Exploring experiences of power in therapeutic relationships between NHS service users and Clinical Psychologists

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This thesis is dedicated to the wonderful people who have been kind enough to share parts of their story with me. Their stories and insights have changed how I think and practice as a clinician and I hope that this thesis will help others think about power and enable better conversations about how power impacts us all.

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Thesis Portfolio Abstract

Exploring experiences of power in therapeutic relationships between NHS service users and Clinical Psychologists

Oliver Farrar

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Background: A positive therapeutic relationship is often cited as the most stable predictor of outcomes in psychotherapy (Horvath, Del Re, Flückinger & Symonds, 2011). However, this is poorly understood from the perspective of the service user. Power is theorised to be an important factor in therapeutic relationships for service users but there is no current empirical research investigating this from a service user perspective.

Aims: This portfolio aims to identify and synthesise the current literature on factors that impact NHS services users' experiences of the therapeutic relationship and undertake novel empirical research into how NHS service users experience of power in therapeutic relationships with Clinical Psychologists.

Methodology: A systematic review was conducted, and from this thematic synthesis investigated factors that impact NHS service users experience of therapeutic relationships. Further, an Interpretative Phenomenological Analysis was undertaken to explore NHS service users' experiences of power in therapeutic relationships with Clinical Psychologists.

Results: Four themes relating to NHS service users' experiences in therapeutic relationships were developed in the systemic review. In the empirical paper, one superordinate theme emerged *'the dynamic tapestry of power',* constructed by three subsidiary themes. These spoke to the different experiences of disempowerment prior to therapy, balancing of power in the relationship and pivotal therapeutic moments or ruptures.

Conclusion: The results demonstrated that that power operates on a number of complex levels within the therapeutic relationship in ways that may not be attended to by clinicians. It also showed how power can be used positively and the benefits of power being made more visible so that it can be attended to by clinicians, service users, and policymakers. Implications and future research options are discussed.

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Chapter 1: Portfolio introduction

This chapter introduces and outlines the portfolio as well as providing the operational definitions used. An overview of the context examined, information on the author and their epistemological and ontological position is also provided.

Aims and outline of the portfolio

This portfolio aims to explore empirically the experience of power in therapeutic relationships between NHS service users and Clinical Psychologists. The experiences of service users are vital to this and are often missed in the current literature which is why at each stage of this portfolio attention is paid exclusively to service user voices. Hearing these voices and developing understanding around experiences of power in therapeutic relationships in the context of the NHS will allow the chance for complex power operations to be better understood and for conversations and action to be taken at the individual, organisational and societal level.

The therapeutic relationship is often cited as the most stable predictor of positive outcomes in psychotherapy (Norcross, 2001 & 2002; Horvath, De Re, Flückinger & Symonds, 2011) and as such better understanding the factors that contribute to it is important. A systematic review looking at factors impacting NHS services users' experiences of the therapeutic relationship is offered. This draws on the knowledge and experience of NHS service users through extracting first order (direct quotes) and second order data (author interpretations) from qualitative empirical papers looking at the experiences of NHS service users engaged in individual psychotherapy. Four themes emerged in this review which point to a number of important factors that impact the therapeutic relationship for NHS service users.

A bridging chapter then provides a more detailed account of some of the theoretical conceptualisations of power. An exhaustive summary of all this literature goes beyond the scope of this portfolio so this chapter focuses on perspectives pertinent to therapeutic relationships and the NHS. This chapter provides important context and rationale that cannot be covered within the limits of the empirical paper.

The question of how NHS service users experience power in the therapeutic relationship with Clinical Psychologists is addressed in the empirical paper. From interviews with service users and using qualitative methodology an interpretive phenomenological analysis developed one superordinate theme that described the experience of power for NHS service users in therapeutic relationships with Clinical Psychologists.

This is then followed by a chapter with further information regarding the methodological approach. The final chapter presents an overall discussion and critique of the whole portfolio.

Definitions

Power

Power, as discussed in greater detail in forthcoming chapters, is conceptualised and written about from a variety of political, social, philosophical, psychological and economic perspectives and as such no unified definition of power is agreed on. Therefore, a broad operational definition will be used to allow for multiple theoretical approaches to be included. This is based on Rollo May's (1998) perspective of power being the ability of individual or groups to cause or prevent change. To ensure the incorporation of all potential theories of power the operational definition will be extended to power being:

> *A dynamic range of structural and relational factors that provide individuals or groups with the ability to cause or prevent change, at the individual, social and ideological level.*

Therapeutic relationship

Like power there are number of definitions offered for the therapeutic relationship between therapist and service user. This thesis will use the operational definition suggested by Gelso and Carter (1985) as the ‘feelings and attitudes that counselling participants have towards one another, and the manner in which they are expressed’ (p. 159). This definition is general but concise, reasonably consensual, and theoretically neutral (Norcoss, 2010). Therapeutic relationship is often used interchangeably with therapeutic alliance or working alliance/relationship, but it is important to note that some authors see the alliance more in terms of overt agreement on goals, tasks, and bond (Kazantzis, Dattilio, & Dobson, 2017). For the purpose of this paper these terms will be used interchangeably to incorporate as many theoretical perspectives as possible.

Wider context

This portfolio is looking at a specific experience, that of power in therapeutic relationships, and experience always takes place within a certain context. This portfolio will look specifically at the NHS context. This is because structural power operations often depend on the economic, political and societal context they are bound in. The NHS as the largest provider of mental health services makes this an important area to examine in terms of number of people it may impact and potential outcomes for policy and practice. When exploring experiences, qualitative methods require some degree of homogeneity to draw comparisons and deviations and as such this portfolio will focus on therapeutic relationships that are developed in secondary community mental health services (the most utilised mental health sector) and with Clinical Psychologists (one of the largest groups of qualified therapy providers in the NHS).

It is also important to note that this portfolio was developed during the COVID-19 pandemic, a time of enormous change and pressure for services, with rapid changes to practice that previously have not been seen in the NHS. The implications of this will be discussed.

The lead author's privilege and position

The lead author and primary analyst is Oliver Farrar, a thirty seven year old, white, cisgender, male, able bodied, middle-classed, well educated, Trainee Clinical Psychologist. He is employed by the NHS, but not by the trust in which participants were recruited, though he has worked in the host trust as part of his clinical placements and prior to training. His experience of oppression and structural power operations are considerably less than many people accessing mental health services. Throughout every stage of this research his privilege, and by extension his power, was considered and the impact this may have on the research. Even with significant efforts made to address the potential impacts of his power and privilege on the research it is impossible to fully separate his lens and his previous experiences. This is reflected on throughout as well as potentially offering insights on something the research aims to address, that is how power is understood by clinicians and researchers. He encourages the reader to keep the above in mind when reviewing this portfolio.

The questions asked in this portfolio will be answered using a qualitative methodology as they are concerned with experience and meaning making. The questions and the epistemological and ontological position of the author are underpinned by philosophy of subtle relativism and social constructivism. This is discussed in greater detail in future chapters.

Chapter 2: Systematic review

Factors that impact on NHS service users’ experience of the therapeutic relationship: A systematic review of service users’ perspectives

Oliver Farrar, Dr Corinna Hackmann, Dr Hannah Zeilig, Dr Gillian Bowden MBE, and Dr Fergus Gracey

Word count: 7534

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Prepared for: Psychology and Psychotherapy: Theory, Research and Practice (see appendix Q for submission guidance)

This review has not yet been registered.

Abstract

Background: A positive therapeutic relationship is often cited as the most stable predictor of outcome in psychotherapy (Norcross, 2001 & 2002). Whilst there is substantial literature around this, little comes directly from service users within specific services, like the NHS. This review asks what factors impact NHS service users' experiences of the therapeutic relationship.

Methods: The literature of adult NHS mental health service users in therapeutic relationships was systematically reviewed. Thematic synthesis (Thomas & Harden, 2008) then brought together the findings from papers focusing on service users without cognitive impairments and outside of hospital settings who received individual psychotherapy.

Results: 4585 papers were identified, and following screening and 14 papers were included, summarised, and their quality assessed**.** Thematic synthesis allowed four superordinate themes to emerge: 'tensions prior to therapy', 'relieving the tension and feeling comfortable enough to talk', 'feeling understood and developing understanding' and 'therapist actions'.

Discussion: This review provided the first synthesis of service users experiences of the therapeutic relationship in this context. The importance of the therapeutic relationship for NHS service users was noted and factors that impact on this are provided. Furthermore, factors that may impact the therapeutic relationship prior to therapy are discussed, which have been less well represented in the literature have also been highlighted as well as indications of the importance of 'direction' and 'flexibility' from the therapist. Suggestions for improvement in the quality of the literature base have also been suggested.

Background

A positive therapeutic relationship has consistently been shown to be the most stable predictor of positive therapy outcomes (Norcross, 2001 & 2002; Horvath, De Re, Flückinger & Symonds, 2011), and as such has gained significant empirical attention (Norcross, 2010). There is conceptual and empirical divergence on the most important factors that contribute to its development, and authors suggest that more research is needed into how the therapeutic relationship develops in different contexts (Norcross & Lambert, 2018) with more evidence needed from qualitative data sources.

An operational definition of the therapeutic relationship has been suggested by Gelso and Carter (1985) as the 'feelings and attitudes that counselling participants have towards one another, and the manner in which they are expressed' (p. 159). This definition is general but concise, reasonably consensual, and theoretically neutral (Norcoss, 2010). 'Therapeutic relationship' is often used interchangeably with therapeutic alliance or working alliance or relationship, but it is important to note that some authors see the alliance more in terms of overt agreement on goals, tasks, and bond (Kazantzis, Dattilio, & Dobson, 2017). For the purpose of this paper these terms will be used interchangeably to incorporate as many theoretical perspectives as possible.

Norcross and Lambert (2019) bring together a number of well evidenced therapist factors and adaptions that impact the therapeutic relationship (Table 1).

Table 1

Table of factors and therapist behaviours impacting on therapeutic relationship

Effectiveness	Elements of the Relationship	Methods of Adapting
Demonstrably Effective	Alliance in psychotherapy (Individual, Child/Adolescent, Couple and Family) Family therapy collaboration Goal consensus Cohesion in group therapy Empathy Positive regard and affirmation Collecting and delivering client feedback	Culture (race/ethnicity) Religion/Spirituality Patient Preferences
Probably Effective	Congruence/Genuineness Real relationship Emotional expression Cultivating positive expectations Promoting treatment credibility Managing countertransference Repairing alliance ruptures	
Promising but insufficient research	Self-disclosure Immediacy	Attachment style
Important but not yet investigated		Sexual orientation Gender identity

In this comprehensive review great attention is paid to the individual therapist and client behaviours and styles of relating, however, much of the research does not incorporate understanding of service user perspectives. This is acknowledged as an area for further research and may be best answered through qualitative methodology investigated in specific contexts (Flückiger, Del Re, Wampold & Horvath, 2018).

There is an impressive corpus of evidence around therapeutic relationship being the most stable predictor of positive therapy outcomes such as symptom reduction and attrition (Horvath et al., 2011). However, much of the literature focuses on standardised, researcher developed, psychometrics or the experiences of clinicians forming these relationships (Levitt, Pomerville & Surace, 2016) and less attention is paid to the qualitative experiences of the service users. This could be an artefact of inhabiting a system that relies and defers to positivist approaches of understanding distress (Howitt, 2010), or that there are fewer opportunities for service users to have agency in research or equitable and meaningful research participation (Trivedi & Wykes, 2002). Regardless of the why, attention to service user voices and experiences is often omitted in literature and textbooks (Gabbard & Freedman, 2006), but when heard, the cultivation and customisation of the therapeutic relationship is put centrally by those using services (Duncan, Miller, & Sparks, 2011).

There is evidence that quantitative and qualitative research methods are not attending to factors important in therapy for service users. For example, a recent review of both qualitative empirical data and service user testimony regarding adverse processes in psychotherapy indicated that there are processes that are not effectively captured in peer reviewed research (Curran et al., 2019), yet are salient in the grey literature. This suggests that perspectives are being missed in the formal literature. Whether this is down to bias due to power imbalances between researcher and participant (Wong, 1998), or that participants with less favourable experiences may be less likely to be included in research (Daya, Hamilton & Roper, 2020) can only be speculated on. However, what is clear is that a number of service user experiences in the therapeutic relationship literature are missing.

The understanding of context is particularly important in research that is exploring experience (Smith, 2007). A therapeutic relationship does not exist in a vacuum and is influenced not just at the relational level but at contextual level (O'Brien, 2001). This means that different contexts, such as culture, political and healthcare will arguably produce different experiences in therapeutic relationships due to the different external demands placed on them. From the scant literature looking at service users' experiences of therapeutic relationships most research comes from outside of the UK and outside of the NHS, providing arguable validity for use in the context of the NHS.

The implications of not attending to contextual pressures on therapeutic relationships are important and this is particularly so in the NHS. Current pressures on the NHS to deliver value for money (NHS, March 2017) means that clinical guidance and policy prioritises developing time limited, highly structured and manualised approaches that are cost effective (National Collaborating Centre for Mental Health, 2021). If the therapeutic relationship is the most stable predictor of outcome but there are aspects of the therapeutic relationship not represented in the literature, potentially due to contextual deviances and through a lack of methodological diversity, then the policy and guidance may not reflect this effectively and impact on outcomes. Furthermore, if policy and resources are directed towards manualised, structured and time limited approaches, then understanding how therapeutic relationships are formed in this context is vital, less the NHS ends up providing technically sound interventions without the time or flexibility to attend to the therapeutic relationship which could potentially deliver poorer outcomes.

This paper will attempt to identify and synthesise the literature that is available regarding the experiences of NHS service users in therapeutic relationships, something which has not been done for this unique context. This will add an important synthesised narrative of service user experience addressing the gap in the literature and providing important insights on what is important, from the perspective of service users, in the therapeutic relationship with potential implications for both policy and practice. The analysis will therefore ask:

> *What factors impact on NHS service users experience of the therapeutic relationship in individual psychotherapy in the community?*

Methods

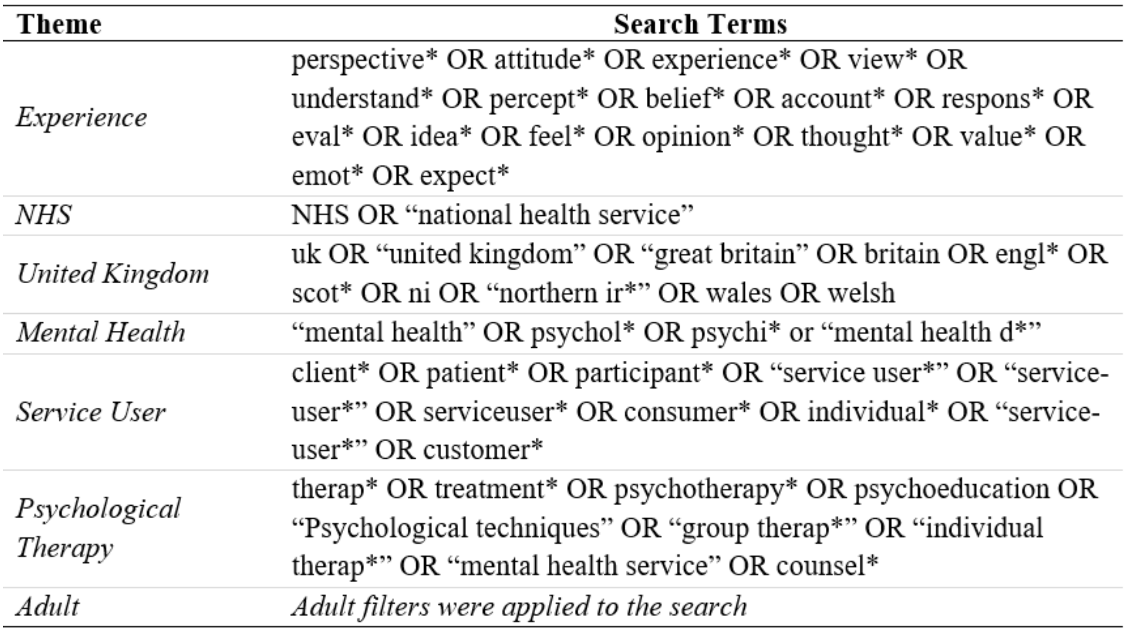
Design

Search strategy

A systematic search strategy was developed to identify papers that could answer the research question. Guidance for systematic review and reporting was done in line with the Preferred Reporting Items for Systematic Reviews and Meta-Analysis (PRISMA) statement (www.prisma-statement.org). A pre-planned comprehensive search was undertaken and PsychINFO, CINAHL Complete and MEDLINE Complete were searched via EBSCO, and EMBASE via OVID on the 7th of May 2023 for all preceding articles. The following search terms were used along with synonyms and closely related words; ‘experience’, ‘NHS’, ‘Mental Health’, ‘United Kingdom’, ‘Service User’, ‘Psychological Therapy’ and ‘Adult’. Terms were developed through examination of similar reviews, database indexes and through research team collaboration. Search terms can be viewed in Table 2. Duplicate articles were removed.

Table 2

Search terms used on PsychINFO, CINAHL, MEDLINE and EMBASE



Theme	Search Terms
Experience	perspective* OR attitude* OR experience* OR view* OR understand* OR percept* OR belief* OR account* OR respons* OR eval* OR idea* OR feel* OR opinion* OR thought* OR value* OR emot* OR expect*
NHS	NHS OR “national health service”
United Kingdom	uk OR “united kingdom” OR “great britain” OR britain OR engl* OR scot* OR ni OR “northern ir*” OR wales OR welsh
Mental Health	“mental health” OR psychol* OR psychi* or “mental health d*”
Service User	client* OR patient* OR participant* OR “service user*” OR “service-user*” OR serviceuser* OR consumer* OR individual* OR “service-user*” OR customer*
Psychological Therapy	therap* OR treatment* OR psychotherapy* OR psychoeducation OR “Psychological techniques” OR “group therap*” OR “individual therap*” OR “mental health service” OR counsel*
Adult	*Adult filters were applied to the search*

Selection criteria

For inclusion in the review articles needed to meet the following criteria:

1. A qualitative research methodology (including mixed methods)
2. Participants are in receipt of psychological therapy (data includes experience of psychological therapy)
3. Participant’s therapy experience delivered in person
4. Therapy received on an individual (one to one) basis
5. Therapy received in NHS service
6. Participants based in the United Kingdom
7. Adult (18 or over) participants at time of study

Qualitative methodology (criterion 1) was broadly operationalised as the use of recognised qualitative methodology (see Moriarty, 2011), open questions and a description of the findings in words rather than numbers. Individual therapy (criterion 4) was chosen to ensure that the confounds of group dynamics or multiple therapists was not reflected in the synthesis. This study is focused on NHS service users as such criterions 5 and 6 were introduced, and adult participants (criterion 7) were selected as the largest cohort of people in receipt of therapy in the NHS (NHS, 2019).

Articles that contained the following were excluded from the study:

A. No data relevant to the therapeutic relationship
B. No relevant first order data (direct quotes from participants)
C. Participants not in receipt of psychotherapy
D. Participants detained formally or informally in an inpatient setting at the time of therapy
E. Participants diagnosed with cognitive impairments (such as Intellectual Disability or Neurodegenerative disorder)

Exclusion of articles not having data relevant to the therapeutic relationship (criterion A) was to assure there was pertinent data regarding the therapeutic relationship, as this is core aspect of the research question. The broadest definition of this was included (see introduction) to capture all possible data within the extracted articles. Articles with limited or no first order data (direct quotes from participants) were also excluded, this was to be sure that service user perspectives and language were fully represented as well as this being a typical quality marker in qualitative research (Yardley, 2000). Participants who were residing in inpatient facilities both informally or under Mental Health Act conditions were also excluded, due to the potential coercive effects of legal (or the threat of legal) restrictions on the therapeutic relationship. Participants with cognitive impairments were also excluded. Full descriptions of rationales for criteria can be found in Appendix E.

Procedure and analysis

Selection procedure

Articles were imported by the lead author into Microsoft Excel and duplicates were removed. The lead author screened all titles and abstracts to exclude articles that did not meet inclusion criteria. Reasons for exclusion were noted and examples of this process can be seen in appendix F. Where there was doubt from the title and abstract screen these articles were included and reviewed in full and discussed with the research team. Following this, full texts were reviewed by the author for inclusion. The reasons for exclusion were noted (figure 1) and an outside researcher reviewed a random sample of 20% of the articles to see if there was consensus. Any queries were addressed with discussion with the research team and consensus was formed. The final included articles were again reviewed by the research team and discussed. Hand searching included the review of reference lists of all included articles to check for relevant studies for synthesis as well as the review of a number of key journals and conference abstracts.

Quality appraisal

The Critical Appraisal Skills Programme (CASP) qualitative assessment checklist was used to assess study quality (see appendix C for example). CASP is commonly used in meta-synthesis to assess credibility, value and relevance of included studies (Hannes & Macaitis, 2012; Dalton, Booth, Noyes & Sowden, 2017). Each study was evaluated on 10 items and classified as either low risk (9-10 items met), or moderate risk (8-5 items met), or high risk (>5 items met) of not being ‘credible, valuable and relevant’. This provided the structure on which to assess the quality of included articles but was not meant to be a binary exclusionary/inclusionary metric for this synthesis as methodological weakness does not reduce the quality of the primary (first order) data which was prioritised in the synthesis and an important part of inclusion criteria. CASP results were reviewed by another researcher independently to check interrater agreement and were discussed until consensus was reached. The results from the CASP and from the screening process developed a supplementary narrative appraisal of quality.

Data extraction

All included articles were read through in full several times during the analysis. Information about participants, their presentations, the type of therapy they received, the focus of the study, the method of analysis and a summary of the themes were extracted.

The complete ‘results’ or ‘findings’ sections were seen as data for this review, however, findings in qualitative research can be difficult to identify which is often complicated by differing reporting styles and misrepresentation of data as findings (Sandelowski & Barroso, 2003). Under guidance from Thomas and Harden (2008) all text labelled as ‘results’ or ‘findings’ throughout the entirety of the paper were extracted. See appendix G for an example of extracted data.

Data were placed into the NVivo (version 12) qualitative data software program. This included first order data, of which this synthesis was especially concerned with, but also contextual information and interpretations from authors as findings (second order data) which was found in both the results and discussion sections of papers.

Thematic Synthesis

The three stages of analysis for thematic synthesis were adopted in line with Thomas and Harden's (2008) recommendations. Themes were discussed with the research team which included Clinical Psychologists, academics, and an expert by experience to gain consensus and challenge a priori assumptions. The ENTREQ (Tong, Flemming, McInnes, Oliver & Craig, 2012) reporting quality framework developed specifically for qualitative synthesis (see appendix B) was also applied to support rigor in the reporting of the synthesis.

The lead author's epistemological and ontological positions align with the methodology selected. The author's ontological position is grossly one of subtle (opposed to radical) relativism, but a position that accepts difference in ontological domains. Particularly for this research the author believes in the reality of individual subjectivity, which allows for an almost critical realist perspective in this domain and allows for the exploration of experience. A soft constructivist epistemological stance is also held by the author and is particularly helpful when considering the importance of language in exploring experience (Burr & Dick, 2017).

The first stage of analysis involved reading and re-reading the data. Following this free or open coding (Braun & Clarke, 2006) was completed on the findings of included articles. This was primarily a descriptive endeavour with line-by-line coding on the content and meaning of text, which included participant quotes (first order data) and author interpretations (second order data). All the data received at least one code and often more. Here the focus was on the data itself so as not to impose an a priori framework, and instead focus on the raw descriptions of the data. The descriptions of codes were primarily based on direct quotes (first order data) and contextualised in the interpretations from the authors (second order data). Throughout this process the first author returned to the supervisory group to discuss coding and ensure interpretation of coding was consistent and relevant.

The second stage involved the grouping of free codes into descriptive themes which were close to, and descriptive of, the data presented in the primary studies (Braun and Clarke, 2006; Thomas and Harden, 2008). This resulted in 37 descriptive themes and the frequency of data points for each theme was tabulated; descriptive themes retained were those that were most well-represented by number of data points. The third stage involved the development of analytic themes. This was initially undertaken by the lead author and reviewed and evolved iteratively by the other authors (Thomas and Harden, 2008). This was a process of engaging with the descriptive themes looking for convergence and divergence and developing analytical themes to represent superordinate or analytical constructs (Thomas and Harden, 2008). Each theme contained a number of subsidiary themes. A number of drafts and iterations were completed and discussed and reviewed with the whole research team until the final set of themes was settled on. This allowed the chance of multiple perspectives to be considered as well the challenging of interpretations and resolution of uncertainties. Finally, the themes were cross referenced with the data to ensure that they were derived and driven by the data. An example of this process can be seen in appendix F and E1.

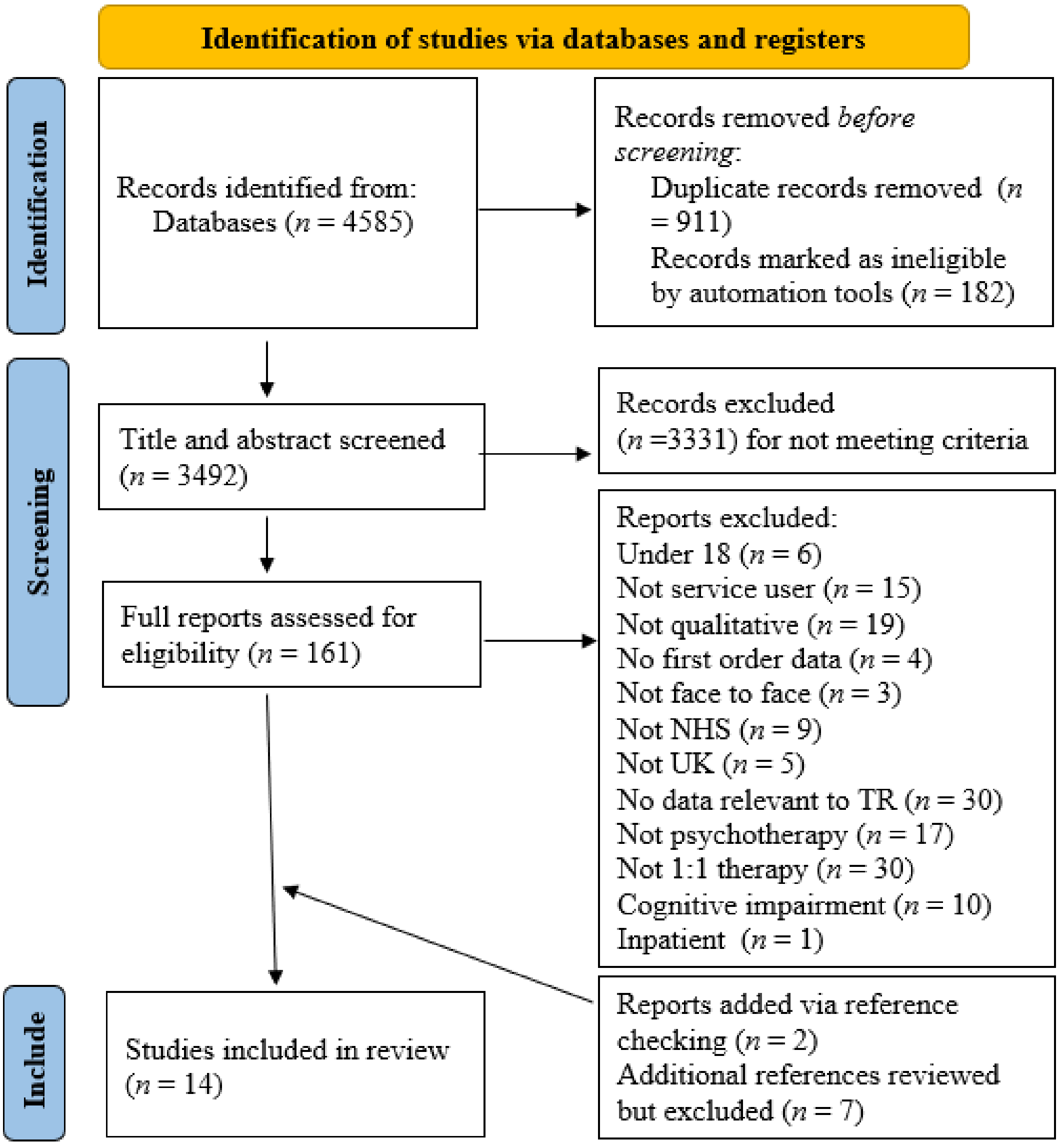
Reflective diaries, supervision and audit trails were used to support quality in the analysis. Thematic synthesis as described by Thomas and Harden (2008) was chosen over other methods as the research question explores qualitative experiences across the literature base.

Results

Data extraction took place on the 7th of May 2023. The searches initially returned 4585 references and following the removal of duplications and records marked as ineligible by automation tools the final number of papers that was screened was 3492. After screening of titles and abstracts 161 papers full texts were reviewed and eligibility determined. Nine papers were also screened through reference checks and hand searching but only two were included in the final review, with a total of 14 papers included following discussion with the research team. The selection process is shown in figure 1.

Figure 1

PRISMA flow diagram



Characteristics of studies

Characteristics and themes of the 14 included studies are displayed in table 3. These studies include 159 adult NHS service users engaged in psychotherapy in the United Kingdom. There were more female participants (59.75%) compared to male (40.25%) with no other gender identities reported. Reported mean ages ran from 22.88 to 50.25. Reporting of participant ethnicity was omitted in 50% of reviewed studies and from those who did report from a possible 74 participants, 8 were reported as non-white. Treatment targets were also varied but therapeutic modalities were primarily Cognitive Behavioural Therapy or Cognitive Therapy (71.43%). The most common exclusion criteria were cognitive impairment, not speaking English and substance use disorder. All but one article used semi structured interviews with the other using a free text questionnaire. Analysis was predominantly Thematic Analysis (*n* = 9) and Interpretative Phenomenological Analysis (IPA, *n* = 4), with one using template analysis.

