapy
GSH - Guided Self Help
CCBT - Computerised Cognitive Behavioural Therapy
CBT - Cognitive Behavioural Therapy
CL - Counselling
MED - Medication
REF - Referral
OTH - Other

Overall Cut-off

Risk Cut-off

core

Appendix Twelve

Age	Gender	Assessmt Form Completed	Goal Attain Side 1	Screening 10 Form Completed	If so, how many	End of Therapy Form	Goal Attain Side 2	Client ID No
47	F	Yes	No	No	N/a	No	No	1
31	F	Yes	Yes	Yes	4 of 4	No	No	2
54	F	Yes	No	Yes	6 of 34	Yes	Yes	3
25	F	Yes	No	Yes	5 of 34	Yes	Yes	4
23	F	Yes	Yes	Yes	9 of 9	No	No	5
35	M	Yes	Yes	Yes	35 of 35	Yes	Yes	6
31	F	Yes	Yes	Yes	17 of 17	Yes	Yes	7
58	F	Yes	Yes	Yes	12 of 12	Yes	Yes	8
26	M	No	No	Yes	12 of 12	Yes	Yes	9
30	F	Yes	Yes	Yes	24 of 24	Yes	Yes	10
26	M	Yes	Yes	No	N/a	No	No	11
35	F	Yes	Yes	Yes	26 of 26	Yes	Yes	12
33	M	Yes	Yes	Yes	26 of 26	Yes	Yes	13
27	F	Yes	Yes	Yes	9 of 9	No	No	14

Highlighted Data is the information that is used in the research
Matrix of data completed 22/10/12

Appendix Thirteen

Age	Gender	Assessmt Form Completed	Goal Attain Side 1	Screening 10 Form Completed	If so, how many	End of Therapy Form	Goal Attain Side 2	Client ID No
30	M	Yes	Yes	Yes	9 of 9	No	No	2/1
29	M	Yes	Yes	Yes	18 of 18	Yes	Yes	2/2
24	F	Yes	Yes	Yes	21 of 21	Yes	Yes	2/3
26	F	Yes	Yes	Yes	5 of 5	No	No	2/4
29	F	Yes	Yes	Yes	11 of 11	No	No	2/5
22	F	Yes	Yes	Yes	5 of 5	No	No	2/6
30	F	Yes	Yes	Yes	13 of 13	Yes	Yes	2/7
48	F	Yes	Yes	Yes	15 of 15	No	No	2/8
22	F	Yes	Yes	Yes	8 of 8	Yes	Yes	2/9
58	F	Yes	Yes	Yes	25 of 25	Yes	Yes	2/10
16	F	Yes	Yes	Yes	6 of 6	No	No	2/11
32	F	Yes	Yes	Yes	19 of 19	Yes	Yes	2/12

Highlighted data is the information used in the research
Matrix of data completed 13/10/13

Appendix Fourteen
LCTC Document 1 (Side 2)
Transcript of responses to question 2, Helpful Aspects of Therapy

'*Could you please describe what you feel has been positive about your therapy. This might be an outcome, insight or experience'.*

6

Helped to realise that I am important, that not everything is my fault & can cope better.
Self worth & self-confidence improved, self esteem has improved.
Learnt a lot, improved knowledge & understanding of myself.

7

Although I've found it difficult, this has been a very positive and powerful experience for me. I'm more aware of my feelings, where they come from & why I behave in certain ways. I've started to make changes to how I think, & to my relationships with family, friends and partner. The best thing for me is that I don't feel guilty or ashamed of who I am anymore. 6 months ago I believed I was a bad person- now I know that I am not. You can't imagine what a relief that is.

8

I am more positive about relationships with other people. I challenge myself more and act on new thoughts and behaviours.

10

- Rediscovering myself and giving time for me to explore my own interests
- Being able to let go of past painful experiences and not carry them around with me.
- Recognising feelings/emotions and experiencing them at the time.