Table 3

Included articles for synthesis

Authors and year	*N*	Gender of participants	Age range	Ethnicity	Participant presentation	Therapy	Study Focus	Data Collection	Data Analysis	Summary of Themes	No. of References	CASP Score	Risk of Bias
1. Mankiewicz, O'Leary & Collier (2018)	9	5=male, 4 = female	mean reported 22.88	8=White, 1=Black British	First Episode Psychosis (FEP)	Cognitive Behavioural Therpay (CBT) for psychosis (p)	Experiences of receiving CBTp for FEP	Semi Structured Interviews	Thematic Analysis	Main themes: service users' prior expectations; therapeutic alliance; challenges of CBTp; and application of CBTp to achieve change	44	10	Low
2. Awenat, Shaw-Núñez, Kelly, Law, Ahmed, Welford, Tarrier & Gooding (2016)	8	2 = female, 6 = male	36.25	8 =White	Psychosis	CBT for suicidality in psychosis	Experiences of people with psychosis of a novel cognitive behavioural therapy targeting suicidality	Semi Structured Interviews	Inductive Thematic Analysis	Main themes: Acceptabilty; In revocery from suicidality	33	9	Low
3. Balmain, Melia, John, Dent & Smith (2021)	6	5 = female, 1 = male	36	6=White	Complex Secondary Mental Health Diffs	Cognitive Analytic Therapy (CAT)	Expereiences of receiving CAT for people with complex mental health problems	Semi Structured Interviews	Interpretive Phenomenological Analysis (IPA)	Main themes: Changes due to CAT; strong emotions evoked by CAT; the process of CAT	35	9	Low
4. Omylinska-Thurston & Cooper (2014)	8	6 = female, 2 = male	50.25	Not reported	Anxeity and Depression relating to Primary Cancers	Intergrative (Including CAT, CBT, and Narrative Therapy)	Helpful Process in psycholgogical therapy for patients with Primary Cancers	Semi Structured Interviews	Thematic Analysis	Main themes: talking and expressing their feelings to someone outside of the family; forming a relationship with their therapist; normalisation through the therapists' expert knowledge; problem-solving and CBT	28	10	Low
5. Hoskins, Blood, Stokes, Tatham, Waller & Turner (2019)	17	17 = female	mean reported 32.2	Not reported	Eating Disorders	CBT for Eating Disorders	Peitents' experiences of brief CBT for Eating Disorders	Qualitative Questionaire	Thematic Analysis	Main themes: The therapeutic relationship; the nature of therapy; its challening but beneficial aspects; ending therapy; and the overall experience of CBT	24	9	Low
6. Marsden, Teahan, Lovell, Blore & Delgadillo (2018)	24	17 = female, 7 = male	mean reported 31.79	21 =White, 1 = Other, 2 = Not reported	OCD	CBT (n = 10) & EMDR (n = 14)	Patients' experiences of CBT and EMDR as treatments for OCD	Semi Structured Interviews	Thematic Analysis	Main themes: Common experiences; specific experiences of CBT; specific experiencse of EMDR	41	9	Low
7. Tyrer & Masterson (2019)	6	5 = female, 1 = male	41.67	Not reported	Low mood and other difficulties	CAT	Clients' experience of change: an exploration of the influence of reformulation tools in CAT	Semi Structured Interviews	Mixed Methods including Template Analysis	Main themes: Overall Change; change in response to reformulation tools; recognising patterns; breaking the links in patterns and working in partnership	35	5	Moderate

Authors and year	*N*	Gender of participants	Age range	Ethnicity	Participant presentation	Therapy	Study Focus	Data Collection	Data Analysis	Summary of Themes	No. of References	CASP Score	Risk of Bias
8. Picariello, Ali, Foubister & Chalder (2017)	14	2 = male, 12 = female	not reported just range 18-64	12=White, 2=Black or Black British	Cronic Fatigue Syndrome	CBT	A qualitative study exploring patients' views of CBT for chronic fatigue syndrome	Semi Structured Interviews	Inductive Thematic Analysis	Main themes: Hopes and Expectations; Real, not imagined; Collaborative therapeutic alliance; Motivation and engagement; Gain and Loss; Change	64	9	Low
9. Griffiths, Mansell, Edge, Carey, Peel & Tai (2019)	12	7 = male, 5 = female	33.25	Not reported	FEP	Method of Levels Therpay (Cognitive Therapy)	Experiences of method of levels therpay amoungst people with FEP	Semi Structured Interviews	Thematic Analysis	Main themes: The therapist's approach; I was in control; Thinking and talking; Looking at problems from a different perspective	53	10	Low
10. Leonidaki, Lemma & Hobbis (2016)	5	3 = male, 2 = female	43	1=White British, 1=Other White, 2=Black British, 1=Asian	Depression	Dynamic Interpersonal Therapy (DIT)	Clients' experiences of DIT	Semi Structured Interviews	IPA	Main themes: The Distinct Features of DIT; Impact of Therapy	38	9	Low
11. Joyce, Tai, Gebbia & Mansell (2017)	14	3 = male, 11 = female	46.43	Not reported	Bipolar	TEAMS therapy (CBT)	Experiences of a Novel Cognitive Behavioural Therapy for Bipolar Disorders	Semi Structured Interviews	Inductive Thematic Analysis	Main themes: Useful elements of therapy; changes from therapy	59	10	Low
12. Low & Murray (2014)	9	4 = male, 5 = female	mean reported 53	Not reported	PTSD	Trauma Focused CBT	Experiences of Trauma Focused CBT	Semi Structured Interviews	IPA	Living with Symptoms before Therapy; Feeling Ready for Therapy; Being Involved; Bringing About Therapeutic Change; and Life After Therapy	25	8	Moderate
13. McManus, Peerbhoy, Larkin & Clark (2009)	8	3 = male, 5 female	mean reported 31.25	6 = White European, 1 = Other, 1 = Other White	Social Phobia	Cognitive Therapy for Social Phobia	Experience of Cognitive Therapy for Social Phobia	Semi Structured Interviews	IPA	Social phobia as a way of being; Learning to challenge social phobia as a way of being: transformative mechanisms of therapy; Challenges faced in the pursuit of change; A whole new world: new ways of being	57	L	Low
14. Gee et al. (2022)	19	13 = male, 6 = female	26.32	Not reported	First Episode Psychosis (FEP)	Social Recovery Therapy (CBT based)	Process evaluation of Social Recovery Therapy	Semi Structured Interviews	Thematic Analysis	Increased self knowledge; sometimes you just need that little bit of a push; you have to face your fears and get over them; increased self agency; more of a cup half full than a cup half empty	29	9	Low

Quality appraisal results

Quality was reviewed through the CASP framework and results of this can be seen in Appendix D. Quality was generally rated highly with low risks of bias according to the CASP framework. Quality was also assessed through the exclusion criteria of having sufficient first order data and information around the therapeutic relationship as these are related in the context and purpose of the review. Thus, papers with moderate risk of bias according to CASP were not excluded (Papers 7 & 12), this is in line with advice from Thomas and Harden (2008). It is worth noting that an area where quality was poor across 7 papers was the author's engagement regarding their relationship to the participants and their epistemological and ontological positions. Further, three papers had issues with either descriptions or execution of analytic procedure. For example, paper 12 by Low and Murray (2014) engaged in an IPA approach, however, this was poorly described and there was limited evidence of engagement with the hermeneutic and phenomenological philosophy underpinning the approach, which weakens the overall interpretations of the study. However, the first order data was pertinent to the current research question and as such was included. It is also worth noting that in the screening process there are a number of studies which may have made useful sources of data for this review, however, their qualitive aspects were often nested in quantitative analysis from larger trials and reported the acceptability and fidelity of treatment opposed to the experience of service users.

Thematic synthesis of studies

Four superordinate themes emerged in the analysis of factors impacting how NHS service users experienced the therapeutic relationship in individual therapy. Each theme has a number of more nuanced subsidiary themes that construct the overall themes.

1. Tension prior to therapy

The first theme relates tensions in the therapeutic relationship prior to therapy, particularly in the amount of hope participants described for therapy as well as their apprehensions and fears. This theme speaks to feelings and attitudes (key factors in subsequent therapeutic relationships) that were held by participants prior to meeting their therapist. This theme was endorsed by 10 of the 14 papers.

1.1 Hope and hopelessness.

Participants indicated how prior to therapy that they had different hopes for change ranging from some hoping to be cured, *'I would go in, and come out cured'* (Lisa, Paper 10), a hope for some improvement, *'But I was like yeah, let's go and give it a go and see what happens'* (John, Paper 12), thorough to hopelessness of anything helping, *'I felt like I was just so far gone that I felt so closed away that like it wouldn't do anything'* (Participant 6, Paper 1). Whether explicitly stated or not the degree of hope a participant held had an impact and indeed an expectation set on the therapist, and thus the therapeutic relationship, particularly on what they expected to receive in the relationship:

> *I hoped that when I went to therapy he [therapist] could give me, give me some cognitive behavioural therapy in ways that I can learn to cope.* (Participant 8, Paper 1)

1.2 Apprehension.

Attitudes around therapy and seeking support were seen to create apprehension in some participants prior to their therapeutic relationships. Stigma and societal narratives around therapy being for the weak, *'And therapy is like a weakness'* (Participant 9, Paper 1), or people with mental illness being locked up were seen, *'I think it was the first time I saw him was that I was scared that if I opened my mouth that I would be locked up… cos you hear about it on TV and they are straight away white jackets the lot.' (Participant 1, Paper 1).* There were also some feelings of shame for participants in seeking help:

> *'feel[ing] stigmatised. . . the [psychiatric hospital] was somewhere where people went when they were seriously ill. . . I felt very ashamed'* (Participant 12, Paper 8)
>
> *'I don't really want to be seen to be in that group of people. . . I am not having mental health problems.'* (Participant 10, Paper 8).

For some participants there was also fear and apprehension in reliving previous traumatic incidents:

> *'I was a bit apprehensive thinking I'll have to delve into some stuff here that might be upsetting and might be hard to deal with, which it was…'* (Participant 19, Paper 9).
>
> *'I was a bit worried that it might be too intensive, you know, I might not be able to cope with it'* (Bob, Paper 2)

This was particularly in first sessions where participants were often speaking of their difficulties for the first time. This appeared to be a time of understandable uncertainty and vulnerability, with a number of participants across articles fearing judgement:

> *'that's key because you're scared this is the first time you've told anyone any of this and it's like oh my god what's she gonna think. What's anyone going to think about this.'* (James, Paper 3)

This apprehension communicated a sense of tension as those participants entered the therapeutic relationship and can speak to how they may have experienced the start of their therapeutic relationships.

2. Relieving the tension and feeling comfortable enough to talk

The second superordinate theme highlights the processes within the relationship that supported the breaking of initial tensions and fears. This allowed participants to feel safer in the relationship and comfortable enough to talk. Relief in being able to talk, not feeling judged, trust, and the therapist's personal qualities supported this. This theme was endorsed by 11 of the 14 articles reviewed.

2.1 Relief in being able to talk.

Some participants described their initial relief in the tension in the relationship coming from just being able to talk with someone, and particularly someone unknown to them:

> *'Also just having someone to talk to about my issues helped me so much as I didn't feel I could speak to family and friends.'* (Participant 12, Paper 5).
>
> *'Just talking about it I think because you keep it to yourself don't you?'* (Vicky, Paper 12)

An affective shift was noted in a number of studies for participants with descriptions of feeling unburdened:

> *'When you're talking about it you don't realise how much weight it lifts off your shoulders… get an hour or so after where you're thinking about it and then you get a massive sigh of relief, like oh I've got through it, and that you've spoke about it, and you feel a lot better afterwards.'* (Participant 9, Paper 1)

2.2 Non-judgemental.

Having a therapist that was non-judgemental, accepting and considered impartial was consistently demonstrated to be a key factor in developing a therapeutic relationship and allowed participants to overcome apprehensions and tensions related to therapy. *'Yeah no definitely it's really important that she was ... non judgmental and accepting ...'* (James, Paper 3). This allowed participants to feel understood and validated in their distress, *'I started most of my sentences [with] "this is going to sound absolutely stupid," and she would say, "no," and she would explain why'* (Sandra, Paper 4). Furthermore, it supported not only how participants felt about their therapists but themselves, and as fear of judgement was often a tension tied to shame and embarrassment, and this being addressed in the therapeutic relationship was important for a number of participants:

> *'I felt like she wasn't looking down on me in any way, which was quite important I think because I guess it's obvious really but you know, you feel sort of, felt embarrassed you've got it.'* (Tom, Paper 13)

For some this had a facilitative effect of supporting them to be open in the relationship, *"she made me feel like I could tell her anything, like a lot of the time I'd feel like if I said stuff I'd be judged about it[…] But she didn't make me feel like that at all"* (Participant 21, Paper 6).

2.3 Trust.

Feeling able to trust their therapist was an important aspect for participants across eight studies. This was important in overcoming apprehensions and tension and was experienced from an interpersonal sense of safety in the relationship, '*I did trust him and things just came out ... I didn't mean to, but I found myself opening up quite easily to him'* (Helen, Paper 2), but also through trust in the professionalism and knowledge of the therapist:

> *'When you talk to family members or friends, they can't understand... they will do their best to but unless they've obviously suffered mental health they can't understand it. With X it's his profession to understand people with problems, mentally, it's refreshing.'* (Participant 8, Paper 1)

For a number of participants this trust allowed for a deeper connection in the relationship, often allowing it to be more open, *'He was like the only person that I really trusted, so I could talk about absolutely anything'* (Participant 6, Paper 1).

2.4 Therapist qualities.

There were a variety of interpersonal qualities that were noted, including having a calming manner, empathy, positivity, and being encouraging as well as becoming familiar with the therapist. This appeared to be important in overcoming apprehensions and relieving tension in the therapeutic relationship.

> *'He was really nice and patient and calm… he had a like a nice nature so I felt comfortable talking about things'* (Participant 8, Paper 11)
>
> *'My relationship with [Therapist] really allowed me to feel comfortable at each session and share personal experiences / problems throughout my therapy.'* (Participant 2, Paper 5)

> *'Initially I was quite sceptical but [Therapist] was so positive and encouraging that I learnt to push my boundaries and made a lot of progress.'* (Participant 6, Paper 5)

3. Feeling understood and developing understanding

The third superordinate theme explores the importance of feeling understood for participants in the therapeutic relationship, as well as the role of normalising distress and creating a shared understanding between therapist and service user. This theme was endorsed by 13 of the 14 articles reviewed.

3.1 Feeling heard and understood.

Feeling understood and listened to by the therapist emerged as an important factor in how participants experienced the relationship. Some participants described not feeling heard by others, *'He listened cos most of the people didn't listen before, didn't really hear me…'* (Participant 6, Paper 1) and how their therapist 'heard' them. This appeared to allow for the important process of feeling understood, which was felt as an empathy from therapists, again another important feeling in the therapeutic relationship:

> *'... I felt as though he [therapist] was taking an interest in me ... he was talking to me as though he knew where I was coming from, he knew what I was going through.'* (Tom, Paper 2)

> *'the therapist was crucial because this was a human being who's got it. . .I wasn't having to justify myself. . .'* (Participant 9, Paper 8).

Participants who did not feel understood had experienced the relationship differently and subjectively felt they had a poorer relationship:

> *'We were always looking at connections, between behaviour and then mood… there just didn't seem to be the connections… what was going on in my life was not relevant to whether I got ill'* (Participant 5, Paper 11)

3.2 Normalising.

Across eight studies the impact of the therapist helping to normalise participants' experiences appeared to help reduce self-blame, isolation and shame:

> *'you think what's wrong with me…the therapy has helped with that…it became clear by the discussions… that I am not alone in this situation…'* (Alec, Paper 4)
>
> *'Being able to ask any questions and to actually talk about the thoughts I have and not feel ridiculous/alone.'* (Participant 4, Paper 5)

This supported positive attitudes and feelings towards the therapist and developed the relationship. *'It's nice to have someone say it's not all your fault. There are so many contributing factors to why we are here.'* (Jane, Paper 3)

3.3 A shared understanding and language.

When a shared understanding of the participants' difficulties was developed collaboratively this allowed some participants to develop greater understanding and insight:

> *'He [the therapist], yeah, he made me see things much more clearly. It was not just me talking all the time, he was able to [pause] uum pinpoint certain things, he was able to uuum, direct me to different path, different way of thinking.'* (Angela, Paper 10)

Clear language was facilitative in developing understanding between therapists and service users, *"I found the therapist really helpful in the way he explained things,* *he used really good language and made me really understand"* (Participant 16, Paper 5). Metaphor and analogies were also seen as helpful in developing links between the concepts therapists were explaining and the experience of participants:

> *'We broke it down into tennis balls and I said look my head now is a game of tennis… in my case what was happening was there were several ball boys and they were all coming on the pitch trying to play tennis at the same time'* (Participant 13, Paper 11)

However, when concepts were not clearly explained, or conversations felt one sided participants did not feel a shared understanding between themselves and their therapists which for some participants disrupted the relationship and the therapy:

> *'I wasn't really sure what I was doing; I was like - why am I doing this?'* (Participant 13, Paper 6)
>
> *'Like, it felt really one-sided and like I couldn't, like. . . it just felt too one-sided. Like, it was just all me talking.'* (Participant 8, Paper 9)

4. Therapist actions

The fourth superordinate theme examines how the therapists' actions impacted on the relationship. This theme was endorsed by all of the 14 articles reviewed.

4.1 Techniques.

This subsidiary theme considered the impact of concrete therapeutic techniques specific to the modality of therapy (such as behavioural experiments, diaries, and therapeutic letters) on the relationship and therapy as well as non-modality specific therapeutic techniques.

Participants from six studies cited specific therapeutic techniques that they found helpful. This appeared to be when techniques were well understood and relevant to the participant:

> *'The most helpful part of my treatment was the 'experiments' me and [Therapist] created in order to face 'fears' or 'problem areas' in my life.'* (Participant 2, Paper 5)

Indeed, participants from one study expressed they did not receive enough concrete techniques which would have supported a better experience in therapy:

> *'But I don't think I got, you know, some solution, you know, about what to do, about how to, let's say, you have for example panic attacks, what you should do? ... To start thinking or to stop thinking, you know, I didn't get anything like, you know, distraction.* (Eric, Paper 10)

However, four other studies reported more ambivalence towards the effectiveness of modality specific psychological techniques, with some reporting that the emotional support aspect of therapy was the most beneficial or that they were unhelpful when not relevant or understood:

> *'I just couldn't get my head around it (SDR [a Cognitive Analytic Therapy formulation tool]), at the time I was just like hazy with all the stuff that was going on, I was worried that I just couldn't take what he was saying'* (Sally, Paper 7)

> *'Normal counselling would have probably been just as good for me'* (Participant 3, Paper 11)

More generic 'soft' therapeutic skills associated with psychotherapy such as curiosity, guided discovery, encouraging reflection, and picking up on non-verbal cues were seen as facilitative to a therapeutic relationship. These skills are often grounded and dependent on relational skills relevant to, and impacting on, the therapeutic relationship and are critical not to just to therapeutic goals but supporting the development of a shared understanding.

> *'He would pick up on maybe a word I said or I dunno maybe a facial expression… I also remember thinking at the time that he's very skilled to pick up those innuendos'* (Participant 2, Paper 11)

> *'. . .it was kind of like, erm, he'd ask me the question, 'Why, why, why?', or trying to probe a little bit deeper than necessarily than, er, say somebody who I ordinarily saw from [the Early Intervention Team]'*. (Participant 24, Paper 9)

However, two participants across two studies found too much curiosity or therapeutic uncertainty to be off putting in the relationship:

> *'The thing is I just didn't like him. Like, I like him as a person, obviously, cos he's nice, but I just mean his style of doing the therapy I just didn't like, because he just was too, he was almost too interested in what, in everything.'* (Participant 8, Paper 4)

4.2 Direction vs flexibility.

For some participants being given direction from their therapist was seen as a supportive aspect of the therapeutic relationship. *'She was encouraging and supportive, yet knew when to push me to get the most effective results for me.'* (Participant 10, Paper 5). This being 'pushed' to do uncomfortable therapeutic tasks was seen as helpful for some participants, especially when it was seen to have future benefits and was done in a supportive manner, in the context of a good relationship:

> *'Sometimes you do need a therapist or someone just to give you that little bit of a push, and also to give people the support as well, because they are kind of pushing you on to do it because they know it's gonna benefit you, and they know you're gonna feel amazing after you've done it, but then they do – they don't do it in an aggressive way, they do it in a supportive way, and I think that's really important.'* (Stephen, Paper 14)

A number of participants explained the benefit they felt in their relationship when they were guided by therapists when seen to be deviating from therapeutic tasks. *'He [the therapist], yeah, he made me see things much more clearly. It was not just me talking all the time, he was able to [pause] uum pinpoint certain things, he was able to uuum, direct me to different path, different way of thinking.'* (Angela, Paper 10). This arguably speaks to how the therapists use their knowledge and power within the relationship positively to help participants either develop new insights or overcome potentially beneficial anxiety provoking tasks. However, some participants in a number of articles felt 'overwhelmed' when therapists were too directive and were not flexible to what they wanted to discuss showing that there are limits to this:

> *'She gets to the point but it was kind of a bit too much [...] I felt I couldn't maybe express everything I would have liked to within that hour [...] it made me question if I should pursue it.'* (Participant 22, Paper 6)

Over nine studies participants overwhelmingly responded positively to therapists who were flexible and adapted therapy to their own wants and needs. This person-centred approach appeared to be empowering clients through giving them more choice and control over their therapy and seemed to strengthen therapeutic relationships.

> *'It was more meaningful for me because I wasn't being forced into some programme or box that you know someone else had decided… the ball was in my court to use the session for what I wanted to'* (Participant 2, Paper 11)

> *'if I want to set the agenda for instance, I feel I can do that, if I had something that I particularly want to talk about. . . it feels very free in that regard'* (Participant 12, Paper 8)

A number of participants noted an empowering element to the flexibility and the sense of control and agency that this afforded.

> *'I was in control. I was in control of it. . . Er, not as in control as in nasty control. More say, like, if there was something I was thinking about at the same time, I knew there was no obligation for me to even bring it out or mention it at that time. A lot of the time I did, a lot of the time. That's what was helpful about a lot of the time.'* (Participant 36, Paper 9)

Finally, participants who were offered flexibility in terms of session timings and therapy duration noted a positive impact whereas across a number of studies there was anxiety regarding the length of therapy and the wish for further sessions. It is worth noting that most therapies offered had a fixed number of sessions:

> *'I think I was in control of when I felt those sessions could end. I don't know how long they would have gone on had I not made that decision. I suppose you can become quite dependent on things. But I don't know for some reason I just felt OK and I thought, ''We've gone as we need to go.'' So I don't know whether control is the right word, the way it's used, but I felt that I had a really big say.'* (Sarah, Paper 12).

Discussion

Overview

The purpose of this review was to identify and synthesise the findings of qualitive studies that include factors that impact on the experience of the therapeutic relationship for NHS service users in individual psychotherapy. The systematic identification of studies brought together 14 studies for thematic synthesis and four themes relating to the experience of the therapeutic relationship for NHS service users emerged: 1. Tension prior to therapy, 2. Relieving the tension and feeling comfortable enough to talk, 3. Feeling understood and developing understanding, and 4. Therapist actions. The results help to better understand factors that are important to NHS services users in individual therapy. These generally align with universally understood and well evidenced factors (see table 1; Norcross & Lambert, 2019). Examples include non-judgment (2.2), trust (2.3) therapist qualities (2.4) and feeling heard and understood (3.1) which align with factors such as ‘empathy’, having a ‘real relationship’, ‘congruence/genuineness’, and ‘positive regard and affirmation’ (Norcross & Lambert, 2018).

Across six papers modality specific therapeutic techniques were noted to be helpful to participants whilst the non-specific therapeutic skills and factors relating to the development of a positive therapeutic relationship were seen across all papers. This is in line with current empirical and anecdotal evidence that the therapeutic relationship has consistently been shown to be a more important factor to service users than explicit predefined therapeutic techniques (Horvath et al., 2011). This does not mean that modality specific techniques are not unimportant, but more that their mechanisms of change are likely to be inextricably linked to the quality of the therapeutic relationship, as described in the writings on the ‘equivalence paradox’ in psychotherapy (Stiles, Barkham, Twigg, Mellor-Clark & Copper, 2006). This review highlights the importance of attention to therapeutic relationship in the delivery and development of psychological intervention in the NHS.

This study also highlights factors specific to the service user on entering the therapeutic relationship and the tensions prior to therapy (superordinate theme 1), including their hope or hopelessness for therapy and their apprehensions around therapy. Apprehensions were noted in a number of studies and were grounded in stigmatising societal attitudes as well as fears around reliving previous traumatic experiences. These are factors exclusive to service users as they occur prior to therapy yet have impacts on the therapeutic relationship once engaged within it. Service user and therapist contributions towards the quality of the therapeutic relationship are often difficult to disentangle (Norcross & Lambert, 2018), and often the evidence is predominantly from therapist factors that impact on the relationship. However, this review highlights some service user factors prior to therapy that may be important in the subsequent development of the therapeutic relationship. This is important to consider as often the experience and context of the service user likely impacts on the relationship. How these factors impact the therapeutic relationship would be an important area where more research is needed.

Another finding of this study is the impact of therapists who were seen to give clear direction to participants or a ‘push’ to complete difficult tasks. This was mostly experienced positively and could be seen as the therapist using their power and knowledge in the relationship for the participant, opposed to against them. Rollo May (1972) describes a positive form of power called ’nutrient power’ – a ‘power for’ or a healthy form of power driven by the concern of the welfare for a group for which that person carries responsibility. The role of positive uses of therapist power could be in important area for future research and one that is poorly described in the literature. Furthermore, the importance of flexibility and empowering participants to have choice in their therapy was seen as important. This is particularly in terms adapting to participants preferences, a well-established method of supporting the therapeutic relationship (Norcross & Lambert, 2018), and in line with the idea of 'patient centred care' (Richards, Coulter & Wicks, 2015). Flexibility in terms of session timings and duration of therapy was also seen as helpful and important in the relationship which arguably are aspects that can be lost within a context, such as a publicly funded healthcare system like the NHS that prioritises the lowest cost and manualised (less flexible) interventions (NHS, 2017). This is why better understanding experience in the unique context of the NHS is important.

Finally, in relation to the quality appraisal of available literature it was highlighted that 50% of reviewed papers did not state the nature of the relationship of the researchers to their participants. This is particularly important in research involving the NHS as often researchers will often be affiliated with the service (or indeed treating) those they are researching. This potentially puts interpretive acts at risk of positive bias. A number of excluded articles also containing qualitative data on participants experience of therapeutic protocols often did not capture experience effectively and were often nested, and poorly described, meaning that potential important data on service user experience was lost. Furthermore, few articles stated explicitly ontological and epistemological assumptions of authors, which in research that includes interpretive actions is vital to be understood by the reader.

Strengths and implications for practice

This review has the following strengths implications for clinical practice in the NHS:

- This review provides the first synthesis of the literature of factors impacting on adult NHS service users experience of the therapeutic relationship. This allows NHS clinicians and policy makers to consider salient factors, as described by NHS service users, in developing therapeutic relationships.
- The importance of the therapeutic relationship to service users is highlighted throughout this study and suggests that continued attention to is paid to this in in the psychological literature, guidance and policy, particularly in the context of the NHS.
- The review demonstrates that there are factors that are external to the therapeutic relationship (such as hope and apprehension prior to therapy) that are service user specific that can impact on it. These are not widely considered in the literature and are important considerations.
- This review highlighted the importance of therapists using their power in the relationship positively (direction) and providing opportunities to empower service users through offering flexibility in their approach.
- Suggestions for improvement in the quality of the qualitative literature, including statements of the relationship of participant to researcher and ontological and epistemological positions have also been highlighted.

Limits

A limitation of this research is that children and people with cognitive impairments were excluded. Future research should aim to incorporate these important voices. Due to the limited number of studies and lack of reporting on certain demographic factors outside of age and gender this review is unlikely to capture valuable diverse experiences, which is a limitation of the current literature base. Future research should aim to capture experiences of participants from explicit demographics, particularly those who are marginalised. This research was conducted by a psychologist and whilst an expert by experience was involved in the research and efforts were made to reduce bias, the lens that the analysis was seen through was a professional lens. Future research should be service user led and could incorporate grey literature, which is likely to garner more diverse experiences than traditional qualitative methods.

Conclusion

This synthesis provides the first synthesis of the literature of factors impacting on NHS service users experience of the therapeutic relationship in individual therapy. It provides insights for clinicians and policymakers in terms of the importance of the therapeutic relationship and what factors are more salient for NHS service users in this context. Suggestions for future research and ways to improve the quality of this are also discussed.

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The Authors declare that there is no conflict of interest.

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Chapter Three: Bridging Chapter

Introduction

This chapter will act as bridge between the systematic review and the empirical paper. The systematic review highlighted the importance of the therapeutic relationship for NHS service users. It also tentatively suggested that power, specifically positive uses of power, within the relationship may be an important area to research, particularly in the context of the NHS to provide robust, contextualised evidence on which to guide policy and practice. This chapter will provide a theoretical and empirical overview of power as well as exploring perspectives within the major therapeutic schools. Additionally, this chapter will provide commentary on the structure and context of the NHS, a politically and ideologically important institution in the UK, and how power held within its structures may impact on the therapeutic relationships of those operating within it. The empirical paper will look at how NHS service users experience power in the therapeutic relationship with Clinical Psychologists and this chapter will add additional context that cannot be covered in that paper.

The therapeutic relationship

An operational definition of the therapeutic relationship has been suggested by Gelso and Carter (1985) as the ‘feelings and attitudes that counselling participants have towards one another, and the manner in which they are expressed’ (p. 159). This definition is general but concise, reasonably consensual, and theoretically neutral (Norcoss, 2010). ‘Therapeutic relationship’ is often used interchangeably with therapeutic alliance or working alliance or relationship, but it is important to note that some authors see the alliance more in terms of overt agreement on goals, tasks, and bond (Kazantzis, Dattilio, & Dobson, 2017).

Freud was the first to consider the therapeutic relationship, particularly in terms of the unconscious projection of past relationships on the therapist or ‘transference’ (Freud, 1940). Several authors developed Freud’s thinking around the importance of a conscious therapeutic alliance between therapist and client (Gitleson, 1962; Greenson, 1965). Following this Greenson (1965) progressed thinking to distinguish therapeutic alliance (a personal bond) and working alliance (task collaboration).

Rogerian influence is also seen throughout the development of the therapeutic relationship literature (Norcross, 2010), particularly the empirical investigation of conditions for therapists to develop it including empathy, positive regard, genuineness and trust (Rogers, Gendlin, Kiesler, & Truax, 1967). This broadened the predominantly psychodynamic perspectives on the relationship, to incorporate other theoretical approaches and find common factors necessary for therapeutic gain. Luborsky (1976) and Bordin (1979) were the first to explore this and noted that different theoretical approaches place different demands on the relationship and therefore the ‘profile of ideal working alliances would differ across approaches’ (Norcross, 2010).

In the following years various psychometrics appeared in the literature to assess the therapeutic relationship, with a recent meta-analysis by Flückiger, Del Re, Wampold & Horvath (2018), which found 39 different measures across 306 studies in articles retrieved between 2011 and 2017. This lack of precise consensual definition and psychometric diversity has made it easier for researchers to embrace the concept of the therapeutic relationship but is problematic in terms of not sharing a clear common point of reference (Flückiger et al., 2018).

Whilst a positive therapeutic relationship has consistently been shown to be the most stable predictor of positive therapy outcomes (Norcross, 2001 & 2002; Horvath, De Re, Flückinger & Symonds, 2011) it is important to note that there are different ways that it is conceptualised and measured. The use of a broad definition in this thesis is to allow for incorporation as many theoretical perspectives as possible.

Power

Power operates on multiple intersecting axes and has been theorised from a range of political, psychological and social perspectives throughout history. There is no unified model or definition about how power operates in society, yet power and its uses remain part of common discourse, albeit in an ambiguous, abstract and often elusive way (Eriksen, 2001). The difference in perspective, the ambiguity and the elusiveness of power means that understanding how power operates is a complex process and makes formal conceptual modelling or definition problematic. This chapter will not offer a formal definition taken from a particular approach but instead offer a working definition that is broad enough to encapsulate different perspectives. Power will therefore be operationalised as:

> *A dynamic range of structural and relational factors that provide individuals or groups with the ability to cause or prevent change (May, 1998) at an individual, social and ideological level.*

Structural power

Structural theories of power look at how power is embedded in social, political and cultural structures and generally describe certain groups or individuals possessing power over others, in a way that is assumed to be unidirectional and generally oppressive. Structural theories lie within the context of modernism. Proctor (2017) argues that structural theories generally see power as something that is possessed and not held within relationships, which is obviously problematic when exploring power in therapeutic relationships. This author argues that the use of structural theories alone in attempting to understand power in therapeutic relationships is insufficient and can lead to structural determinism, which is that peoples' actions and lives are completely dictated by external factors beyond their control and that they are without agency (Proctor, 2017). Whilst structural theories alone are not enough to understand the experience of power in therapeutic relationships, they can shed light on wider power operations and how these permeate the relational and individual level.

Hobbes' and Weber.

Hobbes' concept of power, developed in the 17th Century, is considered the foundation for shaping modernist and structural theories of power. For Hobbes, as described by Clegg (1989), power is possessed and used through individual agency in mechanical and behavioural terms, in that one group uses their power over another which results in a behavioural response, for example police officer stopping a person and ordering them to submit to a search. The importance of Hobbes' on subsequent theories of power cannot be understated as the following theories of structural power also consider power as possession, which is monolithic (held in one place), unitary (in one form) and unidirectional (used by one group of people on to another). Much of the previous literature on power in the therapeutic relationship comes from this perspective, where power is held and exercised by the therapist, often with negative consequences (Masson 1988).

Hobbes centralised power within the state, as he believed people could not have agency and as such, they can only choose from what is already chosen for them by the state. For Hobbes the state chooses which narratives are legitimised, according to rules of science and rationality (Proctor, 2017). A current example of this type of structural power includes what therapies are offered to current NHS service users, in that the predominate legitimised narrative is one of positivism largely rooted in the medical model (Cummins, 2018) and evidence-based practice, as such commissioned services are expected to offer evidenced-based therapies legitimised by statutory bodies. Therefore, it could be argued that choices for practitioners and service users are already made by state sanctioned institutions, informed by the predominant political and intellectual narratives, including how they are delivered and in what amount. These guidelines can be used to provide or restrict services, choice, and essentially agency amongst those operating within them. That's not to say there is no benefit or benevolence to such structures, only that the actors operating within them are influenced by them. Indeed, such structures are arguably the most ethical way to divide public funds.

Like Hobbes, Weber saw the application of power as justified by science and rationality, but he placed power within the bureaucratic and hierarchical systems of the time, and like Hobbes, placed similar importance on the rules of science and rationality that guide those processes. Weber saw increasing bureaucracy as inevitable but was concerned that risk aversity and bureaucratic precision would stifle innovation. This paradigm has shifted little since the late 19th century of Weber's writings and can be seen clearly in the bureaucratic and hierarchical machine that is the NHS. Indeed, the science guiding policy, service delivery and development in the NHS is highly bureaucratised through the National Institute for Health and Care Excellence (NICE), which is an *'an independent public body that provides national guidance and advice to* *improve health and social care in England. NICE guidance offers evidence-based recommendations made by independent committees on a broad range of topics'* (NICE, 2017a), which whilst noble in cause and supposedly independent, suffers from being significantly influenced by powerful intellectual and political agendas (see Dalal, 2018 for a critique of NICE), which permeate from the top down to the delivery of therapy and the relationship. A factor often cited in quality care from its own guidance is that of person-centred care, the irony of this being prescribed within a reductionist (Dalal, 2018) set of guidance is not lost on this author and one of the criticisms raised of such institutions.

Marx.

Marxism argues that power differences are embedded in the fabric of society and that different groups are assigned relative positions in it with different levels of power. Dominant groups emerge, such as upper class, white and male, and act in 'power-over' ways and oppress those from less powerful groups, such as the working class, people of colour and women. This social stratification of groups sees that power remains unequally distributed and systemically imbues privilege, status and materials on some, whilst taking away from others (Crompton, 2008). In this way power is inseparable from certain identities and demographics, such as class, ethnicity, gender, sexuality et cetera (DeVaris, 1994) and demonstrates the intersectionality of power (Crenshaw, 1990).

Marxism focuses on bureaucracy but sees it as part of class conflict and domination and argues that the state cannot wholly represent the public interest due to differing class interests. The state prioritises private ownership through surveilling the population and repressing ideas that systemic change is possible (Fuchs, 2013). Like other structural approaches, Marxism sees power as oppressive and monolithically held, with the upper classes holding power over the working classes. This, as Marx explains, puts those in the lower classes in a powerless and alienated position. The significant overrepresentation of those suffering mental distress being from lower socio-economic groups (Marmot, 2010; Karban, 2016) provides insight into ways psychological distress may be understood through a Marxist lens caused by powerlessness, class status and other social determinants.

Extending Marx's theories and particularly regarding hegemony (the dominance of one group over the ideologies and narratives of another; Hall, 1985), the Marxist author Gramsci, considered how ruling classes control other groups through controlling the dominant ideology or hegemony, which is in line with their interests (Ransome, 1992). Controlling the narratives and ideology allows for the unconscious shaping of individual identity and response, which as Gramsci offers, often appears consensual but with the fear of coercion and control underlying it, say for example with social or legal consequences when people fall outside of the accepted responses. This can be applied to seeking mental health treatment in the UK with the narrative that mental health difficulties need to be treated and that patients can choose to seek treatment, but with the underling possibility that they will be forced to be treated through the Mental Health Act (MHA) or through pressures from others around them, like friends and family. In this way there is implied consent in seeking and accepting treatment, with both social and legal underlying consequences of refusing to provide consent to treatment.

Feminist Authors.

Feminist theories are concerned with the examination of structural inequalities and particularly that all societies that divide the sexes into different economic and political spheres that privilege women less than men (Humm, 1992). Feminist theories are rooted in structural power, with power being monolithically and unitarily used and held by men. First wave feminism seeks to challenge the institutions that seek to oppress (see Heilmann, 2000), whereas second wave feminism challenges the invisibility of oppression, through the ideological power structures of the patriarchy, in the micro-interactions and everyday lives of people (Proctor. 2017). The invisibility of oppression to the unoppressed is important when considering the therapeutic relationship and feminist therapists such as Brown (1994), Lerman and Porter (1990), and Veldhuis (2001) have offered perspectives on a number of ways power is subtly reinforced and specifically how therapists may fail to recognise their power and act obliviously in ‘power-over’ and potentially harmful ways. That is by failing to recognise their own position of power they in effect negate their client’s reality (Brown, 1994).

Feminism has expanded from treating all women as a homogenous group. Important perspectives from black feminists (see Collins, 2000) and socialist feminists (see Eisenstien, 1979) have led to a more nuanced recognition of intersectional factors within oppressed groups. The increase in the acknowledgement of the intersectionality of power and its impacts can be extended to those seeking mental health support to help understand the complexity of structural operations of power.

Structural Power and the NHS

The importance of structural theories of power have been highlighted and the NHS as a unique institutional context, being highly politicised and one of the few international health systems free at the point of access (Benbow, 2018) is highly important maintaining and operating structural power. Founded following the Second World War on the principles of universality, equity, quality, and being paid for by central funding makes the NHS highly susceptible to political and economic power influences (Benbow, 2018). If we accept that power processes are pervasive in both structures and relationships, then these influences become important when thinking about their effects on policy and practice within the NHS, and the development of therapeutic relationships. To date there is no empirical evidence examining how the structure of the NHS and the structural power operations within it impact on the therapeutic relationship.

Demand for NHS services, including mental health services, has increased significantly in the last ten years with increasing pressure on services coinciding with government sanctioned policy of austerity and the stripping back of health and social care provision (Stuckler, Reeves, Loopstra, Karanikolos, & McKee, 2017). Health inequalities perspectives argue that the ever-increasing number of mental health issues in society are rooted in poverty, inequality and injustice (Marmot, 2010; Karban, 2017). These factors are closely tied with structural power, particularly political, economic and ideological power, and with widening societal inequality are likely to become more salient to more people (Murali & Oyebode, 2004). The current (2022/3) ‘cost of living crisis’ and drop in living standards (Corlett, Odamtten & Try, 2022) related to: the war in Ukraine, the fallout from the COVID-19 pandemic, Brexit (Dhingra, Fry, Hale & Jia, 2022), and increasing fuel, gas and electricity costs is increasing these inequalities and as such structural power operations are likely to become more salient and impactful.

The impact of ten years of austerity and the recasting of the role of the welfare state can already be seen to be impactful on the mental health of the population. For example, an analysis of benefit reform by Barr et al. (2016), into the introduction of Universal Credit and the Work Capability Assessment (WCA; originally introduced in 2008 by the Department of Work and Pensions) found a number of significant impacts. This reform meant that people claiming Employment and Support Allowance would be required to undergo an assessment to see if they were fit to work, opposed to receiving that state benefit. They concluded that in areas where more WCAs were conducted there were increases in suicides, anti-depressant prescription, and self-reported mental health problems. The authors concluded that over that three-year period the WCA was linked to 590 suicides, 279,000 additional cases of self-reported mental health problems and 725,000 additional prescriptions for anti-depressants. These statistics, demonstrate the impact of structural power on individuals and the correlates to mental health. Whilst research and attitudes are shifting to incorporate wider perspectives, including in how structural power operates on individuals, the responses and solutions remain tied to traditional medicalised and individualised service models (Cummins, 2018).

Furthermore, ideologically the NHS holds an important place for many people in the UK, with public support remaining stably high over the last thirty years (Robertson, Appleby, Evans & Hemmings, 2019) particularly for the service remaining free at point of use and available to all. Despite the surge in support for the NHS during the early part of the COVID-19 pandemic (Gardner, 2021), satisfaction has fallen from 52% to 36% from 2020 to 2021 (Wellings et al., 2022), which was related primarily to persistent and nationwide difficulties getting a General Practitioner appointment, routine surgery and the lack of staffing in the NHS. Understanding how attitudes impact on experiences of the NHS and by extension the therapeutic relationship is an important gap in the current literature that needs to be addressed.

Postmodern theories of power

Post-modern theorists, Foucault being the most prominent, see power as not something a person or structure can possess, but as a process of enabling and limiting action in relationships (Elias, 1978). Foucault (1980) views power as pervasive in relationships, and as such power is inherent in the micro interactions of individuals, which potentially go on to give shape to more structural forms of power and vice versa. For example, Foucault (1980) perceived language and the production of knowledge as inseparable from systems of power, especially in their ability to create norms, standards, and identities (Boyle, 2020).

For Foucault explicitly defining a model of power was seen as futile and even something that was to be discouraged, instead he provided a more ubiquitous perspective in contrast to the monolithic structural theories that felt power was possessed and exercised unidirectionally. Indeed Foucault (1980) argued *"power is everywhere... because it comes from everywhere"* (p. 93). In contrast to many structural theories, he felt that power was never wholly repressive instead feeling *'where there is power there is resistance'* (Foucault, 1979, p.95) and was concerned with how it was exercised within relations (Foucault, 1980).

In Foucault's 'Madness and Civilisation' (1967), he wrote about how 'madness' emerged due to specific power relations that were more subtle than just the overt use of violence or coercion. Foucault saw the medical profession gaining power not just from their privileged economic, social and intellectual position, but also from the complicity of their patients, *`rather than being a struggle for power between the dominant party [clinicians] and the less powerful party [patients] there is a collusion between the two to reproduce medical dominance'* (Lupton, 1997, p.98). Power dynamics were constructed through persuasion, rhetoric, norms of certain ways of behaving and thinking, and goes someway to helping us better understand how power may be operating on an unconscious and ideological level within therapeutic relationships.

Foucault's analyses in 'Madness and Civilization' (1967) forces us to investigate the way psychotherapy can be used as a form of surveillance and a way of teaching disciplinary techniques to the 'Mad' (Proctor, 2008). He argues how power is exercised discreetly or invisibly against those receiving mental health treatment. This could be seen to be highly prevalent but relatively unseen in the therapeutic relationship, and risks being overlooked by therapists. Structural and bureaucratic processes of risk reporting and management are at the core of most services, meaning that the service user, be it discussed explicitly or not, is under surveillance by the clinician regarding their risk, and the clinician under surveillance for being responsible for managing the risk, with potential and significant consequences for both service user (involuntary detention under the Mental Health Act) or clinician (dismissal or criminal proceedings) acting as an ever-present possibility.

With increased service pressures in the UK, particularly in secondary services, focus on managing and monitoring risk becomes the primary function of services (Liberati et al., 2022). This was significantly intensified during the COVID-19 pandemic due to significant service pressures, and thus the surveillance and possibility of coercive uses of power increased.

Contemporary examinations of power

There is an emerging shift from understanding psychological distress biologically to one concerned with power imbalances (Johnstone & Boyle, 2018) and that the operation of power impacts the functioning of our minds as social phenomena and 'come into the brain' and 'become part of our cerebral biology' (Fausto-Sterling, 2000; Kaiser, Haller, Schmitz & Nitsch, 2009, p.9). The Marmot Review (2010) identifies a clear link, between poverty, inequality and poor mental health, but the continued dominance of medical and individualistic approaches to mental distress prevents full consideration of the impact of social, economic and political factors (Shim,

2014) and as such the power operations within them. An approach that situates thinking about this centrally is work by Johnstone and Boyle on the Power Threat Meaning Framework (PTMF, Johnstone & Boyle, 2018). The PTMF examines the operation of power at biological, coercive, legal, economic, ideological, and interpersonal levels, and the subsequent effects on individuals' experiences of distress. However, this framework does not claim to fully account for all operations of power, particularly the more 'positive' uses of power (Johnstone & Boyle, 2018). Indeed, much of the literature around power focuses on the negative operations of power (Proctor, 2017), and often just at the abstract and philosophical level, and not the empirical level. Developing more robust empirical literature on 'positive' applications of power, such as positive collective power (Arendt, 1968) or nutrient power (May, 1998), could support greater understanding of its use in routine clinical practice.

Positive uses of power

Whilst most structural authors and postmodern authors, speak about how power is used to oppress and control, significantly fewer authors speak about how power is used as force for good. In 1963 Hannah Arendt introduced the idea of power through collectively as a positive force. She found power a positive, relational and freeing notion, with the coming together of people to increase power for everyone, with power being held by the collective opposed to the individual. Arendt's writing has significantly informed the notion of empowerment in psychiatry and other marginalised groups (Proctor, 2017) and the positive collective power that can emerge in groups. A current pertinent example of this is of the Hearing Voices Network, an international user led collective that organises and brings together groups of people who hear voices or have unusual experiences. There is developing evidence that such groups may have certain positive outcomes for individuals that cannot be delivered by traditional psychiatric services (Longden, Read, & Dillon, 2018).

Rollo May (1972) presented a model of the hierarchy of power ranging from negative and destructive uses of power, what May called exploitative, manipulative, and competitive power, which is similar to coercive, ‘power-over’ forms of power presented by other authors. Where he differs is his suggestion of ’nutrient power’ – a ‘power for’ or a healthy form of power driven by the concern of the welfare for a group for which that person carries responsibility. An example might be that of a teacher enforcing rules in a classroom to benefit the learning of their pupils. This could be examined in the form of the therapeutic relationship as a therapist encouraging or directing a service user who is ambivalent about engaging in a potentially beneficial therapeutic task that may be uncomfortable.

Integrative power or ‘power with’ is another healthy power described by May. This is a form of power where one person’s power abets and empowers another so that they can have more freedom of choice. May saw it as a form of power that allows for difference, criticism and conflict to be addressed in a non-violent or non-coercive way. Here there is mutuality and respect where ideas and change can grow through the dialectical process of thesis, antithesis and synthesis, allowing for greater choice within the relationship (Merwin, 2011) and as such empowering the person, reducing inherent power imbalances in the relationship.

Power in therapeutic relationships

Gillian Proctor (2008, 2017) is currently the only author to offer a theoretical perspective explicitly on aspects of power operating within the therapeutic relationship. She describes three aspects of power within therapeutic relationships:

> 1. *Role power* – the authority given by the therapist to define the service user problem and the power that the therapist has within the organisation and institutions where they work.
>
> 2. *Societal power* - arising from structural positions in society of the therapist and service user, such as gender, age and ethnicity.
>
> 3. *Historical power* - power resulting from the personal histories and experiences of power and powerlessness of both therapist and service user. This impacts and determines how individuals are in relationships and how they think and feel behaviour with respect to the power within relationship.

Role power and societal power are contextualised by structural theories of power, but Proctor's perspective on 'historical power' is important and pertinent to understanding the therapeutic relationship and indeed all relationships. These historical roles and experiences are often discussed within therapy but seldom seen from the perspective of power, though there is a shift with more recent theorising from the PTMF (Johnstone & Boyle, 2018).

Therapeutic approaches to power

Different psychological approaches pay different attention to power in their theory and delivery (DeVaris, 1994). David Smail (2008) put it that *"power and interest may have played a highly significant role in shaping the development of our discipline,* *but they have featured hardly at all in the conceptual systems we have constructed to account for the behaviour of others"* (p. 131). For example, in Cognitive Behavioural Therapy (CBT) theory minimal attention is paid to power outside of the formation of collaborative relationships (Spong & Hollanders, 2003), whilst Rogerian theory puts empowerment more centrally. However, in most schools of psychology power is primarily addressed in terms of the therapeutic relationship and not the structural power context and the effects this has on therapeutic relationships (Proctor, 2017).

Furthermore, the dominant political ideologies can be seen to have shaped and influenced major psychotherapy schools and vice versa. For example, the backdrop of the development of Rogerian theory and unconditional respect for the individual reflects the individualistic and libertarian discourses that were, and continue to be, prominent in the United States and United Kingdom. The rise of industries providing psychological services, it has been argued, may be due to the way it fills the niche left in the West's industrial, individualist, post-modern society by the decline of religion, family and community (Parker, 1997).

Humanistic approaches that place total centrality on the individual experience of the client may turn some (if not all) attention away from social determinants of distress. This includes how power operates both structurally and relationally and as such the benevolent focus on the individual therefore comes at a cost, the occlusion of how more distal forms of power impact the individual. This focus and narrative might help explain why social determinants of distress are attended to less in psychological theory compared to the individual ones.

The language and processes utilised by schools of therapy are open to be misused (see Masson, 1988 for a scathing critique) both directly and indirectly. Foucault spoke about the importance of language in constructing and maintaining power; and accepted therapeutic devises such as working ‘collaboratively’ or ‘empowering service users’, whilst apparently benevolent, may indeed act as a ‘ruse’ to control the subject through their own voice (Hart, 2002). For example, if one looks closely at ‘collaboration’ in CBT, an outwardly benign and positive tool to empower service users in therapy, and when applied rigorously arguably achieves its aims, but when used as a rhetorical device may serve to obscure the power differential between therapist and client and at worst runs the risk of the therapist feeling that the inherent power differential is attended to sufficiently when it is not.

Therapists, and particularly psychoanalytic therapists, have historically held an expert position and have been claimed to be neutral observers, unaffected by power (Orange, Atwood and Stolorow, 2015). This positivist epistemological position, whereby a therapist can profess to discover a ‘truth’ about a person without acknowledging how it casts the therapist in a more powerful position relative to the client is extremely problematic and suggests that therapists may unconsciously act in ‘power over’ ways in therapy. This also occurs in other therapeutic schools, for example, in CBT the expert position and authority of the therapist rests on the appeal to science. The assumption in the CBT model is that the therapist can be in an objective position to decide scientifically what is best for the client. However, the therapist cannot be in a completely neutral position and that there are risks in assuming this. Spinelli (1994) points out that the therapist makes judgements on what is rational and desirable, and that these are formed by cultural and societal influences, opposed to scientific appraisal. This runs the risk of imposing socially conformist norms and ideology on the client. Stemming from the ideas of Foucault around the use of language in ‘Madness’, Pilgrim and Treacher (1992) similarly explain ‘*psychologists . . . could play out a highly political role in terms of the management of the population, whilst at the same time* *disowning such a role by pointing to their 'disinterested' scientific training and credentials*' (p. 30).

CBT has attempted to address this through making the approach a 'collaborative' endeavour. However, arguably a therapeutic modality as prescriptive as CBT, and especially when delivered in in the context of highly prescriptive policy and guidance (see Dalal, 2018) can never be fully collaborative. Collaboration, as defined by Beck (1976) explains:

> *'It is useful to conceive of the patient-therapist relationship as a joint effort . . . The partnership concept helps the therapist obtain valuable 'feedback' about the efficacy of therapeutic techniques and further detailed information about the patient's thoughts and feelings' (p. 221).*

With this definition there is implicit expectations and responsibility on the service user, opposed to equality. That is not to suggest throwing the baby out with the bathwater and forgoing all attempts to be collaborative, but simply to make both therapist and client aware of this dynamic so that the potential risks of not attending to it can be attended to. Telford and Farringdon (1996) point to the risks of this and particularly with the client feeling as if they are coming to their own decisions and answers within therapy but in actuality they are being guided by the therapist and model to the socially normative 'right' answer.

Conclusion

This chapter has attempted to provide additional context for how differing perspectives on power may impact on service user experiences of power within the NHS. This is by no means an exhaustive review and attempts to show that theoretical positions on both structural and postmodern conceptions of power can be valid when attempting to understand power within therapeutic relationships and to highlight some of the areas where the empirical aspect of this thesis can address some of gaps in current understanding.

Chapter Four: Empirical Paper

Exploring NHS Service Users Experiences of Power in Therapeutic Relationships with Clinical Psychologists

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Abstract

Background: Little is known about how NHS service users experience power in therapeutic relationships with the psychologists they are working with. This is an oversight as the therapeutic relationship is the most stable predictor of outcomes in therapy (Norcross, 2001 & 2002) and power is theorised to operate in all relationships, and particularly within complex systems, like the NHS.

Methods: This paper uses qualitative methods (Interpretative Phenomenological Analysis) to answer the question, *how do NHS service users experience power in the therapeutic relationship*? Six adults who have experience of therapy in a single NHS Trust were recruited and interviewed. Data from these interviews was analysed to develop themes that answered the research question.

Results: Three subsidiary themes developed the overarching superordinate theme that described the experience of power in the therapeutic relationship – *The dynamic tapestry of power*. Their experience was interpreted as a complex and dynamic tapestry of emotions and experiences, whereby previous experiences of disempowerment shaped and impacted experiences within the therapeutic relationship, and where empowering or disempowering actions of the psychologist had transformative impacts on their experiences.

Discussion: This research brings service user experiences of power into the formal literature and highlights the importance of placing issues of power more centrally in clinical practice. It also offers insights and suggestions around positive uses of power in therapy and the role of gratitude in the NHS.

Introduction

Over 13,000 Clinical Psychologists practice in the United Kingdom (Health and Care Professions Council, 2019), many of whom engage in direct therapy with service users in the NHS within the secondary healthcare sector. Both Clinical Psychologists and service users must navigate complex power dynamics in therapy and within the NHS system. Understanding of power dynamics remains at the theoretical and philosophical level, and there is limited empirical evidence that investigates stakeholder's understanding of how power operates, especially in the context of a therapeutic relationship. This is an important oversight as power may influence the processes and outcomes in therapy, both positively and negatively, often in ways that are not always apparent to both clinician and service user.

Power operates on multiple intersecting axes and has been theorised from a range of political, philosophical, psychological and social perspectives throughout history. There is no unified model of how power operates in society, yet power and its uses remain part of common discourse, albeit in an ambiguous, abstract, and often elusive way (Eriksen, 2001). The difference in perspective, and the ambiguity and elusiveness of power means that understanding how power operates is a complex process and makes operational modelling and definition problematic. However, for the purpose of this research power will be understood from multiple perspectives and conceptualised as a dynamic range of structural and relational factors that provide individuals or groups with the ability to cause or prevent change (May, 1998) at an individual, social and ideological level. Current understanding of power has developed from two overarching perspectives: structural theories and post-modern theories.

Structural theories of power look at how power is embedded in social, political and cultural structures (e.g., government, NHS etc.) and generally describe certain groups or individuals possessing power over others, that is monolithic (held in one place), unitary (in one form) and unidirectional (used by one group of people) in a generally oppressive way. Key authors include Hobbes, Weber and Marx (see Hindess, 1996) as well as Feminist authors (see Sawicki, 1991 for a review).

Structural power processes and inequalities are closely correlated with distress and mental illness (Wilkinson & Pickett, 2009; Marmot, 2010), as well as influencing how institutions (like the NHS) respond to those they support, and with widening societal inequality are likely to become more salient as global inequality rises.

Post-modern theorists understand power as not something a person or structure can possess, but as a process of enabling and limiting action in relationships (Elias, 1978). Foucault (1980) views power as pervasive, yet often concealed (1967), in relationships, and as such power is inherent in the micro interactions of individuals, which potentially go on to give shape to more structural forms of power and vice versa. Foucault resisted offering a formal definition of power and in contrast to structural theories felt power was ubiquitous in all relations.

> *"Power is everywhere...because it comes from everywhere"* (Foucault, 1980, p. 93)

This perspective has implications for therapy and the therapeutic relationship as they are bound in relational processes.

Current psychological understanding of power takes into account both structural and postmodern views. For example, the Power Threat Meaning Framework (PTMF; Johnstone & Boyle, 2018) examines the operation of power at biological, coercive, legal, economic, ideological and interpersonal levels, and its subsequent effects on individuals' experiences of distress. However, this framework does not claim to fully account for all operations of power, especially the more ‘positive’ and empowering uses of power (Johnstone & Boyle, 2018). Whilst most structural authors and post-modern authors, speak about how power is used to oppress and control, significantly fewer authors speak about how power can be a positive force, with the exception of Rollo May and his description of Nutrient Power, ‘a power for another’ or Integrative Power, ‘a power with’ someone (May, 1998).

Psychological approaches pay different attention to power in their theory and delivery (DeVaris, 1994). David Smail (2008) put it that *“Power and interest may have played a highly significant role in shaping the development of our discipline, but they have featured hardly at all in the conceptual systems we have constructed to account for the behaviour of others”* (p. 131). For example, in Cognitive Behavioural Therapy minimal attention is paid to power outside of the formation of collaborative relationships (Spong & Hollanders, 2003), whereas the constructivist stance of systemic therapies pays more attention to power, although often with little unified agreement (Hoffman, 1985). However, in most schools of psychology power is primarily addressed in terms of the therapeutic relationship and not the structural power context and the effects this has on therapeutic relationships (Proctor, 2017).

Gelso and Carter (1985) define the therapeutic relationship as the feelings and attitudes that therapist and client have towards one another. A positive therapeutic relationship has been shown to be the most stable predictor of favourable therapy outcomes , such as symptom reduction and attrition (Horvath, Del Re, Flückiger & Symonds, 2011), and as such forming and maintaining therapeutic relationships is something that has been extensively empirically researched (Norcross, 2010). Much of the literature focuses on the experiences of clinicians forming these relationships (Levitt, Pomerville & Surace, 2016) and less attention is paid to the experiences of the service users. This is an oversight, as the less privileged are often more acutely aware of the operations of power (Fiske,1993).

There is also evidence that power is important to service users but ineffectually captured in the formal literature. For example, Curran et al. (2019) developed a model of process factors linked to negative impacts from therapy in which they found that salient factors differed between the formal literature and grey literature. Interestingly they found that the balance of power between therapist and service user was important in the grey literature but not captured in the formal.

The systemic and relational power structures that frame the therapeutic relationship between clinician and service user may lead to power being ‘unconsciously’ exercised by the clinician (Hardy, 2001, p.47). Despite acknowledgement of the importance of therapeutic relationships and that power may be significant, unconscious and inevitable factor (Proctor, 2017), almost no empirical attention has been placed on understanding the experience and role of power in such relationships and none from the service user perspective.

Furthermore, the scant literature looking at service users’ experiences of therapeutic relationships primarily comes from outside of the UK and the NHS. This provides arguably limited transferability for use in the unique public health context of the NHS, one of the few health systems free at the point of access (Benbow, 2018). The principles of universality, equity, quality, and being paid for by central funding the NHS is founded on makes it highly susceptible to political and economic power influences (Benbow, 2018). If we accept that power processes are pervasive in both structures and relationships, then these influences become important when thinking about their effects on policy and practice within the NHS, and as such the development of therapeutic relationships.

This study will address the gaps in empirical evidence surrounding the experience of power in therapeutic relationships between Clinical Psychologists and NHS service users. Addressing this will support not only the theoretical base, but also support NHS stakeholders in the development and application of policy and practice. Furthermore, addressing this gap should help Clinical Psychologists and service users in the NHS navigate the complex power dynamics more effectively, instead of relying on intuition and fragmented literature from multiple theoretical approaches, which has not been developed for use in the unique context of the NHS. The following research question has been developed to explore this:

How do NHS service users experience power in therapeutic relationships with Clinical Psychologists?

Method

Design

A qualitative design, Interpretative Phenomenological Analysis (IPA, Smith, Flowers & Larkin, 2012) was utilised. IPA's philosophical grounding in phenomenology, hermeneutics and idiography, provided a base to explore the contextual experience of participants. The author's ontological and epistemological positions align with the method of IPA. The author's ontological position is grossly one of subtle (opposed to radical) relativism but a position that accepts difference in ontological domains. Particularly for this research the author wants to acknowledge that there are domains where truth is dependent on context but without the global denial of the reality of individual subjectivity. The denial of individual subjectivity as an ontological position would be somewhat hypocritical in a paper that wants to examine service user experience in the formal literature. Thus, a subtle relativist position allows for an almost critical realist perspective in this specific ontological domain and allows for the exploration of experience and phenomena. Discussions of power often fall within more radical constructivist approaches (Van Dijk, 2015), and as such the analysis will have features of this, but as a way to frame and better understand experience. A soft constructivist epistemological stance, which is compatible with IPA, is also held by the author, and is particularly helpful when considering the importance of language in meaning making (Burr & Dick, 2017) with a research question that is very much concerned with the social context of participants (E.g., the NHS). See Willig (2016) for an interesting discussion on constructivism and more realist approaches co-existing in research examining experience.

Incorporating a lived experience perspective in the development and analysis of this research is important to address inherent power differentials between researcher and participant (Rose & Kalathil, 2019). The research included experts by experience and multiple members of the research team had experience of receiving therapy. This influenced the development of the rationale, research question, operational aspects of data collection and analysis, as well as supporting contextualising the results. Ethical approval was gained from the Health Regulation Authority (NHS research ethics committee) and the University of East Anglia (see appendix H-K).

Participants

Following guidance from Smith et al. (2012), six participants were purposively sampled and recruited from a large mental health trust in England. In line with IPAs requirement of a homogenous sample as well as considering the research question, inclusion and exclusion criteria were applied. Participants were English speaking adults

(18 or older) who had recently or were currently in receipt of secondary NHS community mental health care within a specific mental health trust. Secondary services were examined because of the likelihood of more intensive one to one psychological intervention and it also being the most utilised mental health sector (NHS Digital, 2019). Participants had engaged in individual therapy with a single Clinical Psychologist for a minimum of eight sessions, within the last 24 months, to provide rich accounts of recent experience. Due to the COVID-19 pandemic, therapy took place remotely as well as face-to-face, which was considered in the analysis. Finally, to be included participants had to consent to the professionals co-ordinating their care to be informed of their involvement in the study.

Exclusion criteria includes people subject to Mental Health Act (MHA, 1983) conditions during their therapy. This is because of the significant impact of structural power on the dynamic between service user and clinician. Exclusion criteria also included people who were actively engaged in any psychological therapy at the time of the interviews so as to not interfere with their current therapeutic relationship as well as people without capacity to consent and those with significant cognitive impairments. Appendix L includes greater details on rationales for inclusion and exclusion criteria.

Demographic information (table 1) and the demographics participants perceived their psychologist possessed (table 2) were voluntarily collected to better understand structural differences between participants and clinicians.

Pseudonyms were used to protect the identity of all participants.

Table 1

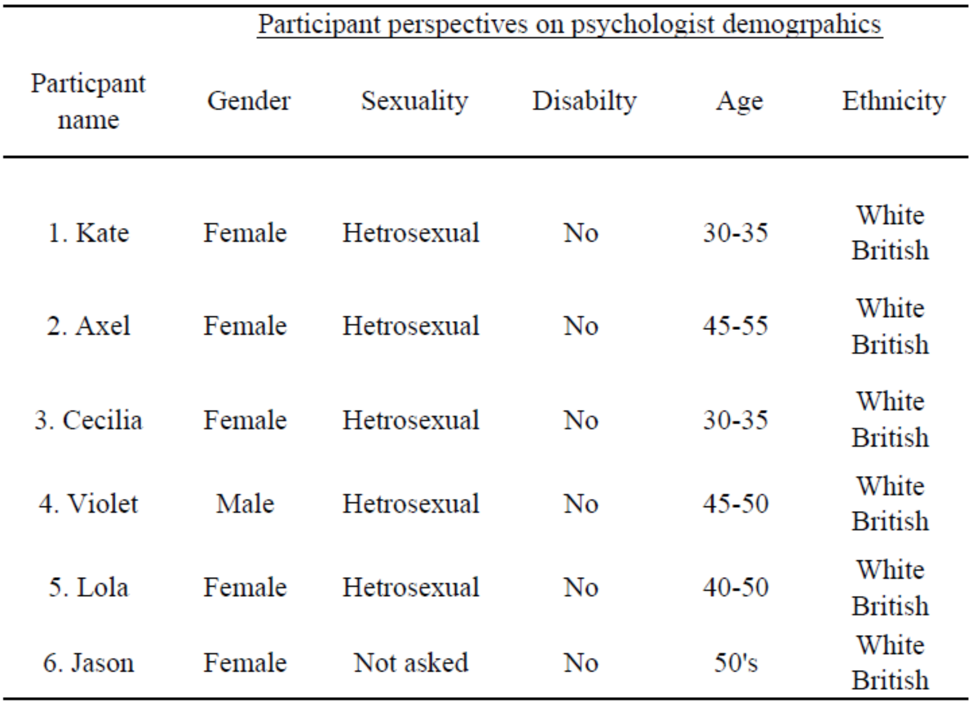
Participant demographic information

Participant Demographics												
Participant name	Age	Gender	Diagnosis	Reported therapy	Ethnicity	Sexuality	Education	Employment (at time of interview)	Employment (at time of therapy)	Disability	Approximate number of therapy sessions	Therapy delivery
1. Kate	26	Female	Anxiety, Depression	CBT	White British	Straight	University	Yes	Yes	No	12	Phone
2. Axel	23	Agender (Trans)	Anxiety, Depression, OCD, ADHD, ASD, PTSD	ACT	White British	Polysexual / Queer	A-level Equivalent	No	No	Yes	24	Online
3. Cecilia	48	Female	BPD	Not known	White British	Lesbian	University	No	Yes	Yes	12	Online
4. Violet	39	Female	Complex PTSD, Substance Use Disorder	Not known	White British	Bisexual	University	No	Yes	Yes	16	Online
5. Lola	36	Female	PTSD	EMDR	White British	Demisexual	University	Yes	Yes	No	16	In person / Online
6. Jason	46	Male	PTSD, Bipolar Affective Disorder	CAT	White British	Not Asked	High School	No	No	Yes	13	In person

**All names are pseudonyms*

Table 2

Participant perspectives on psychologist demographics



	Participant perspectives on psychologist demogrpahics				
Particpant name	Gender	Sexuality	Disabilty	Age	Ethnicity
1. Kate	Female	Hetrosexual	No	30-35	White British
2. Axel	Female	Hetrosexual	No	45-55	White British
3. Cecilia	Female	Hetrosexual	No	30-35	White British
4. Violet	Male	Hetrosexual	No	45-50	White British
5. Lola	Female	Hetrosexual	No	40-50	White British
6. Jason	Female	Not asked	No	50's	White British

Participants were recruited through the host mental health trust with input and guidance from People Participation groups. The study was advertised through a range of media through the trust communications department as well as directly through community mental health teams, third sector affiliates and the Research and Development department of the host trust. Participants were directed to the study website to express interest, screen for eligibility and complete the consent process.

Materials

Semi-structured interviews were utilised, which is typical in IPA (Reid, Flowers & Larkin, 2005). This allowed flexibility for the participant to convey their experience, but with enough structure to answer the research question. The interview schedule was developed in collaboration with the research team and with input from people with lived experience of using services. The schedule was developed iteratively with reference to Smith et al. (2012). A schedule of ten open questions, including narrative, structural, contrast, evaluative, and circular questions was developed along with appropriate and theoretically derived prompts and probes (Smith et al., 2012).

Procedure

Local and national ethical guidance was followed throughout the process and all consenting and eligible participants were interviewed remotely by a secure video platform. Formal interviews lasted between 60-90 minutes including time for questions prior to the interview. Structures to provide additional support to participants were included as well as protocols to handle accusations against any potentially disclosed malpractice. Interview audio was recorded via an encrypted recording device and then transcribed and anonymised. The psychologists with whom they worked with were not informed of their involvement (though normal safeguarding and confidentiality procedures were followed) but the lead care professional (care co-ordinator or GP) were informed. Participants were fully debriefed after the interview and were provided with a £10 Amazon voucher in gratitude for their time.