12

Can accept I won't always get it right but I'm still ok.
Coping mechanisms if I get anxious.
Better relationships with family.
Feel better about myself – don't have to be perfect.
Laughing again. Able to talk to customers more easily.

13

"get into my head" less. Began to relax – my face doesn't feel frozen. I can relax. Learnt a lot about TA that I can use later. More honest with

my Mum and brother. I can look at me – don't have to big everything up. Presented 'me' at an interview and got the job. Understand impact of my family – alcohol & violence.

Struggled to talk about feelings – but better at this.

2/2

It has given me structure - turning up at the same time every week & checking in with the same issues. I have more of a grasp on what I need to do to ensure my own recovery is kept on track. It has been a nice accompaniment to the 12 step programme I attend.

2/3

Relationship with mum has improved massively I've really enjoyed learning about different theories and it makes it easier to understand my actions and how to change/influence situations.

2/7

Adult self (has helped quite a bit) Only really licked it towards the end of therapy, however now I am feeling the benefits of a more 'rational' voice.
Self esteem – still lots of self doubts, but feel more grounded in thye knowledge that these things take time. Trying to think rationally/positively (has helped quite a bit)
Self image – still work in progress but feel I have drawn a line under surgery (has helped quite a bit)

2/9

Being more positive about life
Helped me deal with anger
Helped me come to terms with my past

2/10

It has been interesting to see how childhood experiences have influenced my choices and my decisions as a young adult and later.
I've been encouraged to be less hard on myself for "not doing the right thing" as I see it.

2/12

Having a space where I can sit back and reflect on what's going on with my studies, work and social life – an open ear and being able to develop a different perspective on the things that happen in my dad's life – being able to look at my patterns and distinguish between what's helpful & what's rather in the way.

Appendix Fifteen
LCTC Document 2 (part 2)
Transcript of client's responses to question 3 of Helpful Aspects of Therapy 'If yes, please describe what remains unresolved or what you still feel uncomfortable'

6

Yes, it just feels that this has just been an introduction to changes, want long-term therapy. (Social anxiety)

7.

I have made a good start & taken some big steps, but generally I feel I have a long way to go. These have improved but still ongoing: anxiety & abandonment issues; - assertiveness & self confidence – self esteem; relationships with family and partner.
I haven't really addressed yet:- relationships with friends, social anxiety & paranoia; some traumatic experiences.

8

(Left blank as no unresolved issues)

10

Feelings of anger towards parents that began to be explored but then left due to coming to an end of therapy.

12

I am thinking about starting a family and I have concerns about how I might affect my child – will come to therapy to talk through my worries.

13

Developing intimate relationships – why don't I want to build a partnership – started to open the lid but not ready yet.

2/2

I suppose I never know what will emerge when I'm not expecting it, but I like to think I have good insight into the nature of my difficulties & how to live in the solution.

2/3

I think my relationship with my mum has come a long way and I feel that therapy has provided me with the right tools to deal with situations. If I put my learning into practice I think I can avoid a repeat.
2/7

Feel like I am being launched into a new phase so nervous about what may swing me back into the old state. Still have lots of self doubts, but hoping therapy combined with medication will be helpful.

2/9

(Left blank as no unresolved issues)

2/10

Ageing
Issues with mother but so not impact on my life to a great extent.
Self esteem has increased but could go higher which can have a knock on effect in social situations.

2/12

Slight fear of relapsing – could things go really wrong so I find myself in a really bad place without lapsing how to get out of that? But generally I'm positive and being able to manage bad days & lows – just by letting them pass and waiting for things to look up again

Appendix Sixteen
LCTC Document 3 (part 2)
Transcript of clients response to Helpful Aspects of Therapy form Question 6, 'Have you any additional comments you wish to make about the service you have received?'

6

Really enjoyed it

7

I've been really happy with the service, very good value & I've felt comfortable coming here – everyone has been nice and approachable. Nice atmosphere too.
M (name of therapist) has been great – I've really benefited from our relationship & being able to trust and open up to her. I felt she understood my problems v well & more importantly that she really cared.