Analysis

Anonymised transcripts were analysed in Microsoft Excel. IPA is analytic in focus and pays attention to how the participant makes sense of their experience (Smith et al., 2012). This was an iterative and inductive process, requiring reflexive engagement with the data. This analysis used the steps outlined by Smith et al. (2012). These steps involved immersion in a single participant’s data with specific attention to experience, concerns and understandings; initial noting, paying attention to descriptive, linguistic and conceptual comments. With regards to linguistic noting the analysist's 'soft constructivist' stance was influential here, in terms of attention paid to the social context of subjective accounts and the use of discourse in constructing the experience of participants. This commentary allowed themes to emerge, and the analyst searched for connections across themes, with particular attention to convergence and divergence, potency, and commonality and nuance, between participants and their accounts. Analytic devices suggested by Smith et al. (2012) were used to support 'dialogue' between the data, the analysist, and their psychological knowledge about what it may have meant for participants in this context, allowing for themes to emerge. After this was completed, the analysist moved on to the next case, repeating the previous steps until all cases were examined. The experience of immersion in the preceding data had the potential to influence subsequent analyses. This was something the analyst was mindful of, and as such careful use a reflexive diary and supervision was used to make sure that novel meanings or interpretation were not lost. Once all cases were analysed, the final step involved drawing themes across all participants together and creating master themes for the cohort, looking for potency and connections or disparities between themes, and moving towards a theoretical conceptualisation of related themes. This was done at the abstract and idiographic level, continually moving between the part (individual accounts and themes) and whole (overarching themes and data clusters) to make sure the captured experiential essence was firmly grounded in the data. Furthermore, the analysist considered carefully their ontological and epistemological positions, clarifying these in the context of their prior experience. This allowed for the analyst to engage in 'bridling' (Dahlberg, 2006), a more nuanced form of 'bracketing' (Tufford & Newman, 2012) often adopted in phenomenological research. Bridling allows for more reflexive engagement with the analysist's assumptions and acknowledges the continual impact, and indeed struggle, with bringing these into analytic awareness. The steps outlined by Stutey, Givens, Cureton and Henderson (2020) were used to support this and included a written account of preconceived understandings, reflexive attention to initial analytic assumptions and the use of peer consultation and supervision to more openly explore assumptions. See chapter 5 for more information regarding the exact analytic process.

Quality was monitored using Yardley's (2000) principles, including, sensitivity to context (idiographic and phenomenological approach), commitment and rigour (transparent purposive sampling and regular supervision), transparency and coherence (use of reflexive diaries and clear process records, allowing for independent audit), and focus on impact and importance (discussed in introduction).

Results

The analysis led to one superordinate theme describing the overarching experience of power in the therapeutic relationship and directly answering the research question. This theme contained three subsidiary themes that were temporal but not linear and provide evidence for the overarching theme by examining the experiences of power throughout the relationship. The subsidiary themes will be presented first to show how they construct the superordinate theme, which is in line with the soft constructivist aspects of this analysis, that is, the data and interpretations in the subsidiary themes form the more abstract, higher order analytical theme.

Subsidiary themes

1. *“Past experiences, if you like, had shaped my thinking” - The different threads of disempowerment that shape experience in the relationship*

The first subsidiary theme describes how previous experiences of disempowerment shaped participants’ experience of power and expectations in the therapeutic relationship. Lola explains how *“past experiences if you like had shaped my thinking”* and particularly experiences of disempowerment. This was salient throughout the traumatic and often abusive experiences within participants’ accounts.

However, these experiences were often tempered, with both empowering and compassionate experiences alongside the more disempowering. For Lola this was particularly noticeable in her previous experience of eating disorder services where she was required to be weighed daily. She explained experiences of being weighed with humanity and empathy, but other times where interactions were stripped to a clinical process.

> *“I was treated like a number, come in, get on the scales, I’ll write that down, and see ya later. Who was I? I could have been anyone. She could have just weighed an orange.” - Lola*

Lola’s powerful analogy of being like an object, ‘an orange’, speaks to a feeling of dehumanisation and her choice of the word orange signifying how little she felt valued. The casual tone of ‘*see ya later’* connotes the dismissal she felt and her questioning “w*ho was I?”* speaks to her sense of loss of identity in the context of this seemingly routine clinical interaction. Cecilia described a similar complex experience of positive feelings cut with feeling disempowered in an experience of a psychiatrist from 20 years prior.

> *"She was a lovely lady, but she was very 'there there, there there'. Very much patting you on the head. Very patronising and I very much felt like I was to do as I was told, in that time yeah? A little person, less than human." - Cecilia*

Her descriptions of a lovely lady who nevertheless made her feel patronised and dehumanised and like a *'little person'* highlight powerfully the interwoven experiences of simultaneously caring and disempowering treatment and the tension this created for participants. This was potently echoed across participants, yet those disempowering experiences were the most deeply felt and easily recalled.

Whilst there was convergence across most participants there was divergence in Kate's account, which included fewer direct examples of traumatic experiences, and less salient descriptions of the experiences associated with disempowerment. When asked how power affects her, she was less able to articulate this than all other participants who described traumatic incidents.

> *"Ummm I think to some extent… I'm not quite sure, I don't really see myself as having a struggle with power at this point in my life, I can't really think of any examples to be honest" - Kate*

Whilst the experiences of disempowerment varied across participants, there was commonality in descriptions of feelings of dehumanisation, dismissal or abandonment, judgement or invalidation and fear. These were experienced both within and external to NHS mental health services and from people in more powerful positions, leading most participants to conceptualise power as hierarchical and held over them, and occasionally, as something to be feared.

> *"it [power] can be abused very easily" – Axel*

> *"Power's danger" – Jason*

On top of these, often conflicting, feelings participants expressed a sense of desperation or anxiety on entering the therapeutic relationship. There was nuance in participant accounts from directly stating their desperation to more implicit and felt senses of anxiety.

"I don't know, being quite desperate for my recovery I suppose" – Violet

"you get there and you're desperate" – Axel

This was seen across participants as desperation or anxiety to understand and feel understood in their distress. This was most prominent in Jason's account where he repeated variations of the phrase *"do you know what I mean?"* around 80 times after each point he made. The desperation to be understood in this simple phrase conveyed not only acute desperation, but a chronic experience of not feeling understood by those in power, and potentially by the researcher interviewing him.

Violet described wanting, almost desperately, to be understood by those involved with her care but also to understand herself and her traumatic experiences. This was one of her most important hopes for therapy and she described wanting the experience of *'piecing together my story'* which invites images of a shattered self that wants to be put back together and understood. Across participants there was commonality in terms explicitly stated and interpreted feelings of desperation or anxiety, combined with fears and expectations of disempowerment, connected and moderated with different levels of hope for change, and again shows the complex emotional experience of coming into therapy.

"A little bit of hope that things could get better, but there was obviously a lot of natural distrust wariness and fear" – Axel

There was also desperation or anxiety for help with their distress which was often intensified by frustrations around the amount of time and energy it took to receive support. This was experienced potently by Violet, Axel and Jason and this impacted on what they felt they would accept from services.

> *"I was very much desperately willing to engage in whatever needed to be done to achieve my recovery" - Violet*

As stated by Violet above this desperation meant participants felt more willing to accept what was offered to them, and most received no choice in what they received. Some participants were content with this and found being told what they needed containing. Kate, for example, '*kind of went along with what they recommended'* as she had *"never really been in therapy before I didn't really know what I needed".* This highlights how Kate, and indeed all participants drew on past experiences to construct their expectations (or lack thereof) for therapy. For Axel there was more tension, particularly as they felt the therapy was not addressing their core pain.

> *"Um. I may have expressed the fact that I was displeased because it [the therapy] wasn't addressing trauma, I could have spoken about it, but I didn't because I was like well it's what she's offering. I can't, I can't really, I have no power to do anything about that if that makes sense?" – Axel*

This passage highlights the disempowering position Axel felt and how they felt they needed to silence themself because of it. This is a powerful example of how previously constructed discourses, based in prior experience, have experiential elements such as feeling disempowered. Axel further explains how having to accept other interventions was required to continue receiving care. They describe feeling fear in losing support, a need to be accepting or compliant, and a sense of injustice.

> *“With my care coordinator it was like ‘you have to go to these emotion regulation groups, with all these other young people or you’ll be seen as uncooperative and you won’t get further care’. That… Needs… To… Stop…” - Axel*

This quote helps shine light on how their experience was shaped by not only relational experiences of power but also from wider more structural sources and discourses. Indeed, some participants spoke directly to the NHS and UK context and at the societal and political narratives of feeling grateful for the NHS. Lola for example felt she had *“to be compliant, and to gratefully accept what is offered to me”.* This can be seen as a subtle, yet powerful force influencing how one might be expected to act when coming into therapy. Violet went further by attempting to explain how the NHS being free at the point of need blurs the boundaries of how the NHS is paid for and how this can impact on how it is received.

> *“if we are provided a service, somehow we either need to accept it and be grateful and submissive to it, because we should just be grateful and say thank you because it’s a gift”- Violet*

Violet describes an NHS service as gift because of this, describes a potentially powerful experience that has the impact of making her feel grateful but also submissive to it. The use of the word submissive denotes disempowerment, but woven with gratitude, and the feeling that one cannot refuse what is offered.

These complex and rich experiences came into the therapeutic relationship and shaped how participants’ experience and expect to experience power. Axel sums this up:

> *"then you bring that all into the therapy room at the beginning and you have to work through that, you then have to learn that okay my therapist can actually be helpful despite the massively long wait. Like the therapist, even if the NHS and government don't care about us, the therapist does, um that kind of thing" - Axel*

Note also that Axel looks beyond the interpersonal experiences of disempowerment to the political, structural and ideological, again demonstrating the diverse, complex ways that participants could be open to disempowerment and specifically how the constructive acts and discourses shape the experiential. This was a complex experience of fearing further disempowerment, often through judgement, invalidation or rejection, but moderated with gratitude and hope for change and a sense of tension between these two positions.

2. *"It's never kinda been equal, but yea it didn't feel like at the same time, it didn't feel inequal" - The balancing of power in the relationship*

This subsidiary theme looks at how participants experienced a feeling of tension due to power feeling naturally unbalanced on entering the relationship. They described how often subtle and unconscious acts by themselves attempted to protect from the feelings associated with historical disempowerment, such as feeling judged or dismissed. Participants also described more overt ways they or their psychologists attempted to balance or shift power in the relationship. These acts subtly changed the experience for participants and often brought relief to the tension felt.

As described in the first theme, the tension and imbalance of power was set up and often constructed prior to therapy and was felt as a natural part of their experiences.

Axel describes psychologists as having an obvious and '*natural power'*. They felt this was held within psychologists' role and status.

> *"As a therapist she has the power to say, yes, I will treat you, no I will not treat you, this is the treatment I am offering. I don't get a say in this." – Axel*

This imbalance also appeared to be held partly in participants' identity of being a service user and someone with mental health difficulties, and all service users acknowledged to some extent the existence of historical stigma in being a recipient of mental health services. Lola described how this identification created a *"them and us"* dynamic with the *"power being with the clinicians".* Participants' identification with this group was demonstrated linguistically through accounts through the use of second person language, 'we/us' and 'them/they'.

> *"You can't do that with people with mental health problems because, we, the majority of us feel lonely and empty and disregarded" - Cecilia*
>
> *"why do we only get a mental health day or mental health week" – Jason*
>
> *"we're like mentally ill now, we need help now, we don't need help in a year's time, we want help now" - Axel*

Violet further goes on to describe how her mental health condition *'should not be life sentence'* and asking another clinician '*what crime do I have to commit to get treatment'*. Her drawing on these narratives and providing comparisons to feeling both punished and that she needed to commit a crime to get help give insight into the disempowered and desperate position she felt her mental health condition afforded her. These positions shine light on what the experience entering the relationship felt like for participants and where the imbalance may lay.

Power was used and experienced dynamically and often outside of consciousness by participants.

> *"I think in the beginning I probably tried to assert my power. It's not even necessarily always conscious. It is often on reflection I realise, oh crap I was testing him." – Violet*

All participants initially protected themselves from further disempowerment through subtly managing what they would say to the psychologist or how they presented themselves. Kate for example did not share experiences which made her sound *'petty',* whereas Axel more explicitly described not feeling able to disclose a shameful incident involving a more powerful person due to fearing judgement from the psychologist.

> *"I didn't want my therapist to think less or differently of me, if that makes sense, and that's something I have no power over, but the thing I have the power over was whether I say this or do I not tell her this." - Axel*

Withholding information was one of the few ways participants felt they could hold on to power. This was often in response to fearing disempowerment and the associated, feelings such as abandonment or judgement, again highlighting the experience for participants through their methods of protecting against it. There was nuance in this across participants in the extent that did this. For example, Jason showed the extent and importance of this for him as never allowing his full self to be seen was the only way he felt protected from the perceived dangers of those in power.

> *"And I have had to blend in, I've had to be a chameleon, I've had to for survival" - Jason*

His likening himself to a chameleon, a creature that physically camouflages itself from threats is an image that conveys the real sense of constant threat as well the extent he went to protect himself. Jason further explained that part of his camouflage was telling people what they want to hear, again to manage his image in response to the threats posed by a more powerful other.

> *"You have to adapt any environment, any situation. I pick up on the things that you want to hear, do you understand?" - Jason*

Most participants also adapted through adopting the language of mental health professionals, using words such as *'emotion regulation', 'intrusive memories', 'hypervigilance', 'window of tolerance', 'radical acceptance', 'engagement'* and *'intervention'*. For Violet, Axel and Cecilia this use of language was how they understood their distress and treatment, but also was interpreted as a devise to add to their credibility and demonstrate knowledge.

Participants who had felt significant disempowerment from mental health and statutory services described how they would assert their power more explicitly. For Violet this was through *'showing her anger'* to her psychologist to see if he could *'take it'* and not abandon her in her distress or anger, as she described other clinicians doing.

> *"my previous mental health workers from [trust] would have just bailed on that situation, that was the standard protocol, was leave her to it" – Violet*

Jason who described numerous incidents of disempowerment by people in authority, and specifically being made to feel fearful, abandoned or let down by those who were meant to care for him, explained how he expected his psychologist to give up on him.

> *"because I knew she wanted to quit" – Jason*

He described how his response to the fear of this was to test those he worked with. He explained intensely scrutinising his psychologist as something that was necessary to his survival.

> *"I need to read your body language I need to see the sweat on your brow, do you know what I mean?"*

> *"[with regards to online therapy] I can't see your pupils if they're dilated or not you know I mean, that's how intense I am…"*

His use of seeing '*the sweat on your brow'* or whether peoples' pupils are dilated conjures images of the pressure and possibly fear this intense scrutiny would put people under. This can be interpreted as a form of power and control he was exerting in response to the danger and stress of potential disempowerment through having his psychologist 'quit' on him as he felt many others have. However, for most participants, where the balance of power was more equal, they found they did not have manifest some sort of power explicitly.

> *"It was a more level playing field, so I didn't really need to use power as such. I didn't need to question power or use power against my therapist." – Lola*

Psychologists supported those areas of historical and current disempowerment in subtle ways that felt nurturing to participants. Feeling nurtured looked slightly different for each participant but when consistent had a reparative effect on their feelings of disempowerment in both the relationship and more generally. Participants described the feelings that were opposite to those felt when disempowered, such as validation, humanisation, and feeling understood and accepted, and how this resolved some of the tension on first entering therapy. For Axel, who was wary of invalidation, the psychologist consistently validating, and encouraging them was vitally important.

> *"It was just the consistency in her behaviour so after a few sessions the fact that she remained the same, she still validated my problems, she still encouraged me and praised me when I made achievements, she was still respectful. It was the fact that she was showing me that some people in authority and indeed in the NHS itself can be trusted." - Axel*

This supported not only their relationship with the psychologist but how they felt about the NHS. They consistently felt that the NHS could not be trusted, and whilst this did not fully dissipate it changed their ability to trust in the NHS after years of feeling distrustful.

Opportunities for psychologists to empower participants were seen through offering choice and flexibility within the work they were completing. This was a more direct way of psychologists addressing power in the relationship and indeed giving up some of their power. Axel highlights the importance of this of this being driven by the therapist and the importance of them recognising the powerful position they hold:

> *"people who don't have power will only have if those with power give it up." – Axel*

> *"...if people are aware of the power they hold, then they have the power to not to abuse it." – Axel*

Choices around therapy were generally limited for participants, but small offerings from psychologists, such as choice on what was covered or the pacing of sessions, had important impacts on their experience of power in the relationship. This again relieved some of the tensions and made it feel more of a *'level playing field' (Lola)*.

> *"rather than feel it was, today we going to do X, Y, and Z, and this is what we are going to complete you know it was like, but that's okay, if we can't do it all today will set up another one, for the end of the week" - Lola*

> *"I can remember with the psychologist we didn't always do things in order, we had things we had to go through, but sometimes I wasn't in the right place to do certain things." – Cecilia*

These small acts did not remove the feeling of inequity in the relationship but made it more trusting and equal for those participants that did experience it with their psychologist. For Kate, who overall felt empowered by her psychologist, describes how whilst her experience of power was never equal it did not feel inequal.

> *"it's never kinda been equal, but yea it didn't feel like at the same time, it didn't feel inequal" – Kate*

This quote helps to summarise that power was naturally felt as unbalanced yet there were ways that that this experience may change through the mostly unconscious or indirect actions of participants and psychologists.

3. "I think that was probably a turning point" – Pivotal therapeutic moments and ruptures that transform the experience of power

All participants described particularly pivotal moments where power was thrown sharply into focus which had a transformative impact on how they experienced power and tension in the therapeutic relationship. These were interpreted as 'therapeutic moments' or 'ruptures' in the relationship. There was divergence across participants on how this happened but commonality in terms of the impact it had on them and the relationship. Therapeutic moments were experienced positively, whereby tensions related to fears around disempowerment were greatly softened often leading to feelings greater trust or comfort in the relationship. Whereas ruptures were experienced more negatively, often confirming the expectations of participants that they would be disempowered and felt experience of deflation following the potential hope for change.

Kate provided an example of a therapeutic moment early on in her therapy. She repeatedly spoke about the importance of confidentiality to her, due to a fear of being judged, and for her this was early on in the sessions.

> *"So in the first in the first meeting um confidentiality was mentioned and it made me feel very comfortable to know that it wouldn't be shared outside with people when it wasn't necessary." – Kate*

This allowed her to feel comfortable and a sense of relief in the relationship, something which followed through the rest of the sessions. For Lola it was a moment where she pushed back and had to stop the session which was becoming emotionally and physiologically distressing ("*Stop! I need to stop!*"). It was seen as a pivotal '*turning point'* for her and was linked to her beliefs around being a compliant patient and her fears of disclosing her physiological feelings associated with her trauma to the psychologist, both of which were core aspects of her prior experience.

> *"But because we got to that point I think I've got to go, I can't deal with this and she guided me back down and levelled out some of that adrenaline I was feeling, I think that was probably a turning point where I felt more able, regardless of how I projected onto her to share, I was able to put my projections aside I think at that point and go, she nurtured me, she gave me what I needed in that session, and I didn't have to leave the session, let's go with this, I just felt more trust from that point." – Lola*

Lola’s use of the word ‘nurtured’ can be interpreted as the psychologist using their power to help contain Lola’s distress and take hold some of that distress when she was unable to. This was a transformative moment in their relationship where she was able to change her projections towards her psychologist.

However, other participants experienced ruptures in the relationship and for those participants (Violet and Jason) they audibly deflated when describing their experience in interview, providing further insight to how this was experienced by them. The ruptures were centred around the fears and expectations of being let down and disempowered that were developed prior to therapy, again showing how constructive acts and discourses translated into the experiential. For example, Violet had expected long term trauma and attachment based therapy, but after three months she found out this was not the case. She felt as if this had been concealed from her and as such felt *‘cheated’* out of the recovery she was so desperate for.

> *“he’d let slip, by accident, that we only had something like three months left or something” – Violet*

For Violet, this was having an experience of services letting her down again along with a sense of loss. The felt sense of this being something she had fought for many years for and had been so excited to embark on had felt like it had been for nothing.

> *“I was angry that my entire therapy had been….[implied for nothing]” – Violet*

This also had transformed the relationship between her and the psychologist as it did with those participants who experienced the positive therapeutic moments. However, for Violet this was *‘disconnecting’* from therapy and feeling very angry with her psychologist. She also set to protect herself further in the relationship as she "*put up my boundaries once I found we were on a deadline."* Her trust in him was also damaged and *'even in the last session, after six months, I still didn't believe a word he said'.* This theme highlights the transformative effect that focus on areas of historical disempowerment can have on the experience of participants in the therapeutic relationship.

Superordinate theme

The superordinate theme brings together the subsidiary themes in an overall metaphor of the experience of power in the therapeutic relationship. This is a constructive and interpretative act by the author and aims to provide a summary of the overall experience of power.

The dynamic tapestry of power

The experience of power for participants can be interpreted like a complex tapestry of experiences and emotions, that was continually woven, torn, and patched over a lifetime. Each participant's tapestry was dynamically evolving, often outside of consciousness, as they came into therapy, with threads and tears from intrapersonal, interpersonal, experiential, political and societal sources, continually giving shape to their experience. For these participants the most salient threads and tears in their tapestry were from their numerous experiences of disempowerment, particularly from abuse and trauma. These painful tears were expressed as part of the self and related to the meaning of disempowerment for them, such as fearing others, dismissal, dehumanisation, judgement or rejection.

Participants also described their sense of desperation and anxiety on entering the therapeutic relationship. Desperation and anxiety not just for help, but to understand and be understood. This was interpreted and described as participants feeling they had to gratefully accept the new threads offered to them, which was a subtly disempowering position. There was also a vulnerability and fear in exposing those torn and damaged parts of their tapestry, as it ran the risk of repeated experiences of disempowerment from figures in authority. This fear however was moderated with a hope that these tears might be mended or changed. The tension between fear and hope on entering therapy meant participants were more highly sensitised to possible issues of disempowerment, as power was naturally unbalanced towards the psychologist, and with that brought a sense of tension.

The tapestries of participants and psychologists interacted mostly unconsciously in the therapeutic relationship and shaped how participants experienced power. The feelings associated with the most disempowered parts of their tapestries were most sensitive to new threads of power and were the most protected by participants. Both participants and psychologists attempted balance power in the relationship through relational and dynamic processes and these acts shifted the experience for participants often bringing relief to the tension felt in the imbalance of power. This could be reparative, creating new threads or patches over old tears, but not always.

Participants were most aware of power when relational acts interacted with the most deeply felt and disempowered aspects of their tapestry. These were pivotal moments for participants when power was brought sharply into focus, often in seemingly small and unconscious actions of the psychologist. This had the transformative impact of shifting their experience of power in the relationship for better, or for worse, patching or deepening an old tear. For those whose tears were deepened there were also reparative threads and vice versa, but those pivotal moments shaped their experience beyond all others.

The actions, subtle and often implicit of the psychologist, took on greater meanings for participants when connecting with those deeper tears if they empowered or disempowered them in ways meaningful to their own complex tapestry.

Discussion

The results of this interpretive analysis provides an answer to the question 'how do NHS service users experience power in therapeutic relationships with Clinical Psychologists'. Three subsidiary themes describing 'the different threads of disempowerment that shape experience in the relationship', 'the balancing of power in the relationship', and 'pivotal therapeutic moments and ruptures that transform the experience of power' came together to provide an overall metaphor of the experience of power in the therapeutic relationship for participants. The superordinate theme, 'the dynamic tapestry of power', was an interpretive and constructive act highlighting the complex, dynamic and often unconscious experiences of power in the therapeutic relationship for NHS service users.

This research offers the first explicit empirical investigation from a phenomenological perspective of service users' experience of power in therapeutic relationships with Clinical Psychologists in the NHS. The first core finding of this paper is how previous experiences, constructions and discourses around power shape and impact the therapeutic relationship, something that is not explicitly empirically explored in the current literature. Specifically, the impact of how historical disempowering and empowering experiences, shaped what participants felt they were able to say and do within the relationship. The results provide descriptions of how power operations feel salient, complex and dynamic, yet are also subtle, unconscious or concealed within therapeutic relationships. It supports the evidence from the grey literature (see Curran et al., 2019) that experience of power is important to service users and brings this into the formal literature. The understanding of these participants' experiences has the potential to put power, particularly in terms of empowerment and disempowerment, not as just adjunct considerations for psychologists but as core targets for clinicians in the development of therapeutic relationships and calls for power to be discussed more explicitly in therapy and beyond. This is further supported in the data by the transformational experiences in the relationship described by participants when their most disempowered experiences and feelings were attended to.

The rich tapestry of experience described by participants demonstrates that multiple theoretical perspectives can support the understanding of power in this in context and provides empirical evidence to support development of the theoretical understanding in this context. Processes from both structural theories and postmodern theories were evident, with neither providing universally satisfactory accounts of participant's experience. To review each theoretical approach is beyond the scope of this paper and would be suggested for future research. However, this research does advance understanding in the contemporary literature on how power can be used positively. The reparative effects of psychologists empowering participants, when consistently applied, was described as 'nurturing' and part of the transformational acts of power in the relationship. This required psychologists to give some of their power up. This positive description of power is often neglected in the theoretical literature and is similar to 'Nutrient Power' described by Rollo May (2018). This is a healthy form of power driven by concern of the welfare of the other, and where their power is used 'for' the other. The data illustrates that positive uses of power are important to the therapeutic relationship and suggest that further empirical investigation to support the theoretical understanding of positive uses of power in therapeutic contexts is warranted.

The social context was explicitly attended to in this analysis and drawing from the more constructivist and relativist aspects of the analysis provide greater insight into the experiential elements of participants accounts particularly with societal experiences and discourses around power. For example, the context of entering a therapeutic relationship within the NHS had a number of important considerations for participants, but most strikingly the experience of feeling almost obliged to be grateful for the service they received (or at least demonstrate gratitude). This was often experienced as tension and fear of further disempowerment on entering the relationship, an acutely vulnerable position. Feeling grateful or demonstrating gratitude is on the surface a positive emotion, but for participants, and in the limited literature, does have the potential to be disempowering. For example, Galvin (2004) found gratitude to be unproblematic for able bodied people, but for disabled people it can 'signify an unbearable state of perpetual obligation' (p. 137) and consistent gratitude can be a hallmark of entrenched disempowerment, shame and frustration (Day, Robert & Rafferty, 2020). Indeed, Day et al. (2020) found a meta narrative of a care ethic that is attuned to the voices of the grateful, meaning that the important voices of the those who are not 'grateful' are missed. This has direct implications for how able NHS service users may feel around raising concerns or for seeking additional or different support and as such deserves more empirical attention.

The importance of language was also highlighted in the results and specifically how language was both a tool of constructing and sustaining power differentials between participants and clinicians as well as a way of trying to equalise differentials. The '*them and us'* dynamic that was explicitly and implicitly seen in this data is an arguably common narrative in service user discourse (see, Johnstone, 2000) that both constructs and sustains power differences. The adoption of the language of mental health professionals was also seen as not just a tool for understanding distress but as a linguistic devise to add to participant's credibility and to demonstrate their knowledge. The adoption the old maxim 'knowledge equals power' might be appropriate in this context. However, it is equally possible that participants were co-opted into adopting equal and known language of those in positions of greater power. These can be seen as an almost acculturation process and that the use of language and the discourses of the powerful (the professionals), in the context of previously described power imbalances, impacts on experience, such as feeling empowered or disempowered. More attention and research into this is called for.

Strengths and limitations

A key strength of this research is the sensitivity the analysis paid to the context of participants and the data; a quality indicator monitored through Yardley's (2000) principles. This attention was not just through strong philosophical grounding in IPA (idiography and phenomenology) but also from the soft constructivist epistemological stance taken by the author. This allowed for greater discussion and exploration of how constructive acts and context influence the experience of participants without losing the experiential and allowing for greater understanding participants experience of power. This is important in as it allows the findings to be reviewed against current clinical practice and policy within the NHS as well as highlighting additional areas where further research is needed.

There are limitations to this research, as this research examines only service users, in contact with a single NHS Mental Health Trust, and as such results will have to be considered within this context. This particular trust was under significant pressure regarding its performance over the last decade and that this will have likely impacted on the experience of participants and psychologists. Furthermore, whilst every attempt to ‘bridle’ the assumptions of the analyst was taken, through the use of careful reflexive diaries and supervision, there is likely to be some impact of a priori assumptions on the interpretive acts of this data. These limitations were considered within the context of Yardley’s (2000) principles.

Whilst IPA warrants a relatively homogenous sample, there was limited diversity in this sample. Particularly in terms of being an exclusively white sample (and researcher), and whilst there was diversity in terms of gender identity, sexuality and disability, it is likely that important aspects of the social context relating to structural power may have been occluded. This research can also make no assumptions about how much the psychologists working with the participant’s actively thought about, and attended to, power processes (either individually or through supervisory processes). This may have impacted on the results and exploration of this further from the perspective of both service users and psychologists concurrently would be a valuable future direction for research.

Future research should look at extending the exploration of power within the therapeutic relationship from the perspective of service users in the formal literature and building more robust links with the theoretical literature on power. Future research would also benefit from including a wider and more diverse set of perspectives, as it is likely that salient power operations would be different for say service users who are under MHA conditions, those from ethnic minorities or those with cognitive impairments. Furthermore, greater insight could be gained from recruitment of participants from mental health survivor groups, who speak eloquently in the grey literature about power but remain poorly represented in the formal literature.

This research also highlighted how power may have been used unconsciously and thus not discussed within the relationship. There are empirical (and potentially experimental) opportunities to investigate differences in relationships where power is explicitly discussed and attended to in therapy. This could have wide reaching implications for the development of practice guidance and add to the literature on developing therapeutic relationships in ways that can be operationalised for clinicians. Contemporary psychological approaches such as the PTMF (2018), community psychology, and user-led initiatives are potentially rich areas for empirical investigation into positive uses of power and empowerment and could further develop the empirical base.

Conclusion

NHS service users' experience of power in therapeutic relationships with Clinical Psychologists was interpreted as a complex, dynamic tapestry of experiences and emotions, shaped by previous experiences, constructions and discourses around power that impact the therapeutic relationship. When aspects of disempowerment were closely attended to, they had transformational impacts on the relationship, particularly when power was used positively by the psychologist. This research brings service user experiences of power into the formal literature and highlights the importance of placing issues of power more centrally in clinical practice. The impacts of feeling gratitude for receiving an NHS service and the ways this may be subtly disempowering are also important insights. Finally, psychologists and service users may be using or having power act on them unconsciously, and thus awareness and acknowledgement of power differentials is the only way to address what can be addressed. That is:

> *"…if people are aware of the power they hold, then they have the power to not to abuse it." – Axel*

Chapter Five: Extended Methodology

Introduction

This chapter provides additional details about the methodology and approach described in the empirical paper. The position of the researcher is outlined along with the philosophical positioning of the approach utilised, Interpretative Phenomenological Analysis (IPA; Smith, Flowers & Larkin, 2012). There are also further details pertaining to participants, recruitment, ethics and the analytic process.

Methodological Rationale

Ontology and epistemology

Understanding the philosophical underpinnings of research methods is particularly vital in qualitative research and allows the researcher to explain what they believe about the nature of reality, or ontology, and the nature of knowledge, or epistemology (Merriam & Tisdell, 2016). Qualitative research tends to come from a different philosophical and theoretical perspective compared to experimental and quantitative research and how questions are explored and answered depends on ontology and epistemology. The author has considered their ontological and epistemological position and particularly how these impact on the research questions posed.

Ontology exists on a continuum from realism to relativism. Realism is a pre-social reality or ‘mind independent truth’ (Tebes, 2005) which assumes that there is a knowable truth in the world and that it is accessible through research, whereas relativism sees reality as dependent on human interpretation, language and knowledge. Between these two differing positions sits critical realism, which assumes a knowable world that sits ‘behind’ the subjective and socially located knowledge that the researcher can access (Madill, Jordan & Shirley, 2000). The author would consider themself as subscribing to predominantly a relativist ontological position, and specifically subtle (opposed to radical) relativism but from a position that accepts difference in ontological domains. That is, that within a relativist position there exists the opportunity of 'plurality' dependent on the epistemic system or practice (see Kusch, 2017 for a defence of pluralism), and as such subscribing to a relativist position in certain domains and not necessarily others. Particularly for this research the author wants to acknowledge that there are domains where truth is dependent on context but without the global denial of the reality of individual subjectivity. The denial of individual subjectivity as an ontological position would be somewhat hypocritical in a paper that wants to highlight service user experience in the formal literature. Thus, a subtle relativist position allows for an almost critical realist perspective in this specific ontological domain and allows for the exploration of experience and phenomena.

Epistemology is concerned with the nature of knowledge and what it is possible to know (Braun & Clarke, 2013) and like ontology can sit between relativism and realism. A realist perspective accepts that there is a possible real truth 'out there' which can be accessed through the objective collection of data (aligning with positivist and post positivist epistemologies). Whereas a relativist perspective accepts that knowledge is always dependent on perspective and context, and that a singular truth is impossible (aligning with constructivist epistemologies), and that knowledge or reality is created by the research opposed to accessed by it. Sat between these two epistemologies is contextualism (Henwood & Pidgeon, 1994), which is akin to critical realism, and does not assume a single reality, but multiple realities dependent on the researcher's position. Contextualism remains interested in understanding truth but acknowledges that no single method can get to the truth (Tebes, 2005). Discussions of power often fall within more constructivist approaches (Van Dijk, 2015), and as such the analysis will have features of this, but as a way to frame and better understand experience. A soft constructivist epistemological stance, which is compatible with IPA, is also held by the author, and is particularly helpful when considering the importance of language in meaning making (Burr & Dick, 2017) with a research question that is very much concerned with the social context of participants (E.g., the NHS). See Willig (2016) for an interesting discussion on constructivism and more realist approaches co-existing in research examining experience.

Rationale for IPA

The research team carefully considered the most suitable methodological approach to answer the research question: *"how do NHS service users experience power in the therapeutic relationship with Clinical Psychologists?"* With the question being grounded in experience, in the specific context of the NHS and with a researcher adopting a critical realist position, qualitative enquiry and particularly IPA was deemed the most appropriate approach.

The research question is not seeking empirical generalisations and IPA does not seek to make these but instead is concerned with the detailed examination of human lived experienced and understanding the meanings that people impress upon it. The philosophical underpinnings of IPA, specifically phenomenology, hermeneutics and idiography, allow for this and will be discussed in greater detail in a later part of the chapter. Briefly though phenomenology examines lived experience and in IPA this is a hermeneutic exercise grounded in interpretation. In IPA the researcher is making sense of the participant making sense of an experience, also called the double hermeneutic (Smith & Osborn, 2003). Interpretation can occur on different levels and IPA uses the hermeneutic circle to explore how meanings at different levels of analysis (the part and whole), are linked and explored iteratively. This engagement with hermeneutics also allows for the researcher's position, power and privilege to be accounted for and is a key aspect of why IPA was deemed appropriate for this research. Finally, idiography, which is concerned with the 'particular', does not eschew generalisations (Harré, 1979) but locates them within the 'particular' and explores them with caution (Smith et al, 2012), creating dialogue between the particular and the psychological literature. This is important as there are considerable amounts of fragmented literature around power, therapeutic relationships, and the experience of service users in the NHS, which is important to consider and bring together in the analysis. This aspect allows for tentative suggestions for further research, practice and policy, adding value to findings that other approaches may not.

Philosophical grounding of IPA

Phenomenology

Phenomenology was first theorised by Husserl as a way of better understanding the lived experience of people within specific contexts (Alase, 2017). This focus on experience is critical to IPA and particularly the person's perception of the experience, examined in the way that it occurs (Smith et al., 2012). However, Husserl's conceptions of phenomenology have often been considered too abstract to apply as a qualitative method in its own right (Avis, 2005), and as such a string of other authors have developed his ideas further which has allowed phenomenological approaches to improve their usability in day-to-day research (Alase, 2017) and move away from the descriptive and transcendental interests of Husserl (Smith et al., 2012). Notably Heidegger, Merleau-Ponty and Sartre all start to shift towards viewing the person in the context of culture, relationships, projects and concerns (Smith et al., 2012) and towards a more interpretative account of experience. This shift towards interpretive phenomenology was summarised by van Manen (1990), who explained hermeneutical (or interpretative) phenomenology as being concerned with the 'lived experiences' of participants and the interpretation of the life they have experienced. This is particularly important for this research question and participants as the question is grounded a specific and complex cultural and relational context that requires more than descriptive analysis, because it is examining power, an elusive and difficult to define construct.

Hermeneutics

Hermeneutics is understood as the researcher's attempt to understand another person's experience through being actively involved (Pietkiewicz and Smith, 2012) in the meaning making. The lived experiences of participants are expressed through first order meaning making (the language they use to describe the meaning) which is then interpreted by the researcher to create second order meanings (Smith & Osborn, 2003). This acknowledges that analysis of an experience is co-constructed by researcher and participant, a process known as the double hermeneutic (Smith & Osborn, 2003). Furthermore, interpretation and meaning is sought at different levels within the data with focus shifting between the particular (smaller sections of data) and the whole (more global views) to shape understanding. This non-linear, dynamic, and iterative process allows for greater exploration of the data and dialogue between the researcher's preconceptions and new meanings as they emerge. Whilst the researcher can never fully suspend assumptions, IPA addresses this by suggesting attempting to 'bracket off' personal assumptions when engaging in the data (Moustakas, 1994). A further and more phenomenologically grounded method of doing this is called 'bridling' which allows for more reflexive engagement with the analysist's assumptions and acknowledges the continual impact, and indeed struggle, with bringing these into analytic awareness (Stutey, Givens, Cureton & Henderson, 2020). This will be discussed further.

This philosophical stance is important for this research as it takes the lens and experience of the researcher into account, as the author is a Trainee Clinical Psychologist researching experiences involving psychologists.

Idiography

IPA is concerned with the detailed examination of human lived experienced. Idiography examines the 'particular', the detailed, and the specific, looking at particular groups in particular contexts. This is different to positivist and modernist approaches that dominate psychological scientific enquiry which seek to make empirical generalisations. Whilst idiography does not eschew generalisations (Harré, 1979) it does seek to locate them within the 'particular' and explore them with caution (Smith et al, 2012). Indeed, authors have argued that the detailed analysis of smaller samples provides a unique and valuable perspective on the existing theoretical milieu, offering insight and revision as well as an opportunity to examine the applied validity of theory. Idiography and as such IPA sees an iterative relationship between the particular and the general, which is summed up nicely by Goethe (in Hermans, 1988, p785):

> *'The particular eternally underlies the general, the general eternally has to comply with the particular'.*

The research question is concerned with a particular group (service users who have experienced therapy), in a specific context (the NHS), and is not seeking to make empirical generalisations or make claims of behavioural laws at the population level, and as such IPA, grounded in idiography, is deemed suitable for this examination.

Other considered methodological approaches

Other methodological approaches were also considered; however, IPA was deemed the most appropriate to answer the research question. Appendix F1 details the rationales behind disqualifying other approaches.

Method

Context around participants' experiences

Participants were interviewed in March 2022 and as such all participants had received their (most recent) therapy during the context of the COIVD-19 pandemic. This was a time of extreme pressure on NHS services and whilst the pandemic was seldom spontaneously mentioned by participants it is likely that experiences will have been impacted by this. It is also worth noting that most participants (except Jason), received their therapy online or in Kate's case by phone, which again will have changed the dynamic from being face to face with the psychologist. Participants were able to reflect on this and most did not describe overt difficulties with receiving therapy remotely and most described some benefits to remote therapy, such as reducing initial anxiety over meeting the therapist. However, Violet, who received all her therapy remotely, questioned if her therapist would respond to her distress in the same way if they were in the room together which may have made it harder for her to trust her therapist.

The participants were also recruited from a trust that has been under exceptional pressure from the Care Quality Commission and has received a considerable amount of poor press in the last decade. This is likely to have impacted on different areas of the analysis and comparisons to other participants in trusts without these systemic difficulties may generate different themes (or at least in different intensities).

Researcher's reflexivity

In IPA the researcher engages in the double hermeneutic, that is the co-creation of meaning through the researcher making sense of the participant making sense of an experience. The researcher's position, values and experience are therefore an essential aspect of how the analysis develops. This is especially important in a project looking at power, processes are likely to be operating at multiple and often unseen levels in the relationship. Therefore, reflexive devices were used to support thinking around this before, during and after the analysis. These include, but are not limited to, a reflective journal, supervision and extensive initial noting in the analysis. The following extracts are taken from the author's reflexive journal and offer some context on their position and power, it was written just prior to the analysis after the final interview was completed as a way of summarising previous entries and thoughts:

> *"My experience of oppression and negative power operations in my life have fortunately been limited, but impactful, and have driven my interest in this area. These have been in related to certain aspects of my identity and being, however, they pale in comparison the experience of oppression and disempowerment that most women, people of colour, disabled people, and those living in poverty face. I have considered whether I am therefore, at least in a demographic sense, worthy of tackling a topic of such importance as power, especially considering my belief in that those authors who write most eloquently about power are those whom it is impacted the most. I balance this, at least in my own mind, with the idea often those with power and privilege do not write about power because*

> *often it exposes what is wrong with the status quo and may indeed undermine their own power. Therefore, I will try to offer an honest, accurate and critical perspective on how power operates in therapeutic relationships, regardless of whether that means I offer criticism of myself, my profession or the organisations that I work within."*

'Bracketing' assumptions and previous experiences is something that is encouraged in IPA, so as they do not lead the analysis (Marshall and Rossman, 2011). There remains debate around the extent that a one should 'bracket' assumptions in phenomenological analyses (Ashworth, 1996), but in IPA, full suspension of one's assumptions is not only undesirable but impossible (Braun and Clarke, 2013). IPA encourages engagement in existing theory (Smith et al., 2009) in generating themes and that over 'bracketing' could indeed lead to important aspects of the analysis being missed (Van Manen, 1990). Therefore, the analyst considered another form of 'bracketing' called 'bridling' (Dahlberg, 2006) to support reflexivity in this analysis. 'Bridling' (Dahlberg, 2006) is a more nuanced form of 'bracketing' (Tufford & Newman, 2012) often adopted in phenomenological research. Bridling allows for more reflexive engagement with the analysist's assumptions and acknowledges the continual impact, and indeed struggle, with bringing these into analytic awareness. The steps outlined by Stutey, Givens, Cureton and Henderson (2020) were used to support this and included a written account of preconceived understandings, reflexive attention to initial analytic assumptions and the use of peer consultation and supervision to more openly explore assumptions.

Therefore, this thesis adopts a position of transparency and acknowledgement of assumptions, so that they can be viewed as the lens that the author views the analysis from. The following passage explains some of the author's prior experiences and why they are interested in power.

> *"My interest in power, and reason for turning to clinical psychology, came in part from my previous career as a chef, a path I took for seven years prior to returning to university. The strict hierarchy of the kitchen, the way the powerful within it used and abused their power, and how people had to mould and accept the dominant patriarchal identity of being a chef impacted on me significantly. Later in my psychology career I worked within forensic services. The structural power operations and thinking about creative ways to try and reduce some of the disempowerment felt by those (both service users and colleagues) was a great challenge. These experiences will influence my research and analysis, I must be careful therefore not to cast everything I see in the light of subversive and oppressive power."*

Power operating in the relationship between the researcher and participant was also considered. The following journal entry highlights some of the thinking around this:

> *"It is highly likely that power will be unequal in my relationship with the participants I am interviewing. I approach participants as a representative of the Trust, NHS, and university, all powerful institutions, as well as my own professional power of being a Trainee Clinical Psychologist. I shall approach these interviews expecting to be in a more powerful position, less I use my power unconsciously, because if I am acting in a 'power-over' way I am unlikely to be truly hearing their experiences, instead likely impressing my own on theirs. I will try to address this at every opportunity, primarily through naming it and*

> *offering ways to give the participant choice and permission to guide the interviews.*
>
> *I have considered with my supervisors whether explicitly discussing the power dynamic between me and the participant would be necessary. The position we reached, rightly or wrongly, was to only do so if explicitly indicated in the interview, but that we address factors that may impact on it prior to the interview. The risk of planning to name it is that it may detract from answering the research question and also that it may be my expectations being projected on the participants experience and given greater salience than the participant ascribes."*

Development of interview schedule

The interview schedule was developed using guidance from Smith et al (2012) who view this an iterative process, from conception, development and after the pilot. This was done in collaboration with the supervisory team as well as recruiting an external consultant with lived experience of receiving therapy. Throughout development, the aim of the interview schedule was to prepare an open and sensitive schedule that allows the participant to explain what it is like living in their world not what they think about the researcher's views on the world. Descriptive, narrative, structural, contrast, comparative, circular, and evaluative questions were considered for the research, as well as a number of prompts and probes. The schedule was developed using the following steps outlined in appendix G1. Please see appendix N for the full schedule.

Participants

Decisions around inclusion and exclusion criteria were carefully considered throughout this study. Appendix L explains in detail the criteria as well as the rational for each criterion.

All participants had at some point been in receipt of services through the host trust and were recruited through the trust or their 3rd sector affiliates. Demographic detials are presented in the emperical paper.

Participants had different ranges of experiences with their therapist, with most reporting a good overall relationship (expect for Violet and Jason) and differing outcomes from therapy. Kate, Lola and Cecilia found it very helpful and did not report wanting further therapy to address their difficulties. Axel found the skills learnt in therapy and the relationship positive but felt they needed more support. Violet was grateful for the therapy but felt it fell far short of what she needed and did not address her difficulties, she also reported a therapeutic rupture when she found out the length of therapy was not as long as she needed. Jason did not report a good therapeutic relationship and dropped out of therapy.

Whilst not intentional, the diversity of participants was limited, particularly ethnicity, with all white therapy dyads and research team. This is considered in the extended discussion.

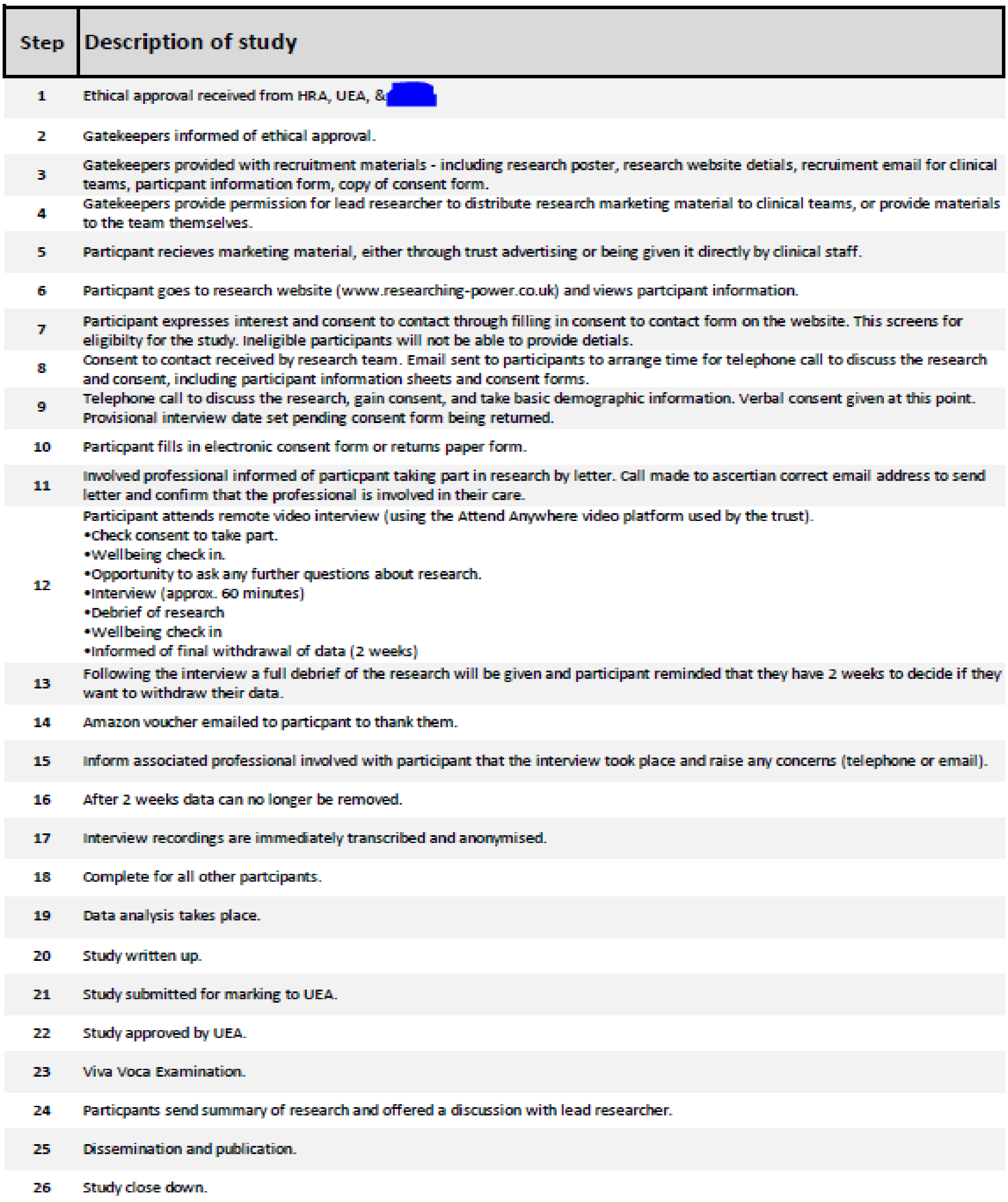
Two additional people provided consent to contact however, one potential participant did not meet the criteria for the study (because they received therapy from primary services) and the other was unable to attend the consent meetings offered due to being physically unwell.

Recruitment & Procedure

The full recruitment procedure can be found in the full ethics application (Appendix I). Figure 1 outlines the procedure from ethical approval to study closedown which is taken from the protocol.

Figure 1

Procedure for participants in the study



Step	Description of study
1	Ethical approval received from HRA, UEA, & [redacted]
2	Gatekeepers informed of ethical approval.
3	Gatekeepers provided with recruitment materials - including research poster, research website detials, recruiment email for clinical teams, particpant information form, copy of consent form.
4	Gatekeepers provide permission for lead researcher to distribute research marketing material to clinical teams, or provide materials to the team themselves.
5	Particpant recieves marketing material, either through trust advertising or being given it directly by clinical staff.
6	Particpant goes to research website (www.researching-power.co.uk) and views partcipant information.
7	Participant expresses interest and consent to contact through filling in consent to contact form on the website. This screens for eligibilty for the study. Ineligible participants will not be able to provide detials.
8	Consent to contact received by research team. Email sent to participants to arrange time for telephone call to discuss the research and consent, including participant information sheets and consent forms.
9	Telephone call to discuss the research, gain consent, and take basic demographic information. Verbal consent given at this point. Provisional interview date set pending consent form being returned.
10	Particpant fills in electronic consent form or returns paper form.
11	Involved professional informed of particpant taking part in research by letter. Call made to ascertian correct email address to send letter and confirm that the professional is involved in their care.
12	Participant attends remote video interview (using the Attend Anywhere video platform used by the trust). •Check consent to take part. •Wellbeing check in. •Opportunity to ask any further questions about research. •Interview (approx. 60 minutes) •Debrief of research •Wellbeing check in •Informed of final withdrawal of data (2 weeks)
13	Following the interview a full debrief of the research will be given and participant reminded that they have 2 weeks to decide if they want to withdraw their data.
14	Amazon voucher emailed to particpant to thank them.
15	Inform associated professional involved with participant that the interview took place and raise any concerns (telephone or email).
16	After 2 weeks data can no longer be removed.
17	Interview recordings are immediately transcribed and anonymised.
18	Complete for all other partcipants.
19	Data analysis takes place.
20	Study written up.
21	Study submitted for marking to UEA.
22	Study approved by UEA.
23	Viva Voca Examination.
24	Particpants send summary of research and offered a discussion with lead researcher.
25	Dissemination and publication.
26	Study close down.

Co-production

"Co-production means professionals and citizens sharing power to plan, design and deliver support together. It's about recognising that everyone has an important contribution to make to improve quality of life for people and communities." (Think Local, Act Personal, n.d.)

Co-production and increasing participation in research is an attempt to make research more democratic and address what Beresford and Croft (2016) call the "relevance gap". That is, making research more relevant, practical and aligned to the lives of whom it seeks to ultimately serve. Benefits of co-production in the literature are noted with benefits in ethics (Staley and Minogue, 2006), research design (Staley, 2009), recruitment (Ennis and Wykes, 2013), synthesis in data (Gillard et al., 2010a), and changes the knowledge produced (Rose, 2014). Furthermore, incorporating a lived experience perspective in the development and analysis of this research is important to address inherent power differentials between researcher and participant (Rose & Kalathil, 2019).

This project has a member of the supervisory panel who has lived experience of receiving therapy from the NHS and who lives with Bipolar, who was involved in all stages of the research, and particularly in the analysis. Input was also sought from the host trust Patient and Public Involvement (PPI) group in terms of recruitment and development of the interview schedule. Multiple members of the research team had experience of receiving therapy, including the author.

The research team considered 'member checking', that is going back to refine the analysis with participants, however, this is not suggested as a method for IPA studies with multiple participants (Larkin & Thompson, 2012). This is primarily due to the combined effects of amalgamation of accounts as well as the impact of the researchers' interpretations on the analysis.

Sample size

IPA is grounded in idiographic enquiry and as such sample sizes are generally small due to the depth and detail the analysis engages in. Smith et al. (2009) emphasized that *"IPA studies are conducted on relatively small sample sizes, and the aim is to find a reasonably homogeneous sample, so that, within the sample, we can examine convergence and divergence in some detail"* (p. 3). There is divergence on the 'ideal' sample size, and as with the idiographic approach the size depends on context, the question posed and the richness of the data (Smith & Osborn, 2003). Smith et al. (2012) suggest three to six participants for a Clinical Psychology Doctorate project; however, they also suggest larger samples of six to ten for more in depth studies, which arguably increases chances of publishing opportunities. High impact journals (indeed most journals) publish predominantly nomothetic research papers, where large sample sizes are important for generalisability. Arguably this has led to qualitative and particularly idiographic and phenomenological researcher to increase sample sizes and small samples are seen as a study limitation through a nomothetic lens. Vasileiou, Barnett, Thorpe and Young (2018) highlight this and put a case for idiographic and qualitative researchers to argue why smaller samples are important, particularly in terms of risking loss of detail in exchange for thematic overview. Indeed, Holland in her IPA study found that, although her original sample size of 13 added vibrancy to her project, it led to data overload and resulted in a greater focus on common themes and a consequent loss of idiographic detail (cited in Wagstaff et al., 2014). Wanting to get the balance between having a paper that was likely to be published in the highest impact journal, whilst not losing the detail of participant accounts the research team agreed on a sample size of eight to ten, with a minimum number of participants being set a six. However, the recruitment ran into some difficulties and as such six participants were recruited.

Author reflection:

> *"Initially I was disheartened by not being able to recruit the number of participants we had set out to. However, this soon dissipated in the analysis, as I realised with greater numbers, I would not have gotten to know the data as intimately as I had. I felt like I was able to step fully into each dataset and immerse myself in it. Should the sample have been significantly larger I believe that my intimacy with the dataset would have diminished and I would have moved from a more phenomenological and idiographic approach to something more akin to thematic analysis. Therefore, in the end I am grateful for my smaller sample, and feel I can defend such a sample more robustly now I am on the other side of the analysis."*

Ethical considerations

Ethical considerations were drawn from the British Psychological Society (BPS) Code of Ethics (2014) and guidance from the Health Research Authority (HRA, 2017). The study gained ethical approval from the HRA North West – Greater Manchester Research Ethics Committee (see appendix H & K), the University of East Anglia and the host Trust (see appendix J). Issues of consent, confidentiality, coercion, deception, risk, burdens to participants, debriefing and conflicts of interest were all closely attended to. Appendix H1 contains a summary of these. Please see the study ethics form (Appendix I) for in depth explanations of how ethical issues were attended to.

The importance of philosophy

The analysis went through a number of iterations to provide the final set of themes. After the first significant analysis the author and research team realised the importance of further engagement in the underpinning philosophies of IPA and particularly phenomenology. Furthermore, the author re-engaged with the philosophical literature to better understand their epistemological and ontological positions. They created an ontological and epistemological position statement, along with prompts for important analytic devices to support this (appendix T). The descriptions of the analysis should be seen within this context, and it should be noted that following re-engagement with the philosophical literature, the analysis was started again from the point of initial noting. With greater phenomenological understanding and clarity on epistemology and ontology, the author and research team have produced a more phenomenological account of participants experiences.

Additional reflective commentary prior to reanalysis

The author provides additional commentary from their reflective diaries that will help the reader better understand the analyst's re-engagement with the philosophical underpinnings of IPA and an update of important preconceptions prior to re-analysis.

Re-engagement with the philosophical underpinnings of IPA.

"My reengagement with the phenomenological literature has been extremely helpful in identifying how I can improve the analysis. In my initial analysis I could not adequately answer the question "but what is their [participant's]

experience of power?" In my re-analysis I must ask: What did it mean to them? Where did it start, where did it stop? The question begs where do I go back to? I think I need to listen to each one again and do initial noting for them [each set of data] and pull out the experience. I need to bridle my assumptions, which I prefer as a method to bracketing. I was excited to create a framework, something which felt clinically useful, and was more for clinicians rather than honouring the experience of my participants. Power was acting on me, power to do the piece of research which met my conceptions of university, NHS expectations and was publishable. I will not do this in my re-write. I owe it to my participants who have taught me more than I can thank them for."

Update on preconceptions.

"This is my second attempt at analysing this data and as such I have a number of preconceptions to be aware of. The most important aspect for me to remember is that my engagement in the literature around power significantly shaped my first iteration of the analysis. This had the consequence of moving me away from the experiential nature of my participants. Therefore, awareness of this in the next analysis will be vital. In searching for meaning and understanding of experience I can easily be drawn into finding frameworks of understanding based in my prior assumptions and knowledge, but with the damaging effect of potentially missing the experience of my participants. Noting these pulls, mindfully, and discussing them with my supervisory team will be important, as well as ensuring that interpretations are firmly grounding in the data. My previously outlined preconceptions still stand but are further framed in the context of my further reading and as such attention into subtle shifts in my

> *position should be attended to and bridled, particularly in the early stages of analysis. A clear audit trail will help me make sure of this."*

Analysis

A flow chart of the analytic process can be found in appendix U and a detailed description of this can be found in appendix J1.

Analysis in IPA is analytic in focus and pays attention to how the participant makes sense of their experience (Smith et al., 2012). The process is iterative and inductive, requiring reflexive engagement with the data. The researcher adopted the steps outlined by Smith et al. (2012), which were used as a guide, as IPA is an iterative process. These steps involve immersion in a participant's data with specific attention to experience, concerns and understandings. The full process for this is outlined in appendix J1.

Table 1 shows an example of the analytic process for Axel:

Table 1

Exemplar of the analytic process for Axel

Transcript	**Initial notes**	**Decriptive**	**Lingustic**	**Conceptual**	**Emerging theme**	**Individual themes**	**Main Subsidary theme**	**Superiordinate theme**
Shame and fear, shame and fear of what the response would be......... And also the fact that I didn't want my therapist to think less or differently of me, if that makes sense, and that's something I have no power over. but the thing I have the power over was whether I say this or do I not tell her this. So I chose not to tell her this because that's the only power I had in that situation, if that makes sense.	Two important points here, the first is about shame and fear about what the response would be. So there was concern for the other what they would say, maybe about the other they would say.	no control over what the therapist thinks of them, but power to not tell them and risk it - fear of the unknown response.	*I chose not to ….* Choice = power / agency	*I don't want my therpaist to think less of different of me* - shame based response, power external and internal to the relationship - crafted by prior expeirences.	shame in the therapy room, risk of disclosure and being thought poorly of (fear of judgement)	Limited options for holding on to one's power	*The balancing of power in the relationship*	The dynamic tapestry of power

Quality

Quality was maintained through adhering to Yardley’s (2000) principles for qualitative research. This framework was selected due to the compatibility with the critical realist perspective taken in this research. Yardley’s ‘four concepts’ are applied flexibility within the chosen approach to support quality in method and application. Full descriptions of the application of this can be found in appendix I1.

Chapter 6: Extended discussion and critical evaluation

Introduction

This chapter will bring together the findings of the portfolio and provide an overall discussion and critical evaluation of the findings, implications, strengths, limits and directions for future research. This will be supplemented by reflective statements from the author to contextualise the author's position to the reader.

Overall findings

This portfolio has presented two novel examinations of service users' experiences in the therapeutic relationship, which moves from a general overview to explicit experiences of power in the therapeutic relationship. This is exclusively from the perspective of people using NHS services. The systematic review supports the empirical paper and there are direct links between the themes of the two papers presented.

Systematic review

The systematic review element of this thesis attended to the voices and experiences of NHS service users in the current literature and sought to draw out factors pertaining to the therapeutic relationship that were not effectively covered in the formal literature in this context. Following a systematic search of the literature, thematic synthesis (Thomas & Harden, 2008) of the current literature of NHS service users experience of the therapeutic relationship in individual therapy was conducted. Four superordinate themes emerged: 1. *Tension prior to therapy*, 2. *Relieving the tension and feeling comfortable enough to talk*, 3. *Feeling understood and developing* *understanding*, and 4. *Therapist actions*. This provided the first review and thematic synthesis in this specific context looking at this specific research question.

The synthesis highlighted the importance of attention to the therapeutic relationship for NHS service users in individual therapy and provided an overview of salient areas in service users' experience, particularly in terms of non-modality specific and 'soft' therapeutic skills and techniques. Interestingly the synthesis drew out factors prior to therapy that impacted on the therapeutic relationship, something that has limited attention in the formal literature. The synthesis also saw therapist behaviours that sought to empower, provide flexibility or direction to participants was supportive in the therapeutic relationship. This was interpretated as power being used positively by therapists, again another area with very limited attention in the literature. Finally, the appraisal of the literature reviewed suggested improvements in terms of authors stating their relationship to participants and their philosophical positioning. These results have direct implications for the following empirical paper.

Empirical paper

The systematic review and current literature indicate that the therapeutic relationship is important for NHS service users. In addition, there may be important factors outside of the typically reported relational factors that might impact on the experience of the therapeutic relationship for NHS mental health service users. Furthermore, there was a suggestion that therapists may use 'positive' forms of power in the relationship. This alongside the dearth of empirical evidence around NHS service users experience of power in the therapeutic relationships, and indeed the need for more experiential evidence generally, provided the base for conducting this empirical piece of research.

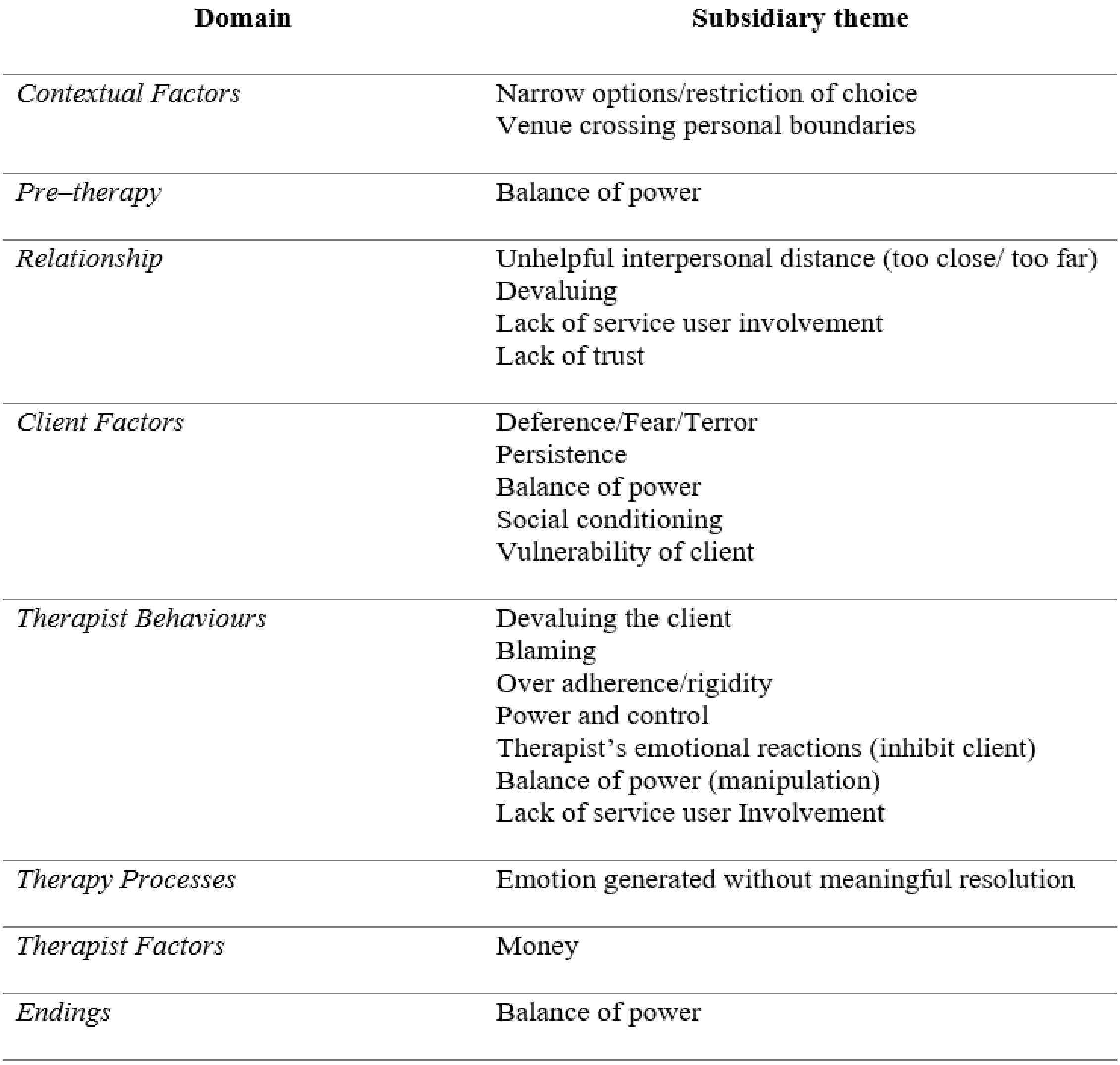
Interpretive phenomenological analysis (IPA) was used to answer the question *how do NHS service users experience power in the therapeutic relationship*? The analysis was conducted from a soft constructivist epistemological stance, and this allowed for greater exploration of how constructive acts influenced the experience of the six participants who took part in the study. The analysis generated one superordinate theme, *the dynamic tapestry of power,* which supported answering the research question. This superordinate theme brings together the three subsidiary themes in an overall metaphor of the experience of power in the therapeutic relationship. This is a constructive act by the author and aims to provide a summary of the overall experience of power.