8
Very pleased with the experience.

10

I am very appreciative of the low cost therapy as without it I would never have been able to afford such extensive therapy.
Finally, M2 (therapist's name) is a wonderful therapist and person!

12

I can't believe how I can now step back and stop myself putting myself down. I can handle set backs better. I like myself and take steps to look after myself. I rescue less often. I feel relaxed for the 1st time in years. Thank you

13

It's been hard for me to say how I feel – but I know what we did was important to me. I am in 12 step – but will come back at some stage to do more personal therapy. I could be myself and felt ok – some laughs – sometimes felt stuck but T (therapist's name) didn't give in.
Thanks.

2/2

I am happy that I was placed with someone with a good understanding of my type of problems. The fact he could relate meant I didn't have to try too hard having him understand me.

2/3

I have found therapy very rewarding. I have loved learning about the theory and felt that this has helped my understanding of myself the most. I always felt comfortable when I got emotional and felt there was compassion.

2/7

I did feel quite abruptly dropped by my first therapist (prior to W (name of therapist)) which resulted in a difficult couple of months of 'script backlash' as she referred to it as. Not sure whether Institute is aware of this. Otherwise great experience with W (name of therapist)

2/9

C (name of therapist) is such a cool therapist!

2/10

My therapist was encouraging, empathetic and showed understanding into my experiences.

2/12

Aware of behaviours when happening – in the moment.
The rush to fix everything is now measured.
Already recommended the service!

Appendix Seventeen
LCTC Document 1 (Side 2) Highlighted to look for themes/eliminate duplicate statements

'*Could you please describe what you feel has been positive about your therapy. This might be an outcome, insight or experience'.*

6

Helped to realise that I am important, that not everything is my fault & can cope better.
Self worth & self-confidence improved, self esteem has improved.
Learnt a lot, improved knowledge & understanding of myself.

7

Although I've found it difficult, this has been a very positive and powerful experience for me. I'm more aware of my feelings, where they come from & why I behave in certain ways. I've started to make changes to how I think, & to my relationships with family, friends and partner. The best thing for me is that I don't feel guilty or ashamed of who I am anymore. 6 months ago I believed I was a bad person- now I know that I am not. You can't imagine what a relief that is.

8

I am more positive about relationships with other people. I challenge myself more and act on new thoughts and behaviours.

10

- Rediscovering myself and giving time for me to explore my own interests
- Being able to let go of past painful experiences and not carry them around with me.
- Recognising feelings/emotions and experiencing them at the time.

12

Can accept I won't always get it right but I'm still ok.
Coping mechanisms if I get anxious.
Better relationships with family.
Feel better about myself – don't have to be perfect.
Laughing again. Able to talk to customers more easily.

13

"get into my head" less. Began to relax – my face doesn't feel frozen. I can relax. Learnt a lot about TA that I can use later. More honest with my Mum and brother. I can look at me – don't have to big everything up. Presented 'me' at an interview and got the job. Understand impact of my family – alcohol & violence.

Struggled to talk about feelings – but better at this.

2/2

It has given me structure - turning up at the same time every week & checking in with the same issues. I have more of a grasp on what I need to do to ensure my own recovery is kept on track. It has been a nice accompaniment to the 12 step programme I attend.

2/3

Relationship with mum has improved massively I've really enjoyed learning about different theories and it makes it easier to understand my actions and how to change/influence situations.

2/7

Adult self (has helped quite a bit) Only really licked it towards the end of therapy, however now I am feeling the benefits of a more 'rational' voice.
Self esteem – still lots of self doubts, but feel more grounded in the knowledge that these things take time. Trying to think rationally/positively (has helped quite a bit)
Self image – still work in progress but feel I have drawn a line under surgery (has helped quite a bit)

2/9

Being more positive about life
Helped me deal with anger
Helped me come to terms with my past

2/10

It has been interesting to see how childhood experiences have influenced my choices and my decisions as a young adult and later.
I've been encouraged to be less hard on myself for "not doing the right thing" as I see it.