The analysis has been situated within the analysist's specific ontological and epistemological positions and reflect the constructive acts and discourses of participants and their impacts on the experiential descriptions. For example, participants' experiences sat within the context of their historical experiences of disempowerment, which were often felt as dehumanising, invalidating and rejecting, as well as creating a sense of fear of those in greater positions of power, created narratives and discourses about how they expected to experience power in the therapeutic relationship. This was moderated with previous positive but less salient experiences such as feeling humanised, accepted and validated, as well as hope for change. This meant that participants experienced a tension on entering the therapeutic relationship between expectations of disempowerment and the hope of empowerment and change. Furthermore, participants described feelings of anxiety and often desperation on entering the relationship which meant that they felt they had to accept, gratefully, what was offered to them. Within the relationship power was initially felt as unbalanced towards the psychologist and there was a felt tension in this as participants often feared further disempowerment and the feelings associated with this. Participants and psychologists, through subtle and often unconscious means attempted to balance power in the relationship. These acts subtly shifted their experience of power often brining relief to the threat of feelings associated with further disempowerment. When the feelings associated with the most disempowered aspects of participants experiences were addressed this brought power sharply into focus for participants and constituted a transformational shift in their experience. When this was positive it was seen as a therapeutic moment and was experienced as feeling more comfort or trust in the relationship. However, some participants experienced ruptures confirming the expectations of disempowerment and with a felt sense of deflation and loss.

Overall, this analysis helps to bring into the formal literature factors important to service users that was captured in the grey literature by Curran et al. (2019), who highlighted a number of negative therapy processes within the grey literature as described by service users (see table 1).

Table 1

Factors reported by service users in grey literature regarding negative therapy processes (Curran et al., 2019)



Domain	Subsidiary theme
Contextual Factors	Narrow options/restriction of choice Venue crossing personal boundaries
Pre–therapy	Balance of power
Relationship	Unhelpful interpersonal distance (too close/ too far) Devaluing Lack of service user involvement Lack of trust
Client Factors	Deference/Fear/Terror Persistence Balance of power Social conditioning Vulnerability of client
Therapist Behaviours	Devaluing the client Blaming Over adherence/rigidity Power and control Therapist's emotional reactions (inhibit client) Balance of power (manipulation) Lack of service user Involvement
Therapy Processes	Emotion generated without meaningful resolution
Therapist Factors	Money
Endings	Balance of power

What was clearly highlighted in this research was the importance of the imbalance of power in the relationship, both before and during therapy. Furthermore, it supports a number of other factors identified such as feeling devalued, lack of choice, lack of trust, deference/fear/terror, and social conditioning. These are important factors that clinicians and policy makers should consider when designing and delivering services.

This superordinate theme was constructed from three subsidiary themes which are detailed below. The following will not just repeat previously described analyses but instead offer links to pertinent psychological literature to better understand the phenomena described.

1. *“Past experiences, if you like, had shaped my thinking” - The different threads of disempowerment that shape experience in the relationship*

The first subsidiary theme describes how previous experiences of disempowerment shaped participants’ experience power and expectations in the therapeutic relationship and created a sense of tension prior to therapy. This theme is closely tied to the first theme in the systematic review, ‘tension prior to therapy’, and expands on this. Understanding how previous experiences impact on present relating and functioning is an important consideration in psychological formulation across psychological approaches (Johnstone & Dallos, 2013) and how power has operated historically in people’s lives may be an important consideration in this. Proctor’s (2008) description of ‘Historical Power’ captures this, as well as the importance placed on historical power operations in the Power Threat Meaning Framework (PTMF; Johnstone & Boyle, 2018). This analysis has highlighted how historical power experiences through institutions (such as care or education systems) and personal trauma impact on the therapeutic relationship, as they often engender negative and coercive power operations. However, this analysis puts particular focus on how historical experiences of power within mental health services and the NHS impact on participants. This is difficult for therapists to directly address, as often they are inhabiting the same system, and challenging that system potentially comes with professional consequences. This leaves a potential unspoken power dynamic that is unable to be directly addressed by the therapist, yet still impacts on the relationship.

The historical experiences of power appeared to shape participants' identities and beliefs. This could be described as a form of ideological power which relates to identities, beliefs and thoughts within individuals that are created through societal norms, stereotypes, and assumptions. This is form of power is summarised nicely in the PTMF (Johnstone & Boyle, 2018) and influences from postmodern authors, such as Foucault can be seen in this description. Participants explained how their identities, particularly relating to their mental health, impacted on their experience of power both within and outside of therapeutic relationships. Societal norms and stereotypes impacted on participants experience of power to different extents and was linked to their previous experiences. All participants acknowledged some form of historical stigmatisation in seeking mental health support. Feeling stigmatised is well evidenced to be a barrier to seeking help (Schomerus & Angermeyer, 2008), and whilst all participants were able to overcome this, it was still acknowledged. This is another way of power operating at a more unconscious level.

Norms around being grateful for receiving an NHS service were raised by five participants. Gratitude is seen as motivating goodwill and care towards the benefactor from the recipient (Algoe & Stanton, 2012). However, serval authors have posited that gratitude can be a problematic paradigm, particularly for those in chronic receipt of health services. In this study several of the participants felt 'obliged' to feel grateful for the service they received, even if it was not truly felt. Galvin (2004) found gratitude to be unproblematic for abled bodied people, but for disabled peoples it can 'signify an unbearable state of perpetual obligation' (p. 137) and consistent gratitude being a potential hallmark of entrenched disempowerment, shame and frustration (Day, Robert & Rafferty, 2020). Violet offered a potential explanation for where this obligation developed from when she described how the NHS being free at the point of service meant that receiving healthcare felt like a gift, and that societal norms meant people should be grateful for gifts they receive. Whilst the NHS is not free for the majority who pay taxes, the fact that service users offer no physical remuneration for services rendered does set up this dynamic. This has implications for how able NHS service users may feel around raising concerns or for seeking additional or different support.

2. *“it’s never kinda been equal, but yea it didn’t feel like at the same time, it didn’t feel inequal” - The balancing of power in the relationship*

This subsidiary theme looks at how participants experienced a feeling of tension due to power feeling naturally unbalanced on entering the relationship. They described how often their subtle and unconscious acts attempted to protect from the feelings associated with historical disempowerment, such as feeling judged or dismissed. Participants also described more overt ways they or their psychologists attempted to balance or shift power in the relationship. These acts subtly changed the experience for participants and often brought relief to the tension felt prior to therapy. This theme also maps on to themes two, three and four in the systematic review, as these describe factors that provide relief to the tensions prior to therapy and support the therapeutic relationship.

The role of therapist and the power inherent within their role was important to participants. Proctor (2008) in her theory of aspects of power in therapeutic relationships points to ‘Role Power’ and the authority of the therapist within their organisation to define participants problems and provide or deny access to resources. This is underacknowledged in the literature and is important consideration for therapists as it could be a way they are operating in ‘power-over’ ways unconsciously with those they are serving, which has been theorised, by several Feminist authors (Brown,1994; Lerman & Porter, 1990; Veldhuis, 2001).

Participant's experience in this theme could be seen as a form of 'interpersonal power' which is drawn from the PTMF (Johnstone & Boyle, 2018) and is a postmodern, relational conception of power (see Foucault, 1980). In this study interpersonal power was seen explicitly in the therapeutic relationship between the participant and psychologist. It was a dynamic process that was impacted by the micro-interactions between therapist and service user that affected trust, feeling humanised, not judged and validated.

The analysis also draws attention to processes that service users use to balance power, as well as the processes they perceive the psychologist uses to balance power in the relationship. This provides novel empirical links to the limited theoretical base of the positive uses of power. Much of previous theoretical understanding of power see therapists and others using their power in generally oppressive ways (Masson, 1989). The author does not share this position, and this is supported by this research. More optimistically, like Totton (2006), who feels that the structural and relational issues of power within therapy can become a creative aspect of therapy, by making the exposure, discussion, and overcoming of differentials integral to the therapeutic relationship. This research alludes to how the discussion of power in therapy is the first step into equalising some of the many imbalances that exist within all therapeutic relationships. Or as Totton (2006) puts it:

> *"The only way to tackle this adequately, I suggest, is that instead of trying hopelessly to eliminate power struggle from the therapeutic relationship, we place it dead centre, highlighting the battle between therapist and client over the definition of reality, baring it to the naked gaze and making it a core theme of our work." (p. 91)*

Putting power and discussions of its impact is a potentially important way that clinicians can address power imbalance head on, opposed to it, being a more unconscious operation in the therapeutic relationship.

Power being used positively was highlighted in this theme and the next. Participants, particularly those who felt that power in their relationship was more equitable theoretically described their therapist using a form of 'Nutrient Power'. 'Nutrient Power', first described by Rollo May (2008) is a healthy form of power driven by concern of the welfare of the other, and where their power is used 'for' the other. Participants describing this explained how their psychologist used their power positively or that it led to positive outcomes. This included suggesting helpful treatments or pushing a participant to engage in a difficult but beneficial aspect of the therapy, such as in the case of Lola. This form of power is grounded in the inherent 'Role Power' (Proctor, 2008) and expertise of the therapist, that when applied benevolently was nurturing to participants. This was in contrast to maternalistic or paternalistic approaches that participants like Cecilia experienced with other clinicians.

A more equitable use of power that was experienced as empowering was also described by participants. This could be seen as a form of 'Integrative Power' (May, 2008), in the form of empowering them and providing choice and flexibility in terms of how their treatments were delivered. Whilst there were structural limits on how much choice and flexibility they could provide, where this was done at the level of the relationship (such as offering choices around topics discussed) this had the effect of making power in the relationship feel more balanced. This is the psychologist using their power 'with' the participant and supports the posited benefits of clinicians empowering services users in therapy where they can and moves services closer towards 'patient-directed care' opposed to traditional paternalistic forms of care (Kumar & Chattu, 2018).

3. *"I think that was probably a turning point" - Pivotal therapeutic moments & ruptures that transform the experience of power*

All participants described particularly potent moments where power was thrown sharply into focus which had a transformative impact on how they experienced power and tension in the therapeutic relationship. These were interpreted as 'therapeutic moments' or 'ruptures' in the relationship.

The phenomenology of potent therapeutic moments is poorly understood in the literature, and this research provides a precursory introduction into this potentially fruitful theoretical domain. Participants described how their therapists attended to aspects of their historical experiences where they expected to feel disempowered in a way that soothed or nurtured them. This allowed for greater trust and openness in the relationship and was described by participants who had greater self-reported therapeutic benefit from their therapy. The results tentatively suggest that therapist actions that target specific areas where the client feels disempowered historically may have significant therapeutic benefit in terms of the therapeutic relationship and thus outcome. Barbro Giorgi (2011), whose work was published posthumously by her husband Amedeo Giorgi, details a phenomenological account of three participant's experiences of pivotal therapeutic moments. These detailed results are summarised thus: "*The results show that the pivotal moment is experienced as a figural moment within the therapeutic process where a serious challenge to old assumptions takes place, necessitating a break from old cognitive, affective and behavioural patterns in a context of trust and safety within the therapeutic relationship.*" (Giorgi, 2011, p. 61). This aligns with the experience of participants in the current study, with emphasis placed on how power develops and impacts on the old cognitive, affective and behavioural patterns.

Ruptures in the therapeutic relationship can be described as major or minor breakdown in the relationship between therapist and client (Safran, Muran & Eubanks-Carter, 2011). During ruptures, Safran and Muran (2000) describe how clients' beliefs about the self and other are being activated. Within the context of this research this can be seen as participants' beliefs around others being activated in terms of their expectations of disempowerment formed from historical experience and how they expected to be treated. Different therapeutic modalities have different approaches to address ruptures in the relationship (Okamoto & Kazantzis, 2001) and it is noted that some approaches put the importance of this more centrally. Specifically in Dialectical Behavioural therapy (DBT; Linehan, 1987) this is put centrally and cites the importance of validation as both a therapeutic strategy and foundation for addressing ruptures (Linehan, 1997). Considering the importance participants in this research placed on validation, this approach is an important consideration for the development of guidance around the supporting the therapeutic relationship.

Personal impact of the work

The following is an extract from the author's reflective journal speaking to the impact of the findings:

> *"Following the interviews and analysis my thinking around how I approach therapeutic relationships is changing. Particularly on starting conversations about power in therapy with colleagues (psychologists and others) as well as the service users I am working with. The quote from Axel has been one I have held*

on to: "if people are aware of the power they hold, then they have the power to not to abuse it." This I think is crucial to understanding the work's impact on me personally. I would go further to say that if people are aware of the power they hold, the power within the institutions they reside in and the power held in the culture that surrounds them, then they have the power to not abuse it. They also make the important point whereby it is the responsibility of the person holding the power to not abuse it and that it is their responsibility to become aware of it, for how can we change what we are not aware of? Putting that responsibility on those with greater power is vital for change, as it all too often falls to the marginalised and disempowered to shine the light on disparity. Now I know I will not be aware of all the different ways I or the systems around me use our power in therapy, but I am now listening closer to the experiences of those I work with, with more attention, and a more critical gaze on the methods of practice taken as the norm."

Overall implications

Overall, this portfolio has shed light on factors important in therapeutic relationships in the NHS and the empirical aspect has provided the first in-depth, idiographic and phenomenological exploration power in these relationships. The implications, both clinical and academic, will be discussed.

1. The importance the NHS service user participants placed on the how previous experiences, constructions and discourses around power shape and impact the therapeutic relationship was a key finding of this thesis. Contextual factors being important in NHS service users experience of therapeutic was alluded to in the systematic revive and was thrown sharply

into relief in the empirical aspect of this paper, situated within the context of previously disempowering experiences both within and outside of the NHS. These historically disempowering (and to a lesser extent empowering) experiences permeated into the therapeutic relationship and therapy as an evolving power process which impacted what participants felt they were able to say and do within the relationship. This was seen by participants as salient, complex and dynamic, whilst also being subtle, unconscious or concealed within the therapeutic relationship. This supports evidence in the grey literature that power processes are important for service users (Curran et al., 2019) and brings this into the formal literature. This thesis suggests that greater attention needs to be paid to NHS service user's experience of power both prior and during therapy, and calls for power to be discussed more explicitly in therapy and beyond. This has implications for those delivering, designing and administrating psychotherapy services.

2. Whilst subtle, the systematic review indicated that positive uses of power by the therapist were important in the therapeutic relationship, but this was seen explicitly in the empirical aspect of this thesis. The positive uses of power are generally poorly represented in the literature (Proctor, 2017), particularly in the context of psychotherapy. This thesis suggests greater empirical and theoretical exploration in the uses of positive power by therapists in psychotherapy. It also has implications in terms of furthering current theories regarding power, specifically highlighting the need for positive power operations to be addressed within the PTMF which by their own account does not account for the positive applications of power (Johnstone & Boyle, 2018).

3. This research draws together some of the disparate theories on power and connects them to service user experience in the specific context of the NHS. This has implications for future researchers to gain alternative, empirically supported, understandings of some of the processes that might be occurring in the aspects of therapy and the therapeutic relationship they are investigating. This is especially important as this portfolio demonstrated that factors are not just situated in the individual and as such, clinicians, researchers and policy makers should consider this in the design and development of services and interventions. This could be incorporating approaches that pay greater attention to power (e.g., the PTMF), or approaches that intend to build social and cultural capital, such as Trauma Informed (Sweeney Clement, Filson & Kennedy, 2016) and Community Psychology approaches (Kagan, Burton, Duckett, Lawthom, & Siddiquee, 2019). This would require a shift in attitudes and policy from a governmental level so that that mental health and broader social care systems can address structural inequalities instead of the traditional focus on individualised models of treating mental distress (Cummins, 2018).
4. Finally, the importance of the therapeutic relationship to NHS service users was highlighted across this thesis. Whilst not a novel finding, it is important to highlight and keep front and centre within the context of an economically and politically pressured NHS. Within a context that prioritises developing time limited, highly structured and manualised approaches that are cost effective (National Collaborating Centre for Mental Health, 2021), this is something that should not be lost to policymakers less the NHS ends up providing technically sound interventions without the time or flexibility to

attend to the therapeutic relationship which could potentially deliver poorer outcomes.

Strengths and limits

There are a number of strengths to this portfolio. The first is that data was drawn exclusively from NHS service user perspectives in both the systematic review and empirical aspect of this portfolio. This helps to address the dearth of service user voices in research (Gabbard & Freedman, 2006) and especially of those using NHS services. The unique perspectives offered build on indications in the grey literature that power is important to service users but are not captured effectively in the formal literature (Curran, et al., 2019). Where possible the perspectives of people with lived experience of receiving therapy from NHS services were incorporated in the different design stages, including having a member of the research team who is an expert by experience. This has implications for the quality and relevance for this research (Beresford and Croft, 2016) particularly for NHS service users.

Secondly, this research examines an area that is both clinically and politically important. It illuminates the connection between the clinical (interpersonal/postmodern explanations power) and the political (structural power) and how both are important in developing therapeutic relationships. This is especially important in the current context of the NHS where there is political and economic pressure to meet demands with fewer resources. The structural impacts of power highlighted are likely to become more salient in the current economic and political climate and something that cannot be fully addressed at the level of the individual clinician. Empirical attention that highlights this is vital if these structural issues are to be addressed at a political and societal level, and this is something this research does, albeit it in very focused area.

Thirdly, the methodologies utilised were suitable to answer the research questions and were compatible with the author's epistemological and ontological positions. The relativity novel incorporation of soft constructivist epistemological stance allowed for greater exploration of how constructive acts influenced the experiential, whilst an ontology grounded in the pluralism of subtle relativism allowed for the for constructive acts to be investigated whilst not denying participant's subjective reality. This was vital in a paper that was exploring power, which is typically the domain of more relativist and social constructionist positions and approaches, and a strength of this thesis is being able to capture sensitivity to this specific and highly political context whilst not losing the experiential essence of participants' descriptions. IPA also has philosophy grounded in hermeneutics and this allowed for the issues around the author's power, perspective and experience to be examined in the research in ways other approaches would not have. To support the readers understanding of this, so they are able to form their own judgements, reflective statements have been provided throughout. The commitment to quality and rigour, supported by the framework provided by Smith, Flowers and Larkin (2012) and Yardley (2000) allowed for a robust analysis with implications for transferability.

Finally, the study has a range of theoretical, clinical and organisational research implications, which were discussed previously in this chapter. These also illuminate numerous possibilities for future research, which will also be explored later. Each participant requested a summary of the study finding and commented on the how they felt the research was important. This highlights the personal importance of the research to the very group it intends to serve.

Despite the strengths of this project there remain a number of limitations. Firstly, there are issues pertinent to the sample and the diversity of participants, psychologists and researchers in terms of diversity. Whilst IPA warrants a relatively homogenous sample, there was limited diversity in this sample. Particularly in terms of being an exclusively white sample (and researcher), and whilst there was diversity in terms of gender identity, sexuality and disability, it is likely that important aspects of the social context relating to structural power may have been occluded. The relative lack of diversity was also noted within the systematic review aspect of this thesis.

Secondly, the empirical aspect of this research was completed in a single NHS trust (that was under significant pressure), looking at NHS service users who had received secondary care from exclusively Clinical Psychologists. Whilst these factors add to the homogeneity of the sample it certainly cannot account for the experiences of the many other people in UK who received therapy outside of these contexts. It will be up to the reader to judge whether there is transferability to other contexts. The author believes many of the themes that emerged traverse these contextual boundaries and can at the very least start conversations about their impact in other contexts to improve our understandings of phenomenological experiences in areas which are relevant to clinical psychology and beyond.

Finally, the research was led by a privileged Trainee Clinical Psychologist fulfilling the requirements of Clinical Psychology doctorate during the COVID-19 pandemic (2019-2022). The author being a psychologist working during a time unprecedented restrictions and uncertainty creates a unique context for research and arguably dynamic between participant and researcher. Whilst attempts to attend and bridle (bracket) the assumptions associated with these factors have been attempted throughout (e.g., supervision, reflective diaries, co-production) it is likely that these issues will have impacted on the analysis. The author has offered reflections on his privilege in earlier chapters, but the following passage expands on the impact of the pandemic:

> *"I think I expected the impact of the pandemic on participants to feature more in emergent themes, however, this was not the case. I wonder, now that we are two years on from the start of the pandemic, that it has become, as threatened, 'the new normal', and that participants (as indeed I) have accepted the newer ways of working and doing therapy? I wonder if the saliency of COVID-19 would have increased had interviews been completed at the start of the pandemic? Considering this was a time when structural (coercive?) power was being used in ways that have not been seen in the UK before to restrict people for their protection? Furthermore, the initial outpouring of gratitude for those working in the NHS at the start of the pandemic is not what it is now. I guess this has made me think about just how important an idiographic approach that is sensitive to context is."*

Future research

Whilst this research provides novel insight into how a small sample of NHS service users experience power in the therapeutic relationship with Clinical Psychologists there remains many aspects of this area to explore. Some of these have been covered in the implications section of this chapter and additional suggestions will be made here.

1. Exploring mental health service user experiences of power within different contexts and between different professionals is an obvious extension of this research. Exploring the experiences of service users who are systemically disempowered and poorly represented in the literature, such as those under Mental Health Act conditions, legal restrictions, or service users with cognitive impairments could provide invaluable insights into how structural

power operates in therapeutic relationships. Further, as the empirical aspect of this thesis was exclusively concerned with Clinical Psychologists expansion of this research question to other areas of the rapidly expanding psychological workforce would be suggested.

2. This research has highlighted the importance of making power visible and encouraging discussions around how power operates within therapeutic relationships. There are empirical (and potentially experimental) opportunities to investigate differences in relationships where power is explicitly discussed and attended to in relationships. This could have wide reaching implications for the development of practice guidance and add to the literature on developing balanced therapeutic relationships in ways that can be operationalised for clinicians.
3. Finally, the issues with this research being led by a psychologist and the impact of this may have on participants, could best be addressed through a fully service user led investigation of power in the therapeutic relationship. The author would also encourage future research to incorporate voices from mental health survivor groups and the hard-to-reach populations of people who have dropped out of therapy. Arguably, this is a cohort of people whom power has most impacted on in the relationship in terms of outcomes and distress, and as such their perspectives would be vital to include.

Dissemination

The systematic review and the empirical research paper have been written for submission for publication in the journal ‘Psychology and Psychotherapy: Theory, Research and Practice’. This journal was chosen due to the journal’s focus on theoretical advancement and grounding empirical analysis within a wider theoretical context. This is particularly important as the theory guiding power in therapeutic relationships is often drawn from multiple perspectives and positions as well as being underdeveloped with regards to the therapeutic relationship. Furthermore, the research will be presented to the host trust for dissemination, as well as lay summaries provided to the host trust to disseminate to service users and professionals. Summaries will also be posted on the research website for wider access and summaries provided to participants as well as the opportunity to discuss it with the author. The research will be submitted for presentation at the University of East Anglia Annual Clinical Psychology Conference.

Overall conclusion

This thesis suggests that NHS service users experience power with Clinical Psychologists as a *dynamic tapestry of power* within the therapeutic relationship. The importance participants placed on the how previous experiences, constructions and discourses around power shape and impact the therapeutic relationship and participant experience in therapy is a key finding of this thesis, along with the positive uses of power, the importance of contextual sensitivity and overall importance of the therapeutic relationship. The implications of this thesis for service users, clinicians, and policy makers have been discussed along with suggestions for future research. However, as therapists and service users are often using or having power act on them unconsciously and as such awareness and acknowledgement of power differentials is the only way to address what can be addressed. That is "*...if people are aware of the power they hold, then they have the power to not to abuse it." – Axel*

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Chapter One: Portfolio introduction

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Appendix A: PRISMA checklist

Section and Topic	Item #	Checklist item	Location where item is reported
TITLE			
Title	1	Identify the report as a systematic review.	Front page
ABSTRACT			
Abstract	2	See the PRISMA 2020 for Abstracts checklist.	Front page
INTRODUCTION			
Rationale	3	Describe the rationale for the review in the context of existing knowledge.	Introduction
Objectives	4	Provide an explicit statement of the objective(s) or question(s) the review addresses.	End of introduction
METHODS			
Eligibility criteria	5	Specify the inclusion and exclusion criteria for the review and how studies were grouped for the syntheses.	Search Strategy and Selection Criteria
Information sources	6	Specify all databases, registers, websites, organisations, reference lists and other sources searched or consulted to identify studies. Specify the date when each source was last searched or consulted.	Search Strategy and Selection Criteria
Search strategy	7	Present the full search strategies for all databases, registers and websites, including any filters and limits used.	Table 2
Selection process	8	Specify the methods used to decide whether a study met the inclusion criteria of the review, including how many reviewers screened each record and each report retrieved, whether they worked independently, and if applicable, details of automation tools used in the process.	Search Strategy and Selection Criteria
Data collection process	9	Specify the methods used to collect data from reports, including how many reviewers collected data from each report, whether they worked independently, any processes for obtaining or confirming data from study investigators, and if applicable, details of automation tools used in the process.	Data extraction
Data items	10a	List and define all outcomes for which data were sought. Specify whether all results that were compatible with each outcome domain in each study were sought (e.g. for all measures, time points, analyses), and if not, the methods used to decide which results to collect.	n/a
	10b	List and define all other variables for which data were sought (e.g. participant and intervention characteristics, funding sources). Describe any assumptions made about any missing or unclear information.	n/a
Study risk of bias assessment	11	Specify the methods used to assess risk of bias in the included studies, including details of the tool(s) used, how many reviewers assessed each study and whether they worked independently, and if applicable, details of automation tools used in the process.	Data extraction
Effect measures	12	Specify for each outcome the effect measure(s) (e.g. risk ratio, mean difference) used in the synthesis or presentation of results.	n/a
Synthesis methods	13a	Describe the processes used to decide which studies were eligible for each synthesis (e.g. tabulating the study intervention characteristics and comparing against the planned groups for each synthesis (item #5)).	Selection procedure
	13b	Describe any methods required to prepare the data for presentation or synthesis, such as handling of missing summary statistics, or data conversions.	n/a
	13c	Describe any methods used to tabulate or visually display results of individual studies and syntheses.	n/a
	13d	Describe any methods used to synthesize results and provide a rationale for the choice(s). If meta-analysis was performed, describe the model(s), method(s) to identify the presence and extent of statistical heterogeneity, and software package(s) used.	Thematic Synthesis
	13e	Describe any methods used to explore possible causes of heterogeneity among study results (e.g. subgroup analysis, meta-regression).	n/a
	13f	Describe any sensitivity analyses conducted to assess robustness of the synthesized results.	n/a
Reporting bias assessment	14	Describe any methods used to assess risk of bias due to missing results in a synthesis (arising from reporting biases).	n/a

Section and Topic	Item #	Checklist item	Location where item is reported
Certainty assessment	15	Describe any methods used to assess certainty (or confidence) in the body of evidence for an outcome.	n/a
RESULTS			
Study selection	16a	Describe the results of the search and selection process, from the number of records identified in the search to the number of studies included in the review, ideally using a flow diagram.	Figure 1
	16b	Cite studies that might appear to meet the inclusion criteria, but which were excluded, and explain why they were excluded.	Figure 1
Study characteristics	17	Cite each included study and present its characteristics.	Table 3
Risk of bias in studies	18	Present assessments of risk of bias for each included study.	Results, Reviewed studies
Results of individual studies	19	For all outcomes, present, for each study: (a) summary statistics for each group (where appropriate) and (b) an effect estimate and its precision (e.g. confidence/credible interval), ideally using structured tables or plots.	n/a
Results of syntheses	20a	For each synthesis, briefly summarise the characteristics and risk of bias among contributing studies.	Reviewed studies
	20b	Present results of all statistical syntheses conducted. If meta-analysis was done, present for each the summary estimate and its precision (e.g. confidence/credible interval) and measures of statistical heterogeneity. If comparing groups, describe the direction of the effect.	n/a
	20c	Present results of all investigations of possible causes of heterogeneity among study results.	n/a
	20d	Present results of all sensitivity analyses conducted to assess the robustness of the synthesized results.	n/a
Reporting biases	21	Present assessments of risk of bias due to missing results (arising from reporting biases) for each synthesis assessed.	n/a
Certainty of evidence	22	Present assessments of certainty (or confidence) in the body of evidence for each outcome assessed.	n/a
DISCUSSION			
Discussion	23a	Provide a general interpretation of the results in the context of other evidence.	discussion
	23b	Discuss any limitations of the evidence included in the review.	limits
	23c	Discuss any limitations of the review processes used.	limits
	23d	Discuss implications of the results for practice, policy, and future research.	Implications for practice
OTHER INFORMATION			
Registration and protocol	24a	Provide registration information for the review, including register name and registration number, or state that the review was not registered.	Title page
	24b	Indicate where the review protocol can be accessed, or state that a protocol was not prepared.	Title page
	24c	Describe and explain any amendments to information provided at registration or in the protocol.	n/a
Support	25	Describe sources of financial or non-financial support for the review, and the role of the funders or sponsors in the review.	funding
Competing interests	26	Declare any competing interests of review authors.	Declaration of interests
Availability of data, code and	27	Report which of the following are publicly available and where they can be found: template data collection forms; data extracted from included studies; data used for all analyses; analytic code; any other materials used in the review.	n/a

Appendix B: ENTREQ checklist

	Item	Guide and description	Area reported
1	Aim	State the research question the synthesis addresses	Background
2	Synthesis methodology	Identify the synthesis methodology or theoretical framework which underpins the synthesis, and describe the rationale for choice of methodology (e.g. meta-ethnography, thematic synthesis, critical interpretive synthesis, grounded theory synthesis, realist synthesis, meta-aggregation, meta-study, framework synthesis).	Design, Search strategy, Thematic synthesis
3	Approach to searching	Indicate whether the search was pre-planned (comprehensive search strategies to seek all available studies) or iterative (to seek all available concepts until theoretical saturation is achieved).	Search strategy
4	Inclusion criteria	Specify the inclusion/exclusion criteria (e.g. in terms of population, language, year limits, type of publication, study type).	Search strategy, Selection Criteria
5	Data sources	Describe the information sources used (e.g. electronic databases (MEDLINE, EMBASE, CINAHL, psychINFO, Econlit), grey literature databases (digital thesis, policy reports), relevant organisational websites, experts, information specialists, generic web searches (Google Scholar), hand searching, reference lists) and when the searches were conducted; provide the rationale for using the data sources.	Search strategy, selection procedure
6	Electronic Search strategy	Describe the literature search (e.g. provide electronic search strategies with population terms, clinical or health topic terms, experiential or social phenomena related terms, filters for qualitative research and search limits).	Search strategy, Selection procedure
7	Study screening methods	Describe the process of study screening and sifting (e.g. title, abstract and full text review, number of independent reviewers who screened studies)	Selection criteria, Selection procedure
8	Study characteristics	Present the characteristics of the included studies (e.g. year of publication, country, population, number of participants, data collection, methodology, analysis, research questions).	Results, Reviewed studies
9	Study selection results	Identify the number of studies screened and provide reasons for study exclusion (e.g. for comprehensive searching, provide numbers of studies screened and reasons for exclusion indicated in a figure/flowchart; for iterative searching describe reasons for study exclusion and inclusion based on modifications t the research question and/or contribution to theory development).	Figure 1, Results

	Item	**Guide and description**	**Area reported**
10	Rationale for appraisal	Describe the rationale and approach used to appraise the included studies or selected findings (e.g. assessment of conduct (validity and robustness), assessment of reporting (transparency), assessment of content and utility of the findings).	Data extraction, Thematic synthesis
11	Appraisal items	State the tools, frameworks and criteria used to appraise the studies or selected findings (e.g. Existing tools: CASP, QARI, COREQ, Mays and Pope [25]; reviewer developed tools; describe the domains assessed: research team, study design, data analysis and interpretations, reporting).	Data extraction
12	Appraisal process	Indicate whether the appraisal was conducted independently by more than one reviewer and if consensus was required.	Data extraction
13	Appraisal results	Present results of the quality assessment and indicate which articles, if any, were weighted/excluded based on the assessment and give the rationale.	Reviewed studies
14	Data extraction	Indicate which sections of the primary studies were analysed and how were the data extracted from the primary studies? (e.g. all text under the headings "results /conclusions" were extracted electronically and entered into a computer software).	Data extraction
15	Software	State the computer software used, if any.	Selection procedure, Data extraction
16	Number of reviewers	Identify who was involved in coding and analysis.	Thematic Synthesis
17	Coding	Describe the process for coding of data (e.g. line by line coding to search for concepts).	Thematic Synthesis
18	Study comparison	Describe how were comparisons made within and across studies (e.g. subsequent studies were coded into pre-existing concepts, and new concepts were created when deemed necessary).	Thematic Synthesis
19	Derivation of themes	Explain whether the process of deriving the themes or constructs was inductive or deductive.	Thematic Synthesis
20	Quotations	Provide quotations from the primary studies to illustrate themes/constructs, and identify whether the quotations were participant quotations or the author's interpretation	Results
21	Synthesis output	Present rich, compelling and useful results that go beyond a summary of the primary studies (e.g. new interpretation, models of evidence, conceptual models, analytical framework, development of a new theory or construct).	Discussion

Appendix C: Exemplar of CASP checklist

CASP
Critical Appraisal
Skills Programme

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CASP Checklist: 10 questions to help you make sense of a **Qualitative** research

How to use this appraisal tool: Three broad issues need to be considered when appraising a qualitative study:

- Are the results of the study valid? (Section A)
- What are the results? (Section B)
- Will the results help locally? (Section C)

The 10 questions on the following pages are designed to help you think about these issues systematically. The first two questions are screening questions and can be answered quickly. If the answer to both is "yes", it is worth proceeding with the remaining questions. There is some degree of overlap between the questions, you are asked to record a "yes", "no" or "can't tell" to most of the questions. A number of italicised prompts are given after each question. These are designed to remind you why the question is important. Record your reasons for your answers in the spaces provided.

About: These checklists were designed to be used as educational pedagogic tools, as part of a workshop setting, therefore we do not suggest a scoring system. The core CASP checklists (randomised controlled trial & systematic review) were based on JAMA 'Users' guides to the medical literature 1994 (adapted from Guyatt GH, Sackett DL, and Cook DJ), and piloted with health care practitioners.

For each new checklist, a group of experts were assembled to develop and pilot the checklist and the workshop format with which it would be used. Over the years overall adjustments have been made to the format, but a recent survey of checklist users reiterated that the basic format continues to be useful and appropriate.

Referencing: we recommend using the Harvard style citation, i.e.: *Critical Appraisal Skills Programme (2018). CASP (insert name of checklist i.e. Qualitative) Checklist. [online] Available at: URL. Accessed: Date Accessed.*

CASP
Critical Appraisal
Skills Programme

Paper for appraisal and reference:

Section A: Are the results valid?

1. Was there a clear statement of the aims of the research?

Yes ☑
Can't Tell ☐
No ☐

HINT: Consider
- what was the goal of the research
- why it was thought important
- its relevance

Comments: "Given the growing emphasis on providing early intervention to individuals experiencing complex and severe psychological distress, it seems pertinent to gain an in-depth understanding of subjective appraisals of interventions that are extensively funded across EIP teams in the NHS. Such insight would help the clinicians to increase their awareness of individually valued change mechanisms,thus encourage uptake and promote active participation in the offered therapies." - Yes see this quote

2. Is a qualitative methodology appropriate?

Yes ☑
Can't Tell ☐
No ☐

HINT: Consider
- If the research seeks to interpret or illuminate the actions and/or subjective experiences of research participants
- Is qualitative research the right methodology for addressing the research goal

Comments: Yes, a thematic analysis of data was undertaken and this was indeed appropriate to answer the research question "Therefore, the aim of this study was to explore the experiences of receiving CBTp among individuals with FEP within an EIP service."

Is it worth continuing?

3. Was the research design appropriate to address the aims of the research?

Yes ☑
Can't Tell ☐
No ☐

HINT: Consider
- if the researcher has justified the research design (e.g. have they discussed how they decided which method to use)

Comments: Yes - "Thematic analysis was chosen for a number of reasons. As outlined by Braun and Clarke (2006), such method offers researchers in psychological sciences numerous advantages, including flexibility and relative ease of use in qualitative research. It produces results that are generally accessible to relatively educated general public, provides useful and focused summary of key features of large body of transcribed data, highlights similarities and differences across a given data set, and might generate unanticipated results. Furthermore, as argued by Alhojailan (2012), such method allows data to be analysed at any time during the study, where there is no association between the initially gathered information and the result of the investigation. Finally, thematic analysis has been shown to be appropriate when samples are defined before proceeding with the study, while, in contrast, analysis by grounded theory relies on theoretical sampling that is determined during the process of data collection (Alhojailan, 2012)."

4. Was the recruitment strategy appropriate to the aims of the research?

Yes ☑
Can’t Tell ☐
No ☐

HINT: Consider
- If the researcher has explained how the participants were selected
- If they explained why the participants they selected were the most appropriate to provide access to the type of knowledge sought by the study
- If there are any discussions around recruitment (e.g. why some people chose not to take part)

Comments: Yes - clear discussion of this and context.

5. Was the data collected in a way that addressed the research issue?

Yes ☑
Can’t Tell ☐
No ☐

HINT: Consider
- If the setting for the data collection was justified
- If it is clear how data were collected (e.g. focus group, semi-structured interview etc.)
- If the researcher has justified the methods chosen
- If the researcher has made the methods explicit (e.g. for interview method, is there an indication of how interviews are conducted, or did they use a topic guide)
- If methods were modified during the study. If so, has the researcher explained how and why
- If the form of data is clear (e.g. tape recordings, video material, notes etc.)
- If the researcher has discussed saturation of data

Comments: Yes, semi structured interviews and procedure well described as well as a discussion of ways data contamination was avoided, topic guide used and described, form of data described.

6. Has the relationship between researcher and participants been adequately considered?

Yes ☑
Can't Tell ☐
No ☐

HINT: Consider

- If the researcher critically examined their own role, potential bias and influence during (a) formulation of the research questions (b) data collection, including sample recruitment and choice of location
- How the researcher responded to events during the study and whether they considered the implications of any changes in the research design

Comments: Nice relfexive statement but limited detial about what it is. Excellent part on epistemological positions

Section B: What are the results?

7. Have ethical issues been taken into consideration?

Yes ☑
Can't Tell ☐
No ☐

HINT: Consider

- If there are sufficient details of how the research was explained to participants for the reader to assess whether ethical standards were maintained
- If the researcher has discussed issues raised by the study (e.g. issues around informed consent or confidentiality or how they have handled the effects of the study on the participants during and after the study)
- If approval has been sought from the ethics committee

Comments: Procedure outlines some of the ethical procedures, as well as clear statement of ethical approcal.

8. Was the data analysis sufficiently rigorous?

Yes ☑
Can't Tell ☐
No ☐

HINT: Consider
- If there is an in-depth description of the analysis process
- If thematic analysis is used. If so, is it clear how the categories/themes were derived from the data
- Whether the researcher explains how the data presented were selected from the original sample to demonstrate the analysis process
- If sufficient data are presented to support the findings
- To what extent contradictory data are taken into account
- Whether the researcher critically examined their own role, potential bias and influence during analysis and selection of data for presentation

Comments: Good description of analytic process. Clear use of quotes to illuminate how themes developed. Good amount of first order data (quotes), own role considered.

9. Is there a clear statement of findings?

Yes ☑
Can't Tell ☐
No ☐

HINT: Consider whether
- If the findings are explicit
- If there is adequate discussion of the evidence both for and against the researcher's arguments
- If the researcher has discussed the credibility of their findings (e.g. triangulation, respondent validation, more than one analyst)
- If the findings are discussed in relation to the original research question

Comments: Yes, clear in discussion. Good engagement with strengths and weaknesses. Answers research question.

Section C: Will the results help locally?

10. How valuable is the research?

HINT: Consider
- If the researcher discusses the contribution the study makes to existing knowledge or understanding (e.g. do they consider the findings in relation to current practice or policy, or relevant research-based literature
- If they identify new areas where research is necessary
- If the researchers have discussed whether or how the findings can be transferred to other populations or considered other ways the research may be used

Comments: Highly relevant to context and good clear indications of where future research is needed.

Appendix D: CASP scores for systematic review papers

Table 1

CASP Scores for included studies

CASP Criteria	1. Mankiewicz, O’Leary & Collier (2018)			2. Awenat, Shaw-Núñez, Kelly, Law, Ahmed, Welford, Tarrier & Gooding (2016)			3. Balmain, Melia, John, Dent & Smith (2021)			4. Omylinska-Thurston & Cooper (2014)		
	Yes	No	DK	Yes	No	DK	Yes	No	DK	Yes	No	DK
1. Was there a clear statement of the aims of the research?	x			x			x			x		
2. Is a qualitative methodology appropriate?	x			x			x			x		
3. Was the research design appropriate to address the aims of the research?	x			x			x			x		
4. Was the recruitment strategy appropriate to the aims of the research?	x			x			x			x		
5. Was the data collected in a way that addressed the research issue?	x			x			x			x		
6. Has the relationship between researcher and participants been adequately considered?	x			x			x			x		
7. Have ethical issues been taken into consideration?	x			x			x			x		
8. Was the data analysis sufficiently rigorous?	x				x				x	x		
9. Is there a clear statement of findings?	x			x			x			x		
10. How valuable is the research?	x			x			x			x		
Total out of 10	10			9			9			10		

Table 1

CASP Scores for included studies

CASP Criteria	5. Hoskins, Blood, Stokes, Tatham, Waller & Turner (2019)			6. Marsden, Teahan, Lovell, Blore & Delgadillo (2018)			7. Tyrer & Masterson (2019)			8. Picariello, Ali, Foubister & Chalder (2017)		
	Yes	No	DK	Yes	No	DK	Yes	No	DK	Yes	No	DK
1. Was there a clear statement of the aims of the research?	x			x			x			x		
2. Is a qualitative methodology appropriate?	x			x			x			x		
3. Was the research design appropriate to address the aims of the research?	x			x			x			x		
4. Was the recruitment strategy appropriate to the aims of the research?	x			x				x		x		
5. Was the data collected in a way that addressed the research issue?	x			x				x		x		
6. Has the relationship between researcher and participants been adequately considered?		x				x		x				x
7. Have ethical issues been taken into consideration?	x			x				x		x		
8. Was the data analysis sufficiently rigorous?	x			x			x			x		
9. Is there a clear statement of findings?	x			x				x		x		
10. How valuable is the research?	x			x			x			x		
Total out of 10	9			9			5			9		

Table 1

CASP Scores for included studies

CASP Criteria	9. Griffiths, Mansell, Edge, Carey, Peel & Tai (2019)			10. Leonidaki, Lemma & Hobbis (2016)			11. Joyce, Tai, Gebbia & Mansell (2017)			12. Low & Murray (2014)		
	Yes	No	DK	Yes	No	DK	Yes	No	DK	Yes	No	DK
1. Was there a clear statement of the aims of the research?	x			x			x			x		
2. Is a qualitative methodology appropriate?	x			x			x			x		
3. Was the research design appropriate to address the aims of the research?	x			x			x			x		
4. Was the recruitment strategy appropriate to the aims of the research?	x			x			x			x		
5. Was the data collected in a way that addressed the research issue?	x			x			x			x		
6. Has the relationship between researcher and participants been adequately considered?	x			x			x				x	
7. Have ethical issues been taken into consideration?	x					x	x			x		
8. Was the data analysis sufficiently rigorous?	x			x			x					x
9. Is there a clear statement of findings?	x			x			x			x		
10. How valuable is the research?	x			x			x			x		
Total out of 10	10			9			10			8		

Table 1

CASP Scores for included studies

CASP Criteria	13. McManus, Peerbhoy, Larkin & Clark (2009)			14. Gee et al. (2022)		
	Yes	No	DK	Yes	No	DK
1. Was there a clear statement of the aims of the research?	x			x		
2. Is a qualitative methodology appropriate?	x			x		
3. Was the research design appropriate to address the aims of the research?	x			x		
4. Was the recruitment strategy appropriate to the aims of the research?	x			x		
5. Was the data collected in a way that addressed the research issue?	x			x		
6. Has the relationship between researcher and participants been adequately considered?		x			x	
7. Have ethical issues been taken into consideration?	x			x		
8. Was the data analysis sufficiently rigorous?	x			x		
9. Is there a clear statement of findings?	x			x		
10. How valuable is the research?	x			x		
Total out of 10		9			9	

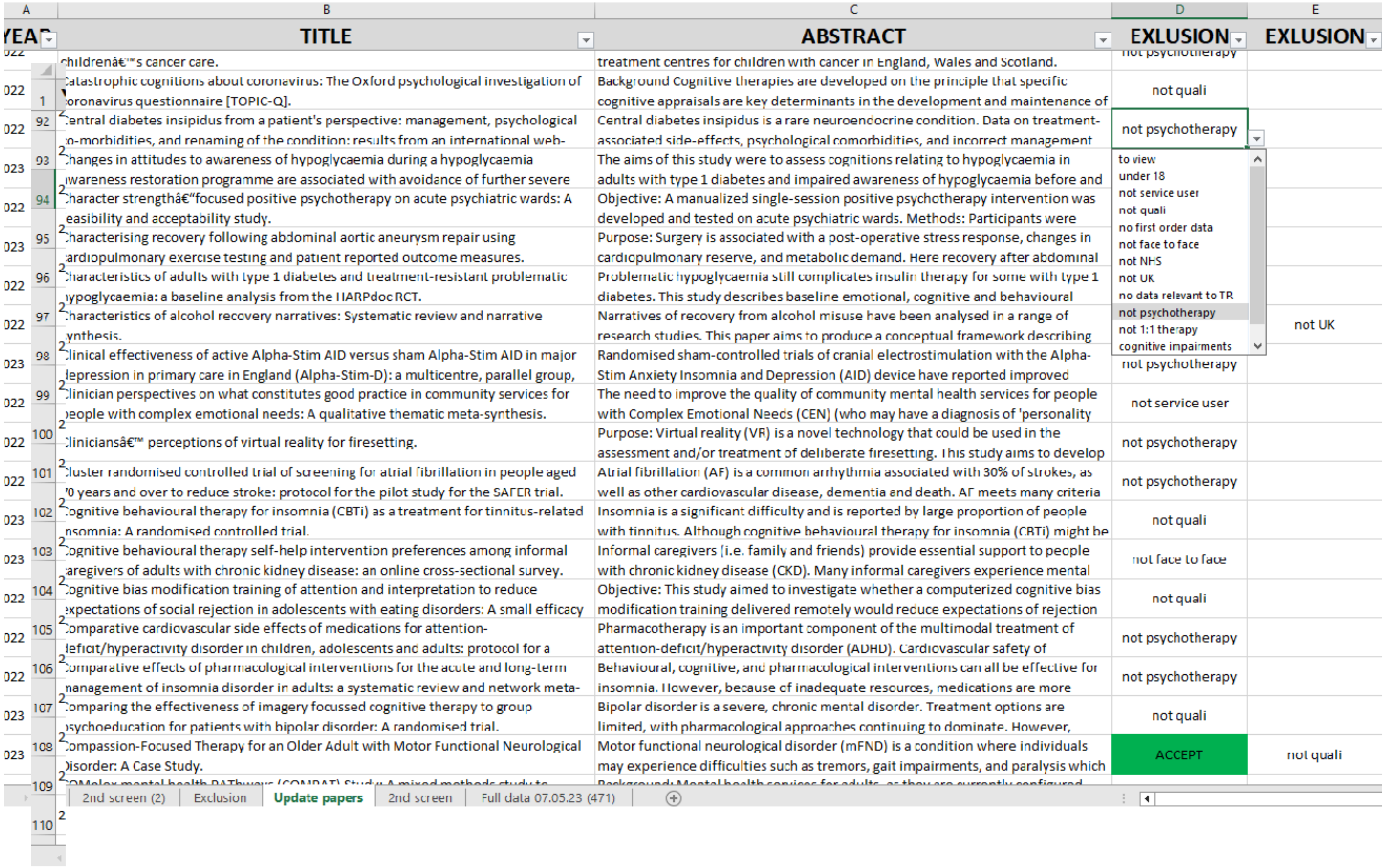
Appendix E: Inclusion and exclusion criteria and rationale for systematic review

Table 1

Inclusion and exclusion criteria for the systematic review

Criteria #	Criteria	Rationale
	Inclusion criteria	
1	A qualitative research methodology (including mixed methods)	The research question is looking at experience which is best captured through qualitative methods.
2	Participants are in receipt of psychological therapy (or their data is exclusively part of the results)	The research question is interested in service user perspectives exclusively as these are not as well represented in the formal literature
3	Participants therapy experience delivered in person	This is to exclude therapy that was delivered by electronic means as the research question is interested in the interactions between therapist and service user.
4	Therapy received on an individual (one to one) basis	This criterion is to focus the research and increase the likelihood of information pertinent to the therapeutic relationship. Group process are likely to dilute the therapeutic relationship between participant and therapist. Furthermore the empirical aspect of this thesis is concerned with individual therapy.
5	Therapy received in NHS service	The research question focuses in on the context of the NHS.
6	Participants based in the United Kingdom	As above. The NHS is based within the UK.
7	Adult (18 or over) participants at time of study	The empirical aspect of this thesis is concerned with adults and as adults are the largest recipients of MH services this was chosen.
	Exclusion criteria	
A	No data relevant to the therapeutic relationship	The research question is looking at factors impacting the therapeutic relationship and as such a paper that meets criteria but has no data that can support answering the question is not going to add anything to the synthesis.
B	No significant first order data (direct quotes from participants)	Participant quotes form a core aspect of the synthesis process as part of the ethos of this paper was to highlight the voices of service users. Papers that contain just interpretive descriptions and minimal first order data are unlikely to support this ethos.
C	Participants not in receipt of psychotherapy	The therapeutic relationship exists in the context of a psychotherapy to be explored. Whilst therapeutic relationships exist within other contexts, this thesis is focused on psychological processes and professions.
D	Participants detained formally or informally in an inpatient setting	This thesis focuses on community service users as the largest group in receipt of therapy. Also due to the potential coercive effects of legal or the threat of legal restrictions on the therapeutic relationship.
E	Participants with cognitive impairments (such as Intellectual Disability or Neurodegenerative disorder)	This thesis focuses on participants without cognitive deficit.

Appendix F: Example of selection process for systematic review



	YEAR	TITLE	ABSTRACT	EXLUSION	EXLUSION
	022	hildrenâ€™s cancer care.	treatment centres for children with cancer in England, Wales and Scotland.	not psychotherapy	
1	022	atastrophic cognitions about coronavirus: The Oxford psychological investigation of oronavirus questionnaire [TOPIC-Q].	Background Cognitive therapies are developed on the principle that specific cognitive appraisals are key determinants in the development and maintenence of	not quali	
92	022	entral diabetes insipidus from a patient's perspective: management, psychological o-morbidities, and renaming of the condition: results from an international web-	Central diabetes insipidus is a rare neuroendocrine condition. Data on treatment- associated side-effects, psychological comorbidities, and incorrect management	not psychotherapy	
93	023	hanges in attitudes to awareness of hypoglycaemia during a hypoglycaemia wareness restoration programme are associated with avoidance of further severe	The aims of this study were to assess cognitions relating to hypoglycaemia in adults with type 1 diabetes and impaired awareness of hypoglycaemia before and		
94	022	haracter strengthâ€"focused positive psychotherapy on acute psychiatric wards: A easibility and acceptability study.	Objective: A manualized single-session positive psychotherapy intervention was developed and tested on acute psychiatric wards. Methods: Participants were		
95	023	haracterising recovery following abdominal aortic aneurysm repair using ardiopulmonary exercise testing and patient reported outcome measures.	Purpose: Surgery is associated with a post-operative stress response, changes in cardiopulmonary reserve, and metabolic demand. Here recovery after abdominal		
96	022	haracteristics of adults with type 1 diabetes and treatment-resistant problematic ypoglycaemia: a baseline analysis from the HARPdoc RCT.	Problematic hypoglycaemia still complicates insulin therapy for some with type 1 diabetes. This study describes baseline emotional, cognitive and behavioural		
97	022	haracteristics of alcohol recovery narratives: Systematic review and narrative ynthesis.	Narratives of recovery from alcohol misuse have been analysed in a range of research studies. This paper aims to produce a conceptual framework describing		not UK
98	023	linical effectiveness of active Alpha-Stim AID versus sham Alpha-Stim AID in major lepression in primary care in England (Alpha-Stim-D): a multicentre, parallel group,	Randomised sham-controlled trials of cranial electrostimulation with the Alpha- Stim Anxiety Insomnia and Depression (AID) device have reported improved	not psychotherapy	
99	022	linician perspectives on what constitutes good practice in community services for eople with complex emotional needs: A qualitative thematic meta-synthesis.	The need to improve the quality of community mental health services for people with Complex Emotional Needs (CEN) (who may have a diagnosis of 'personality	not service user	
100	022	liniciansâ€™ perceptions of virtual reality for firesetting.	Purpose: Virtual reality (VR) is a novel technology that could be used in the assessment and/or treatment of deliberate firesetting. This study aims to develop	not psychotherapy	
101	022	luster randomised controlled trial of screening for atrial fibrillation in people aged 0 years and over to reduce stroke: protocol for the pilot study for the SAFER trial.	Atrial fibrillation (AF) is a common arrhythmia associated with 30% of strokes, as well as other cardiovascular disease, dementia and death. AF meets many criteria	not psychotherapy	
102	023	ognitive behavioural therapy for insomnia (CBTi) as a treatment for tinnitus-related nsomnia: A randomised controlled trial.	Insomnia is a significant difficulty and is reported by large proportion of people with tinnitus. Although cognitive behavioural therapy for insomnia (CBTi) might be	not quali	
103	023	ognitive behavioural therapy self-help intervention preferences among informal aregivers of adults with chronic kidney disease: an online cross-sectional survey.	Informal caregivers (i.e. family and friends) provide essential support to people with chronic kidney disease (CKD). Many informal caregivers experience mental	not face to face	
104	022	ognitive bias modification training of attention and interpretation to reduce xpectations of social rejection in adolescents with eating disorders: A small efficacy	Objective: This study aimed to investigate whether a computerized cognitive bias modification training delivered remotely would reduce expectations of rejection	not quali	
105	022	omparative cardiovascular side effects of medications for attention- eficit/hyperactivity disorder in children, adolescents and adults: protocol for a	Pharmacotherapy is an important component of the multimodal treatment of attention-deficit/hyperactivity disorder (ADHD). Cardiovascular safety of	not psychotherapy	
106	022	omparative effects of pharmacological interventions for the acute and long-term nanagement of insomnia disorder in adults: a systematic review and network meta-	Behavioural, cognitive, and pharmacological interventions can all be effective for insomnia. However, because of inadequate resources, medications are more	not psychotherapy	
107	023	omparing the effectiveness of imagery focussed cognitive therapy to group sychoeducation for patients with bipolar disorder: A randomised trial.	Bipolar disorder is a severe, chronic mental disorder. Treatment options are limited, with pharmacological approaches continuing to dominate. However,	not quali	
108	023	ompassion-Focused Therapy for an Older Adult with Motor Functional Neurological isorder: A Case Study.	Motor functional neurological disorder (mFND) is a condition where individuals may experience difficulties such as tremors, gait impairments, and paralysis which	ACCEPT	not quali

Appendix G: Example of data extracted for systemic review

Example of extracted data for systematic review taken from paper 12 (Low & Murray, 2014).

Results

Analysis identified five key themes (see below). In the following each is presented in turn and supported by excerpts from the research interviews. Pseudonyms are used to ensure anonymity.

Living with Symptoms Before Therapy

Participants gave accounts of their mental states prior to receiving trauma-focused cognitive behavioural therapy (Trauma-Focused-CBT). These descriptions often centred on their perceived 'breakdown' of their sense of self following their traumatic experiences. A loss of identity, believing that they were 'no longer the same person' (Mohamed) and 'losing confidence' in themselves and their abilities were reported;

I felt like I'd got a personality disorder. And he [therapist] said well a lot of people feel like that, that they're going crazy and stuff like that, but I did actually feel I was completely disintegrating. (Sarah).

Prior to the therapy sessions participants described feeling 'bewildered', with their minds being 'mixed up at the time' (Lisa). Feelings of guilt associated with their traumatic experiences were also frequently reported, with some initially thinking that they would not recover;

Yeah and I'm glad I saw it through now. Because at the time I couldn't see. It was like fog. And I couldn't see getting any better really. So I'd have used any excuse to put anything off. (Rebecca).

A range of symptoms associated with suffering from PTSD were discussed by participants. These included intrusive memories and images associated with the traumatic event, negative and suicidal thoughts, and the suppression of these thoughts, negative behaviours, such as using alcohol to try to cope with the difficult feelings and thoughts, and difficulties sleeping. These symptoms experienced prior to therapy were found to improve for participants in a number of ways following completion of the therapeutic process;

I remember before coming here I had the violent mood swings, not being able to sleep, not being able to eat. Just wanting to shut myself off completely. I mean a couple of times I'd go upstairs and lock the door and I would stay upstairs for two days. Completely shut off. Not eating, not drinking nothing for two days. So like I said without this place, I probably wouldn't be here. (John).

Such symptoms impacted not only on the lives of participants, but also their partners and family members. Additional challenges associated with PTSD were 'out of character' behaviours, such as feeling irritable and on occasions being aggressive with people close to them;

So everybody, my family, was aware that I was shorttempered. They were leaving me alone. I'd lock myself in my study out the way. I just lost interest in everything… I knew I was short with people, but I couldn't stop myself from being short with them… I was volatile. (Mohamed).

These accounts reflect the distressing symptoms participants experienced prior to receiving Trauma-Focused- CBT. Their lives, as well as people close to them, were affected negatively in a number of ways.

Feeling Ready for Therapy

Following recognition of their symptoms, participants reported thoughts around wanting change by accepting some therapeutic help. Descriptions centered on the time they spent waiting for therapy, and what it meant for them to receive their diagnosis;

So when I got the initial diagnosis of severe posttraumatic
stress disorder, I felt a great relief actually…
But for me having that label was actually a
relief because it gave a name to this demon, the
suffering. (Sarah).

By the time participants were referred for therapy, most felt prepared and ready for this help. They prioritised therapy over other areas of their lives, as they recognised it was something which they really needed;

I was desperate for help, yes I was I admit that.
(Lisa).

However, some interviewees were not aware at the time that they were unwell, and partners and family members often played a key role in helping them to identify that something was wrong;

Well I was as ready as I'm ever going to be. […] It
was my partner who picked up on it. It was causing a
lot of rifts between me and her. But I was like yeah,
let's go and give it a go and see what happens. (John).

There was some variation between participants' accounts relating to the speed at which they actually received therapy following their referral. Some were very satisfied with the length of time they had to wait, thinking they did not have to wait very long at all for therapy. Conversely, others would have liked to have received the help a lot sooner, believing they had to wait too long;

Well I was a bit anxious over the length of time. I
thought it was a good wait. I suppose everybody has
that problem, but in my circumstances I thought it
was quite a wait…I mean I was looking forward to it.
I really was looking forward to coming here and I
thought it was a long wait… I would have been
happier if it had been sooner. (Brian).

Alongside discussion of their decision that some therapeutic help would be beneficial, participants discussed the factors associated with the therapeutic process and the therapeutic relationship that were of primary importance to them. These issues are addressed in the following theme.

Being Involved

A strong sense of involvement in therapy was wanted and enabled for participants. This related not only to themselves, but also partners, friends and family members who attended the therapy sessions.[1] As such, therapy was described as a collaborative process;

The therapist takes the time to listen to what I want to
say, apart from having to listen to what he wants to
say. We worked through the problems and we worked
together on it, and we come up with some answers.
I've been quite happy with it. (Brian).

Participants often decided on the direction therapy should take, along with the pace at which they moved along at. As a result, they felt understood; they felt their therapists listened to them and respected their views, which resulted in them feeling more involved in the therapeutic process;

It was taken at my pace. You know, my therapist
suggested things what sort of like… Instead of saying
do this do that, she made suggestions and I sort of
come out with suggestions and then she said, ''Oh
yeah, try that.'' (Rebecca).

Along with feeling very involved in the therapeutic process, participants described becoming semi-independent during therapy. This related to making decisions for themselves during therapy, and also by using techniques learnt in therapy independently and outside of the therapeutic environment;

Yeah because Louise made suggestions and I'd try it
and she'd ask me when I went back, ''Did you try it?''
I'd be honest and say yes or no, or I did it a different
way to what she said… I decided on my own and she
said, ''Well that was good, you worked that out for
yourself.'' And I felt a lot easier with it. (Rebecca).

Participants also recognised the possibility of becoming 'dependent' on therapy and the therapeutic relationship but felt in control of when the therapy sessions came to an end;

I think I was in control of when I felt those sessions
could end. I don't know how long they would have
gone on had I not made that decision. I suppose you
can become quite dependent on things. But I don't

know for some reason I just felt OK and I thought,
''We've gone as we need to go.'' So I don't know
whether control is the right word, the way it's used,
but I felt that I had a really big say. (Sarah).

This idea of taking control and becoming more independent was also emphasised in relation to other areas of participants' lives, outside of the therapeutic environment.

Participants described becoming more positive, and engaging in activities that they had previously stopped taking part in.

Bringing About Therapeutic Change

All participants provided accounts of the factors they found facilitative of therapeutic change for them personally. Once again, these accounts emphasized their own agency in bringing about therapeutic change. Empathy, understanding, being non-judgemental and patient were identified by participants as important characteristics for therapists to possess, but participants also emphasised the need to talk to someone who was a stranger to them. As a result, participants often felt more comfortable and able to be open with their therapist than with family members;

She was very, very good… Louise's patience. Her
ability to pull the conversation back to where it
should be if I had wandered off anywhere. Her
understanding, her empathy. […] I wanted to speak to
someone who was a total stranger to me, didn't know
me and I didn't know them… (Mohamed).

Specific tools used during therapy were identified as beneficial. Being exposed to and discussing the traumatic event was described by participants as being important, as was psychoeducation concerning their reactions to the traumatic events;

Just talking about it I think because you keep it to
yourself don't you?... He's like instilled that what
happened in the incident and things, that I was not
wrong in reacting in that way. Because you do think.
(Vicky).

The homework element of therapy allowed participants to 'practise' the techniques learnt during therapy at home independently. Some suggested that this helped to 'move things on' during therapy. Participants also emphasised the importance of questioning their thought processes and thinking patterns during therapy, whilst recognising that their 'thoughts were just thoughts';

I think it was probably having somebody to listen and
help me explore more objectively the situation that I
found myself in. And sort of be able to take a step
back. And also some of the techniques that were sort
of discussed and going away and practicing those and
actually coming back and finding that they were
working. (Diane).

Other techniques which were found to be beneficial for participants included the concept of mindfulness, relaxation during anxious situations, and the diagrammatic work completed with their therapists. Feelings of safety were identified as important for some individuals, with therapy and the therapeutic relationship being described as a 'little safe house' and a 'safety valve' for them;

So diagrammatically again we were able to look at
those patterns of behaviour and my belief system,

which is a very entrenched belief system… So examining when things happen and how that belief system comes into play, and you know, questioning it, again which is a very important… I felt Richard gave me the tools to understand my own belief system and I was able to reinterpret things myself. I had the facilitation to examine my own beliefs and ideas with help and support. Rather than directing me, he facilitated me. (Sarah).

The flexibility in the use of time within therapy sessions and when each session took place were important aspects of therapeutic change for participants. Individuals placed importance on ‘never feeling the pressure of time’. They described valuing the fact that therapy sessions were ‘allowed to run over’. The length of time between appointments was also important, providing necessary time to ‘deal with things’ between sessions. One participant commented on the importance of the support provided by her therapist in-between sessions. She reported how at one point she was unsure whether to continue with the therapy sessions. However, her therapist telephoned her and this had encouraged her to begin attending again.

Life After Therapy

Participants discussed the effects of receiving therapy. It was recognised that the initial therapy sessions were quite ‘draining’ and many reported becoming upset during these sessions. However, gradually the therapy sessions became easier for participants;

I honestly can’t remember coming here for the very first time… but I remember parts of it… I remember being like a little kid crying my heart out in front of

Simon. A couple of times when I was talking about
my experiences and sort of like reliving them. That
was uncomfortable, but I knew that you've got to do
that otherwise you aren't going to get anywhere. So it
was just like a stepping-stone that I had to face.
(John).

Participants described the effects therapy had on the symptoms of PTSD they experienced. Many suggested that their sleep had improved, with participants no longer suffering from disturbed sleep and nightmares. The ability to *'re-evaluate negative thoughts and behaviours' (Sarah)* associated with the traumatic experience was also of central importance. Participants believed that therapy provided them with hope again after feeling 'hopeless and helpless';

But I am sleeping much better, I'm eating. Certainly
my sleep patterns have changed, although I've had a
couple of nights where it is not quite right. But I am
not having the nightmares and not waking up and
then not being able to go back to sleep… I can go
back to sleep. I don't have this constant feeling of
impending doom anymore. (Sarah).

The effects of therapy on other areas of their lives were highlighted by participants. Positive effects were reported in terms of improvements in relationships with partners, family members and work colleagues. Participants noted how '*things had become quite stressful at home, but following therapy they have settled down again' (Diane).*

Some also discussed the positive effects in terms of their work, with completion of therapy often resulting in them returning to paid or voluntary employment.

So I think I've done well to get where I've got to
today… It enabled me to focus on other things, other
points of my life… I went to MENCAP and learnt
how to be a carer. (Patrick).

Participants discussed how the techniques and 'tools' acquired during therapy could be used to help them to cope with other issues in their lives, as well as being able to transfer them to other situations;

In my sessions I was introduced to the idea of
mindfulness and that was a concept I have never sort
of come across before. And going away and learning
a little bit more about that and actually trying to use
some of them techniques to sort of, help with perhaps
anger issues and things like that… It's something that
I can take away and continue to use and I do use in
other situations. (Diane).

Although participants stated how the therapy that they received had helped with many aspects of their lives, some discussed how *'everything is still not perfect' (Sarah*). A number of participants still held very strong feelings towards their traumatic experience;

I'm not saying it took away everything or the guilt
and all that, because it hasn't, because I've still got it.
But it did help a lot. (Lisa).

Participants recognised that there were still things they felt unable to do and 'may not be able to do for a long time' (John). However, participants could now 'recognise the signs' (John) and felt more able to cope than prior to receiving therapy. Some still had periods when things were difficult, and a few had not regained interest in activities they previously enjoyed. Others believed that they had actually changed as people, and would 'never be the same again' (Mohamed).

Discussion

Prior research has employed qualitative methods to examine service-user perspectives following CBT for a number of conditions. However, no research exists which uses qualitative methodology to investigate service-users' experiences of receiving Trauma-Focused-CBT for PTSD. The present study therefore aimed to explore the positive experiences of such individuals. The aim of the study was not to evaluate the efficacy of Trauma-Focused-CBT, but rather to highlight what aspects of the therapeutic process participants found beneficial for them and stimulate thought about these. The themes presented represent participants' beliefs around the factors they found important in facilitating therapeutic change.