2/12

Having a space where I can sit back and reflect on what's going on with my studies, work and social life – an open ear and being able to develop a different perspective on the things that happen in my dad's life – being able to look at my patterns and distinguish between what's helpful & what's rather in the way.

Appendix Eighteen
LCTC Document 2 (part 2) Highlighted to show themes/duplicated answer

'If yes, please describe what remains unresolved or what you still feel uncomfortable'

6

Yes, it just feels that this has just been an introduction to changes, want long-term therapy. (Social anxiety)

7.

I have made a good start & taken some big steps, but generally I feel I have a long way to go. These have improved but still ongoing: anxiety & abandonment issues; - assertiveness & self confidence – self esteem; relationships with family and partner.
I haven't really addressed yet:- relationships with friends, social anxiety & paranoia; some traumatic experiences.

8

(Left blank as no unresolved issues)

10

Feelings of anger towards parents that began to be explored but then left due to coming to an end of therapy.

12

I am thinking about starting a family and I have concerns about how I might affect my child – will come to therapy to talk through my worries.

13

Developing intimate relationships – why don't I want to build a partnership – started to open the lid but not ready yet.

2/2

I suppose I never know what will emerge when I'm not expecting it, but I like to think I have good insight into the nature of my difficulties & how to live in the solution.

2/3

I think my relationship with my mum has come a long way and I feel that therapy has provided me with the right tools to deal with situations. If I put my learning into practice I think I can avoid a repeat.

2/7

Feel like I am being launched into a new phase so nervous about what may swing me back into the old state. Still have lots of self doubts, but hoping therapy combined with medication will be helpful.

2/9

(Left blank as no unresolved issues)

2/10

Ageing
Issues with mother but so not impact on my life to a great extent.
Self esteem has increased but could go higher which can have a knock on effect in social situations.

2/12

Slight fear of relapsing – could things go really wrong so I find myself in a really bad place without lapsing how to get out of that? But generally I'm positive and being able to manage bad days & lows – just by letting them pass and waiting for things to look up again

Appendix Nineteen
LCTC Document 3 (part 2) Highlighted to show themes/ duplicate responses

'Have you any additional comments you wish to make about the service you have received?'

6

Really enjoyed it

7

I've been really happy with the service, very good value & I've felt comfortable coming here – everyone has been nice and approachable. Nice atmosphere too.
M (name of therapist) has been great – I've really benefited from our relationship & being able to trust and open up to her. I felt she understood my problems v well & more importantly that she really cared.

8
Very pleased with the experience.

10

I am very appreciative of the low cost therapy as without it I would never have been able to afford such extensive therapy.
Finally, M2 (therapist's name) is a wonderful therapist and person!

12

I can't believe how I can now step back and stop myself putting myself down. I can handle set backs better. I like myself and take steps to look after myself. I rescue less often. I feel relaxed for the 1st time in years.
Thank you

13

It's been hard for me to say how I feel – but I know what we did was important to me. I am in 12 step – but will come back at some stage to do more personal therapy. I could be myself and felt ok – some laughs – sometimes felt stuck but T (therapist's name) didn't give in.
Thanks.

2/2

I am happy that I was placed with someone with a good understanding of my type of problems. The fact he could relate meant I didn't have to try too hard having him understand me.

2/3

I have found therapy very rewarding. I have loved learning about the theory and felt that this has helped my understanding of myself the most. I always felt comfortable when I got emotional and felt there was compassion.

2/7

I did feel quite abruptly dropped by my first therapist (prior to W (name of therapist)) which resulted in a difficult couple of months of 'script backlash' as she referred to it as. Not sure whether Institute is aware of this. Otherwise great experience with W (name of therapist)

2/9

C (name of therapist) is such a cool therapist!

2/10

My therapist was encouraging, empathetic and showed understanding into my experiences.

2/12

Aware of behaviours when happening – in the moment.
The rush to fix everything is now measured.
Already recommended the service!

Appendix Twenty

Preliminary outline of the exhaustive statement, Q2 in response to, ‘could you please describe what you feel has been positive about your therapy. This might be an outcome, insight or experience’.

Themes are in no particular order of importance I am putting onto the statements – in the order of the previous Appendix 14

****

Statements about my cognitive recognitions

not everything is my fault
how childhood experiences have influenced my choices
able to develop a different perspective on things that happens in my dad’s life
I don’t feel guilty or ashamed
I won’t always get it right
Don’t have to be perfect
Don’t have to big everything up
Understand impact of my family
Helped me come to terms with my past
Be less hard on myself

****

Statements about my core self and beliefs

Self worth & self-confidence improved, self esteem has improved
now I know that I am not a bad person
Feel better about myself
I am important

****

Learning from therapy

Understanding of myself
Where (my feelings come from and why I behave in certain ways
Learnt a lot about TA
Enjoyed learning about different theories
Learnt a lot, improved knowledge

****

How relationships have changed due to therapy

More positive about relationships with other people
Changes to relationships with family, friends and partner
I am positive about relationships with other people
Better relationships with family
Able to talk to customers more easily
More honest with my mum and brother
Relationship with mum has improved massively

****

What did you notice that was different about being in therapy

I've found it difficult
Giving me time to explore my own interests
It has given me structure

****

What differences do you notice about how you have changed since being in therapy

I'm more aware of my feelings
I've started to make changes to how I think
Can cope better
I challenge myself more
Act on new thoughts and behaviours
Recognising feelings/emotions
Experiencing them at the time
My face doesn't feel frozen
I have more of a grasp of what I need to do
Easier to understand my actions and how to change/influence situations
Trying to think rationally and positively
Being more positive about life
Helped me deal with anger

Appendix Twenty One

Preliminary outline of the exhaustive statement 2, Q3 in response to, ‘If yes, what remains unresolved or what do you feel uncomfortable about’.

Themes are in no particular order of importance I am putting onto the statements – in the order of the previous Appendix 15

****

Statements about ability to work through issues within time frame

Just been an introduction to changes, want long term therapy
I feel I have a long way to go
Still ongoing
I haven’t really addressed yet
Began to be explored but then left due to coming to an end of therapy
Could go higher

****

Statements about positives

Taken some big steps
Have improved
Good insight into the nature of my difficulties
How to live in the solution
Come a long way
Right tools to deal with situations
Launched into a new phase
Not impact on my life to a great extent
Self esteem has increased
I’m positive
Able to manage bad days and lows
I think I can avoid a repeat

****

Other reason work was not completed

Started to open the lid but not ready yet

****

Fears of the future

I have concerns how I may affect my child
I never know what will emerge
Nervous about what may swing me back into the old state
Slight fear of relapsing

****

Appendix Twenty Two

Preliminary outline of the exhaustive statement 3 in response to, ‘Have you any additional comments about the service you have received?’

Themes are in no particular order of importance I am putting onto the statements – in the order of the previous Appendix 16

****

Statements about the experience of being in therapy at the LCTC

Really enjoyed it
Really happy/very pleased with the service
Very appreciative of the low cost therapy
Found therapy very rewarding
I have loved learning (theory)
Has helped my understanding (theory)
Some laughs
I didn’t have to try too hard (to be understood)

****

Statements about their therapist

Has been great
Able to trust and open up to her
Understood my problems
More importantly she really cared
A wonderful therapist and person
She didn’t give in
He could relate
Abruptly dropped by first therapist
Great experience with therapist
Cool therapist!
Encouraging, empathetic
Understanding into my experiences
Comfortable when emotional
There was compassion

****

Statements regarding The Manchester Institute for Psychotherapy

Comfortable
Everyone has been nice
Approachable
Nice atmosphere

Not sure if the institute is aware of this

****

Statements regarding the fee that the clients pay

Very good value
Never would have been able to afford such extensive therapy

****

karenfburke@hotmail.co.uk

www.karenfburke.co.uk