It has previously been suggested that some service-users struggle to conceptualise their ill-health (Kinderman et al. 2006). Prior to therapy, some participants in this study did not view themselves as being unwell. Partners and family members often played a key role in helping them to identify that help was required. However, generally participants were aware of the symptoms they experienced, and explained how these impacted on their lives in a negative way. They also recognised the negative impact of their behaviour on their partners and family members. As reported by Ehlers et al. (2009), secondary problems may occur if PTSD remains untreated. Along with the core symptoms of PTSD, depression, interpersonal conflict, alcohol use and sleep difficulties were identified by participants in this study. For these particular participants it is apparent that receiving Trauma-focused-CBT had a significantimpact on many of their symptoms, however certain symptoms seemed to decrease more than others. Participants reported a number of positive changes in relation to their behaviour and thinking patterns. With the help of therapists, participants were able to re-evaluate their thoughts and provide alternative explanations. In addition, participants reported that therapy provided them with hope for the future, improved their relationships with others and increased their motivation to return to employment.

Participants reported that following completion of therapy some of their symptoms of PTSD were still present. Trauma-related guilt associated with their traumatic experiences was still reported by a number of participants following completion of therapy. Kubany et al. (2004) defines guilt as an unpleasant feeling accompanied by a belief that one should have thought, felt or acted differently. He recognises that not only is trauma-related guilt unhelpful, but these feelings are also very difficult to change. On-going identity issues were also still noted by a number of individuals. Some described being changed as people following their traumatic experience and how they 'would never be the same again'. It is possible that Trauma-focused-CBT specifically targets certain symptoms of PTSD (Ehlers and Clark 2000), or that a greater number of sessions are needed in order to eradicate these particular symptoms. Therapists could be aware of this when working with clients and make sure that more of the therapy sessions are spent targeting these symptoms. This would ensure therapists' time and resources are used more efficiently.

Participants emphasised factors they found facilitative of therapeutic change. The most researched factor involved in CBT appears to be the 'therapeutic alliance'. In line with previous research (Hansson et al. 1993; Gordan 2000; Rossberg 2004), empathy and understanding were identified as important characteristics for therapists to possess. However, participants in this study also described being non-judgemental and patient as significant therapist characteristics.

These characteristics encouraged participants to be open and honest with their therapists, consequently facilitating therapeutic change. The building of this therapeutic relationship appears to be a generic requirement in all CBT therapies, with some researchers claiming that the outcome of CBT therapies is dependent on the quality of this relationship (Borrill and Foreman 1996). Participants in this research also emphasised the importance of feeling safe in the therapeutic environment. However, this may be specific to this client group given the nature of PTSD. Participants' wanted to contribute to their own recovery' by being involved in the therapeutic process. Participants' own preference for involvement, then, provided a good fit with the collaborative emphasis of CBT (Chadwick et al. 1996). Therapists should therefore recognise that allowing individuals to feel in control during the therapy sessions may facilitate therapeutic change for participants with PTSD. However, participants described feeling 'overwhelmed' during the earlier stages of therapy, which indicates that more guidance may be required from therapists during this initial period.

While clients in previous research (Borrill and Foreman 1996; Laberg et al. 2001) have reported a sense of the psychologist being in control and leading their CBT therapy sessions, participants in this study experienced therapy as a collaborative process. They described feeling in control throughout the therapy sessions and became more independent as the sessions went on, particularly with regards to using 'tools' acquired during therapy independently. This has been discussed in previous research, with therapy being described as a skill-teaching process whereby skills learnt during therapy are practised and applied outside of therapy (Clarke et al. 2004). This need for participants to feel in control and contribute to their own recovery seemed to be especially important for participants in this research.

Participants in the research by Bevan et al. (2010) recognised the importance of on-going support, by having follow-up appointments with their therapists following completion of therapy. In addition, participants in this study highlighted the value of support from therapists being provided between the therapy sessions. They also valued the flexibility of the therapy sessions, by 'never feeling the pressure of time' and 'being allowed to run over'. This ensured they did not have anything left 'hanging in the air' following completion of the therapy sessions. This is in contrast to participants in research by Laberg et al. (2001) who reported that due to time constraints placed on therapy, they completed their therapy sessions still having unresolved issues. Therapists should consider this when working with clients with PTSD. If possible, it would be beneficial for therapists to leave a short time period immediately following the therapy sessions, which would provide participants with an opportunity to settle themselves before leaving. This is especially true given that many participants reported that 'things were stirred up during the sessions'. Similarly, as many participants reported that 'everything was still not perfect' following therapy, further follow-up sessions would provide a chance to recap on what was learnt during therapy and ensure the 'skills' acquired had been sustained.

Research has demonstrated that even though serviceusers can express high levels of motivation to change, they still report difficulties in following through with that motivation (Bevan et al. 2010). This can be expressed both in terms of completing homework tasks and addressing their distressing beliefs during therapy. However, participants in this study discussed completing their homework tasks without any difficulties and actually finding the homework beneficial. The importance of homework compliance in CBT has long been recognised (Dunn et al 2002). Participants suggested that the homework given to them during therapy was important as it helped to maintain the ‘focus’ of therapy at home. This enabled them to become more independent by practicing these skills at home without their therapist’s support. Although therapy was found to benefit participants in a number of ways, the recognition that their lives were ‘still not perfect’ was expressed. There were still things they ‘felt unable to do’ following therapy, but participants’ reported feeling prepared, and ‘more able to cope’ than prior to receiving therapy. They also discussed how the benefits of therapy would continue despite their sessions coming to an end.

Reference

Lowe, C., & Murray, C. (2014). Adult service-users’ experiences of trauma-focused cognitive behavioural therapy. *Journal of Contemporary Psychotherapy, 44*, 223-231. DOI: https://doi.org/10.1007/s10879-014-9272-1

Appendix H: Confirmation of ethical opinion from NW Greater Manchester Research ethics committee

Health Research Authority

North West - Greater Manchester West Research Ethics Committee
Barlow House
3rd Floor
4 Minshull Street
Manchester
M1 3DZ

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

16 August 2021

Dr Gillian Bowden
Department of Clinical Psychology and Psychological Therapies, School of Medicine
University of East Anglia
Norwich Research Park, Norwich
NR4 7TJ

Dear Dr Bowden

Study title:	**Exploring experiences of power in therapeutic relationships between NHS service users and Clinical Psychologists**
REC reference:	**21/NW/0114**
Protocol number:	**291953**
IRAS project ID:	**291953**

Thank you for your submission on 8th August 2021, responding to the Research Ethics Committee’s (REC) request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

Good practice principles and responsibilities

The UK Policy Framework for Health and Social Care Research sets out principles of good practice in the management and conduct of health and social care research. It also outlines the responsibilities of individuals and organisations, including those related to the four elements of research transparency:

1. registering research studies
2. reporting results
3. informing participants
4. sharing study data and tissue

Conditions of the favourable opinion

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

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

Guidance on applying for HRA and HCRW Approval (England and Wales)/ NHS permission for research is available in the Integrated Research Application System.

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

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

Registration of Clinical Trials

All research should be registered in a publicly accessible database and we expect all researchers, research sponsors and others to meet this fundamental best practice standard.

It is a condition of the REC favourable opinion that **all clinical trials are registered** on a publicly accessible database within six weeks of recruiting the first research participant. For this purpose, ‘clinical trials’ are defined as the first four project categories in IRAS project filter question 2. Failure to register a clinical trial is a breach of these approval conditions, unless a deferral has been agreed by or on behalf of the Research Ethics Committee (see here for more information on requesting a deferral: https://www.hra.nhs.uk/planning-and-improving-research/research-planning/research-registration-research-project-identifiers/

If you have not already included registration details in your IRAS application form, you should notify the REC of the registration details as soon as possible.

Further guidance on registration is available at: https://www.hra.nhs.uk/planning-and-improving-research/research-planning/transparency-responsibilities/

Publication of Your Research Summary

We will publish your research summary for the above study on the research summaries section of our website, together with your contact details, no earlier than three months from the date of this favourable opinion letter.

Should you wish to provide a substitute contact point, make a request to defer, or require further information, please visit: https://www.hra.nhs.uk/planning-and-improving-research/application-summaries/research-summaries/

N.B. If your study is related to COVID-19 we will aim to publish your research summary within 3 days rather than three months.

During this public health emergency, it is vital that everyone can promptly identify all relevant research related to COVID-19 that is taking place globally. If you haven't already done so, please register your study on a public registry as soon as possible and provide the REC with the registration detail, which will be posted alongside other information relating to your project. We are also asking sponsors not to request deferral of publication of research summary for any projects relating to COVID-19. In addition, to facilitate finding and extracting studies related to COVID-19 from public databases, please enter the WHO official acronym for the coronavirus disease (COVID-19) in the full title of your study. Approved COVID-19 studies can be found at: https://www.hra.nhs.uk/covid-19-research/approved-covid-19-research/

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

After ethical review: Reporting requirements

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

- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol
- Progress and safety reports
- Notifying the end of the study, including early termination of the study
- Final report
- Reporting results

The latest guidance on these topics can be found at https://www.hra.nhs.uk/approvals-amendments/managing-your-approval/.

Ethical review of research sites

NHS/HSC sites

The favourable opinion applies to all NHS/HSC sites taking part in the study, subject to confirmation of Capacity and Capability (in England, Northern Ireland and Wales) or management permission (in Scotland) being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Non-NHS/HSC sites

I am pleased to confirm that the favourable opinion applies to any non-NHS/HSC sites listed in the application, subject to site management permission being obtained prior to the start of the study at the site.

Approved documents

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

Document	*Version*	*Date*
Copies of materials calling attention of potential participants to the research [Email to clinical teams informing of recruitment to study]	v2.0	10 January 2021
Copies of materials calling attention of potential participants to the research [PDF Research flyer infographic]	v.2	06 June 2021
Copies of materials calling attention of potential participants to the research [Recuitment Email]	v.3	25 May 2021
Copies of materials calling attention of potential participants to the research [Website Page 1- home page (www.researching-power.co.uk)]	v.2	06 June 2021
Copies of materials calling attention of potential participants to the research [Website Page 2 - about the research - (www.researching-power.co.uk)]	v.2	06 June 2021
Copies of materials calling attention of potential participants to the research [Website Page 3 - taking part - (www.researching-power.co.uk)]	v.2	06 June 2021
Copies of materials calling attention of potential participants to the research [Website Page 4 - contact - (www.researching-power.co.uk)]	v.2	06 June 2021
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [Sponsor evidence of I&I cover]	v1.0	16 March 2021
GP/consultant information sheets or letters [Letter to LCP & GP Informing of Research]	v.2	25 May 2021
Interview schedules or topic guides for participants [Interview Protocol and topic guide]	v1	06 June 2021
IRAS Application Form [IRAS_Form_03082021]		03 August 2021
Letter from sponsor [Sponsor Insurance and Indemnity Cover Letter]	v1.0	16 March 2021
Letters of invitation to participant [Covering email for participant info and consentl]	v.2	25 May 2021

Letters of invitation to participant [Covering letter for participant information packl]	v.2	25 May 2021
Other [Sponsor evidence of professional indemnity]	v1.0	16 March 2021
Other [NEW DOCUMENT - Protocol for handling accusations against previous theraputic interventions]	v2	08 June 2021
Other [NEW DOCUMENT - Details of amendments made following Review from GM West Ethics Board 18th April 2021]	v.1	06 June 2021
Participant consent form [Participant Consent Form]	v.2	25 May 2021
Participant consent form [PDF qualtrics electronic participant consent form]	v3	25 May 2021
Participant information sheet (PIS) [Partcipant information sheetl]	v4	25 May 2021
Referee's report or other scientific critique report [Feedback from initial proposal/protocol from UEA internal reviewer]	v1.0	03 November 2020
Referee's report or other scientific critique report [List of updates from original thesis proposal / project protocol]	v1.0	21 November 2020
Research protocol or project proposal [Updated thesis proposal protocol l]	v3	06 June 2021
Summary CV for Chief Investigator (CI) [CV Gillian Boweden - CI]	v1	17 November 2020
Summary CV for student [CV Oliver Farrar - Student PI]	v.2	05 July 2021
Summary CV for supervisor (student research) [CV Corinna Hackmann - Secondary Supervisor]	v1.0	12 March 2021
Summary CV for supervisor (student research) [CV Hannah Zeilig - Secondary Supervisor]	v1.0	12 March 2021
Summary, synopsis or diagram (flowchart) of protocol in non technical language [Research Flow Chart]	v1.0	10 January 2021

Statement of compliance

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

User Feedback

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

HRA Learning

We are pleased to welcome researchers and research staff to our HRA Learning Events and online learning opportunities– see details at: https://www.hra.nhs.uk/planning-and-improving-research/learning/

IRAS project ID: 291953   Please quote this number on all correspondence

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

Yours sincerely

Miss Rebecca Throup
Approvals Administrator
PP
Dr Gideon Smith
Chair

Email: gmwest.rec@hra.nhs.uk

Enclosures: “After ethical review – guidance for researchers” *[SL-AR2]*

Copy to: Polly Harrison

Lead Nation England: approvals@hra.nhs.uk

Appendix I: IRAS ethics application

Welcome to the Integrated Research Application System

IRAS Project Filter

The integrated dataset required for your project will be created from the answers you give to the following questions. The system will generate only those questions and sections which (a) apply to your study type and (b) are required by the bodies reviewing your study. Please ensure you answer all the questions before proceeding with your applications.

Please complete the questions in order. If you change the response to a question, please select 'Save' and review all the questions as your change may have affected subsequent questions.

Please enter a short title for this project (maximum 70 characters)
Exploring power in therapeutic relationships (v.2)

1. Is your project research?

● Yes ○ No

2. Select one category from the list below:

○ Clinical trial of an investigational medicinal product

○ Clinical investigation or other study of a medical device

○ Combined trial of an investigational medicinal product and an investigational medical device

○ Other clinical trial to study a novel intervention or randomised clinical trial to compare interventions in clinical practice

○ Basic science study involving procedures with human participants

○ Study administering questionnaires/interviews for quantitative analysis, or using mixed quantitative/qualitative methodology

● Study involving qualitative methods only

○ Study limited to working with human tissue samples (or other human biological samples) and data (specific project only)

○ Study limited to working with data (specific project only)

○ Research tissue bank

○ Research database

If your work does not fit any of these categories, select the option below:

○ Other study

2a. Please answer the following question(s):

a) Does the study involve the use of any ionising radiation?	○ Yes	● No
b) Will you be taking new human tissue samples (or other human biological samples)?	○ Yes	● No
c) Will you be using existing human tissue samples (or other human biological samples)?	○ Yes	● No

3. In which countries of the UK will the research sites be located?*(Tick all that apply)*

☐ Scotland
☐ Wales
☐ Northern Ireland

3a. In which country of the UK will the lead NHS R&D office be located:

● England

○ Scotland

○ Wales

○ Northern Ireland

○ This study does not involve the NHS

4. Which applications do you require?

☑ IRAS Form
☐ Confidentiality Advisory Group (CAG)
☐ Her Majesty's Prison and Probation Service (HMPPS)

Most research projects require review by a REC within the UK Health Departments' Research Ethics Service. Is your study exempt from REC review?

○ Yes ● No

5. Will any research sites in this study be NHS organisations?

● Yes ○ No

5a. Are all the research costs and infrastructure costs (funding for the support and facilities needed to carry out the research e.g. NHS support costs) for this study provided by a NIHR Biomedical Research Centre (BRC), NIHR Applied Research Collaboration (ARC), NIHR Patient Safety Translational Research Centre (PSTRC), or an NIHR Medtech and In Vitro Diagnostic Co-operative (MIC) in all study sites?

Please see information button for further details.

○ Yes ● No

Please see information button for further details.

5b. Do you wish to make an application for the study to be considered for NIHR Clinical Research Network (CRN) Support and inclusion in the NIHR Clinical Research Network Portfolio?

Please see information button for further details.

○ Yes ● No

The NIHR Clinical Research Network (CRN) provides researchers with the practical support they need to make clinical studies happen in the NHS in England e.g. by providing access to the people and facilities needed to carry out research "on the ground".

If you select yes to this question, information from your IRAS submission will automatically be shared with the NIHR CRN. ***Submission of a Portfolio Application Form (PAF) is no longer required.***

6. Do you plan to include any participants who are children?

○ Yes ● No

7. Do you plan at any stage of the project to undertake intrusive research involving adults lacking capacity to consent for themselves?

○ Yes ● No

Answer Yes if you plan to recruit living participants aged 16 or over who lack capacity, or to retain them in the study following loss of capacity. Intrusive research means any research with the living requiring consent in law. This includes use of identifiable tissue samples or personal information, except where application is being made to the Confidentiality Advisory Group to set aside the common law duty of confidentiality in England and Wales. Please consult the guidance notes for further information on the legal frameworks for research involving adults lacking capacity in the UK.

8. Do you plan to include any participants who are prisoners or young offenders in the custody of HM Prison Service or who are offenders supervised by the probation service in England or Wales?

○ Yes ● No

9. Is the study or any part of it being undertaken as an educational project?

● Yes ○ No

Please describe briefly the involvement of the student(s):
This project is being undertaken as part of the thesis component of a Doctorate in Clinical Psychology. The student will be named as the Principal Investigator and will be involved in data collection and the writing up of the research. The primary academic supervisor will be the Chief Investigator.

9a. Is the project being undertaken in part fulfilment of a PhD or other doctorate?

● Yes ○ No

10. Will this research be financially supported by the United States Department of Health and Human Services or any of its divisions, agencies or programs?

○ Yes ● No

11. Will identifiable patient data be accessed outside the care team without prior consent at any stage of the project (including identification of potential participants)?

○ Yes ● No

Integrated Research Application System
Application Form for Research involving qualitative methods only

IRAS Form (project information)

Please refer to the E-Submission and Checklist tabs for instructions on submitting this application.

The Chief Investigator should complete this form. Guidance on the questions is available wherever you see this symbol displayed. We recommend reading the guidance first. The complete guidance and a glossary are available by selecting Help.

Please define any terms or acronyms that might not be familar to lay reviewers of the application.

Short title and version number: (maximum 70 characters - this will be inserted as header on all forms)
Exploring power in therapeutic relationships (v.2)

Please complete these details after you have booked the REC application for review.

REC Name:
REC: North West - Greater Manchester West Research Ethics Committee

REC Reference Number: 21/NW/0114	**Submission date:** 20/03/2021

PART A: Core study information

1. ADMINISTRATIVE DETAILS

A1. Full title of the research:

Exploring experiences of power in therapeutic relationships between NHS service users and Clinical Psychologists

A2-1. Educational projects

Name and contact details of student(s):

Student 1

	Title	Forename/Initials	Surname
	Mr	Oliver	Farrar

Address Department of Clinical Psychology, Norwich Medical School
University of East Anglia
Norwich Research Park, Norwich
Post Code NR4 7TJ
E-mail o.farrar@uea.ac.uk
Telephone 07824 607598
Fax

Give details of the educational course or degree for which this research is being undertaken:

Name and level of course/ degree:
Doctorate in Clinical Psychology (ClinPsyD)

Name of educational establishment:
University of East Anglia

Name and contact details of academic supervisor(s):

Academic supervisor 1

Title	Forename/Initials	Surname
Dr	Gillian	Bowden

Address Department of Clinical Psychology and Psychological Therapies, School of Medicine
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Fax

Academic supervisor 2

Title	Forename/Initials	Surname
Dr	Corinna	Hackmann

Address [redacted]
[redacted] [redacted]
E-mail [redacted]
Telephone [redacted]
Fax

Academic supervisor 3

Title	Forename/Initials	Surname
Dr	Hannah	Zeilig

Address School of Health Sciences
University of East Anglia
Norwich Research Park, Norwich
Post Code NR4 7TJ
E-mail h.zeilig@fashion.arts.ac.uk
Telephone [redacted]
Fax

Please state which academic supervisor(s) has responsibility for which student(s):
Please click "Save now" before completing this table. This will ensure that all of the student and academic supervisor details are shown correctly.

Student(s)	**Academic supervisor(s)**
Student 1 Mr Oliver Farrar	☑ Dr Gillian Bowden ☑ Dr Corinna Hackmann ☑ Dr Hannah Zeilig

A copy of a current CV for the student and the academic supervisor (maximum 2 pages of A4) must be submitted with the application.

A2-2. Who will act as Chief Investigator for this study?

○ Student

● Academic supervisor

○ Other

A3-1. Chief Investigator:

Title	Forename/Initials	Surname
Dr	Gillian	Bowden

Post	Clinical Lecturer / Tutor
Qualifications	[redacted]
ORCID ID	0000 0002 9830 3258
Employer	University of East Anglia
Work Address	Department of Clinical Psychology and Psychological Therapies, School of Medicine University of East Anglia Norwich Research Park, Norwich
Post Code	NR4 7TJ
Work E-mail	g.bowden@uea.ac.uk
* Personal E-mail	
Work Telephone	01603 591213
* Personal Telephone/Mobile	
Fax	

** This information is optional. It will not be placed in the public domain or disclosed to any other third party without prior consent.*
A copy of a current CV (maximum 2 pages of A4) for the Chief Investigator must be submitted with the application.

A4. Who is the contact on behalf of the sponsor for all correspondence relating to applications for this project?
This contact will receive copies of all correspondence from REC and HRA/R&D reviewers that is sent to the CI.

Title	Forename/Initials	Surname
	Polly	Harrison

Address	Research and Enterprise Services University of East Anglia Norwich Research Park, Norwich
Post Code	NR4 7TJ
E-mail	researchsponsor@uea.ac.uk
Telephone	01603 597948
Fax	

A5-1. Research reference numbers. *Please give any relevant references for your study:*

Applicant's/organisation's own reference number, e.g. R & D (if available):	N/A

Sponsor's/protocol number:	291953
Protocol Version:	V.2
Protocol Date:	26/10/2020
Funder's reference number (enter the reference number or state not applicable):	N/A

Project website: www.researching-power.co.uk

Additional reference number(s):

Ref.Number Description	Reference Number

Registration of research studies is encouraged wherever possible. You may be able to register your study through your NHS organisation or a register run by a medical research charity, or publish your protocol through an open access publisher. If you have registered your study please give details in the "Additional reference number(s)" section.

A5-2. Is this application linked to a previous study or another current application?

○ Yes ● No

Please give brief details and reference numbers.

2. OVERVIEW OF THE RESEARCH

To provide all the information required by review bodies and research information systems, we ask a number of specific questions. This section invites you to give an overview using language comprehensible to lay reviewers and members of the public. Please read the guidance notes for advice on this section.

A6-1. Summary of the study. *Please provide a brief summary of the research (maximum 300 words) using language easily understood by lay reviewers and members of the public. Where the research is reviewed by a REC within the UK Health Departments' Research Ethics Service, this summary will be published on the Health Research Authority (HRA) website following the ethical review. Please refer to the question specific guidance for this question.*

This study is looking at how NHS service users experience power in therapy with Clinical Psychologists. This is not currently well understood, and we hope that better understanding power in this relationship will help make the therapy more effective.

Service users in NHS community mental health teams can be offered talking treatments for support with a number of issues. Often this will be done on a one to one basis with a Psychologist. The relationship between the service user and Psychologist is very important. This is because it takes trust and courage to talk about things that might be sensitive for them. Research shows us that the strength of this relationship is an important factor in how effective the therapy is.

We also know that this relationship might feel unequal for either the Psychologist or the service user. When a relationship feels unequal it might be because one person has more or less ‘power’ than the other at different times. We want to understand more about how service users experience power and how this happens in therapy. We think that this will help people understand power in this relationship better and hopefully do things differently to make the relationship stronger. This is important because we know that a stronger relationship between a Psychologist and service user means that the therapy is likely to be better.

We will do this by interviewing 8-10 NHS mental health service users for approximately 60 minutes who have been in therapy and asking them to talk about their relationship with their therapist. This will be done remotely by video link. We will then analyse this data using a method called Interpretive Phenomenological Analysis to see how individuals make sense of their relationship with their therapist.

A6-2. Summary of main issues. *Please summarise the main ethical, legal, or management issues arising from your study and say how you have addressed them.*

Not all studies raise significant issues. Some studies may have straightforward ethical or other issues that can be identified and managed routinely. Others may present significant issues requiring further consideration by a REC, HRA, or other review body (as appropriate to the issue). Studies that present a minimal risk to participants may raise complex organisational or legal issues. You should try to consider all the types of issues that the different reviewers may need to consider.

Purpose and design

There are over 13,000 practicing Clinical Psychologists currently in the United Kingdom (Health and Care Professions Council, 2019), many of whom engage in direct individual therapy with NHS service users. Clinical Psychologists and service users must navigate complex power dynamics within therapy and within the NHS. However, there is currently a lack of empirical work on this subject. Yet, the limited research has shown that power can influence processes and outcomes in therapy and can have significant consequences if misused.

Part of the difficultly of developing an empirical base to research power is due to the multiple theoretical, political and psychological conceptualisations of it throughout history. These understandings have developed from two general perspectives, structural theories, that view power as embedded in social structures of society (see Hindess, 1996 for a review), and postmodern theories, whereby power is seen and used in a variety of dynamic relational processes (see Foucault, 1980). However, from assimilating these multiple perspectives it is apparent that power operations are important and pervasive in all structures and relationships.

Recent psychological efforts to understand the influence of power are evident in the Power Threat Meaning Framework (Johnstone & Boyle, 2018). This examines the operation of power at biological, coercive, legal, economic, ideological and interpersonal levels, and the subsequent effects on individuals' experiences of distress. However, this framework does not claim to fully account for all operations of power, especially the more 'positive' uses of power (Johnstone & Boyle, 2018). Indeed, much of the literature around power focuses on the negative operations of power (Proctor, 2017), and often just at the abstract and philosophical level, and not the empirical level. Developing more robust literature on 'positive' applications of power, such as positive collective power (Arendt, 1968) or nutrient power (May, 1998), could support greater understanding of its use in routine clinical practice, particularly within the therapeutic relationship.

The relationship between therapist and service user has been shown to be the most stable predictor of positive therapy outcomes (Horvath, Del Re, Flückiger & Symonds, 2011), and as such forming and maintaining therapeutic relationships is something that has been extensively empirically researched (Norcross, 2010). Much of the literature focuses on the experiences of clinicians forming these relationships (Levitt, Pomerville & Surace, 2016) and less attention is paid to the experiences of the service users. This is misguided, as the less privileged are often more acutely aware of the operation of power (Fiske, 1993).

Different psychological approaches pay different attention to power in their theory and delivery (DeVaris, 1994). For example, in Cognitive Behavioural theory minimal attention is paid to power outside of the formation of collaborative relationships (Spong & Hollanders, 2003), whilst Rogerian theory puts empowerment more centrally. However, in most schools of psychology power is primarily addressed in terms of the therapeutic relationship and not the structural power context and the effects this has on therapeutic relationships (Proctor, 2017) and seldom explored in terms of the service user perspective (Levitt et al., 2016).

Furthermore, the scant literature looking at service users' experiences of therapeutic relationships primarily comes from outside the UK and the NHS. This provides arguable validity for use in the context of the NHS as the NHS is a unique public health context, being highly politicised and one of the few international health systems free at the point of access (Benbow, 2018). Founded following the Second World War on the principles of universality, equity of access, quality, and being paid for by central funding makes the NHS highly susceptible to political and economic power influences (Benbow, 2018). If we accept that power processes are pervasive in both structures and relationships, then these influences become important when thinking about their effects on policy and practice within the NHS, and the development of therapeutic relationships.

Despite acknowledgement of the importance of therapeutic relationships and that power is a significant and inevitable factor in these relationships (Proctor, 2017) one would expect direct empirical attention to this. However, almost no research has focussed on understanding the experience and role of power in therapeutic relationships, and none from the perspective of the service user (Levitt et al., 2016).

This study will address the gaps in empirical evidence surrounding the experience of power in therapeutic relationships between Clinical Psychologists and NHS service users. Addressing this will support NHS stakeholders in the development and application of policy and practice, as well as developing the theoretical base. Furthermore, addressing this gap should help Clinical Psychologists and service users in the NHS navigate the complex power dynamics more effectively, in the context of individual psychological therapy.

Therefore, this study will attempt to answer the question: How do NHS service users experience power in therapeutic relationships with Clinical Psychologists?

The primary academic supervisor and secondary supervisors have been involved in the development of the proposal and research question. All supervisors have experience (including lived experience of accessing NHS services and therapy) of power relationships between Clinical Psychologists and service users in the NHS and believe the study is of academic and clinical interest to the both service users, clinicians, stakeholders and policy makers.

Incorporating a lived experience perspective has been central to this project, especially considering the nature of the question and the population being examined. This has been addressed from the outset by incorporating a member of the research team who has lived experience of mental health difficulties as well as academic research experience in the area. This team member has been involved with the development and supervision of the research. In addition, we have involved consultants with lived experience in the development of the interview schedule. These perspectives have significantly shaped the research and supported the thinking around the most appropriate ways to conduct the research, including recruitment strategy, ethics, methodology, interview schedule development and data analysis.

Design:

A qualitative approach, Interpretive Phenomenological Analysis (IPA, Smith, Flowers & Larkin, 2013) will be used to answer the research question. This exploratory question is concerned with a particular experience of individuals (psychological therapy) in a specific context (the NHS) and IPA's grounding in phenomenology (the study of lived experience), hermeneutics (interpretation of meaning) and ideography (examination of the 'particular') will support answering this. For these reasons IPA was chosen over other qualitative approaches.

IPA does not seek to make empirical generalisations but is concerned with the detailed examination of human lived experienced and understanding the meanings that people impress upon it. Ideography, which is concerned with the 'particular', does not eschew generalisations (Harré, 1979) but locates them within the 'particular' and explores them with caution (Smith et al, 2013), creating dialogue between the particular and the psychological literature. This means that this approach can be suitable for not only answering the research question, but also developing the literature base around power in therapeutic relationships.

Furthermore, this research is focused on power and there are inherent power differentials in research between participant and researcher (Rose & Kalathil, 2019). IPA allows for acknowledgment of this and so power, privilege and the researchers position can be accounted for. The student conducting the research who is the Principal Investigator (PI) is a Trainee Clinical Psychologist who is white and identifies as male and middle class; he will come with assumptions and expectations of participants and the psychologists they are discussing, viewed through his particular lens. IPA addresses this through a stance of openness and awareness (Dahlberg, Drew & Nystrom, 2001) so researchers can attempt to 'bracket off' these in the data gathering stage and acknowledge them in the analytic stages (Smith et al., 2013). Flexibility, empathy, and a desire to enter the participant's world will also support the researcher to 'bracket off' assumptions. IPA also sits with the researcher's epistemological position that is between Critical Realism and Constructivism, making both theoretically compatible. Consideration of power in the relationship between the researcher and the participant and how this will affect the data generated and the analysis will be critical and can be explored within an IPA methodology. This 'live' power dynamic will be explicitly considered during the interview and interpretive stages; and will be addressed in research supervision and reflexive diaries.

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DeVaris, J. (1994). The dynamics of Power in Psychotherapy. Psychotherapy: Theory, Research and Practice, 31(4), 588 - 593.

Fiske, S. T. (1993). Controlling other people: The impact of power on stereotyping. American psychologist, 48(6), 621-628.

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Levitt, H. M., Pomerville, A., & Surace, F. I. (2016). “A qualitative meta-analysis examining clients’ experiences of psychotherapy: A new agenda": Correction to Levitt, Pomerville, and Surace (2016). Psychological Bulletin, 142(10), 1067–1067. https://doi.org/10.1037/bul0000079

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Norcross, J. C. (2010). The therapeutic relationship. In Duncan, B. L., Miller, S. D., Wampold, B. E., & Hubble, M. A. (Eds.) The heart and soul of change: Delivering what works in therapy (pp. 113–141). American Psychological Association.

Proctor, G. (2017). The dynamics of power in counselling and psychotherapy: Ethics, politics and practice, 2nd Edition. Monmouth: PCCS books.

Rose, D., & Kalathil, J. (2019). Power, Privilege and Knowledge: the Untenable Promise of Co-production in Mental “Health.” Frontiers in Sociology, 4(7), 1–11. https://doi.org/10.3389/fsoc.2019.00057

Smith, J. A., Flowers, P., & Larkin, M. (2012). Interpretative Phenomenological Analysis: Theory, Method and Research. London: SAGE Publications.

Spong, S. and Hollanders, H. (2003). Cognitive Therapy and Social Power. Counselling and Psychotherapy Research, 3(3), 216 – 222.

Recruitment

Participants will be recruited from [redacted] ([redacted] secondary services in [redacted] The research will be presented to People Participation Leads (PPLs) across the five care groups across the trust who will act as gatekeepers. PPLs sit on care group leadership teams and have vast experience of working within the mental health service and have lived experience of mental health. PPLs have been consulted to develop the recruitment and research strategy as active participation is important to this research as well as increasing the voice of people with lived experience in shaping the research.

Following ethical approval being received, PPLs will receive the study marketing material. This includes a recruitment poster, a recruitment email, a recruitment tweet, and a link to the study website which contains the full participant information sheet, a visual representation of the participant information, and a link to questionnaire where the participant provides consent to contact and acts as an eligibility screen. These materials are enclosed in this application.

PPLs will distribute the recruitment poster and tweet through their own internal marketing platforms, which include the trust website ([redacted] a newsletter and the [redacted]). This will provide a link to the study website (www.researching-power.co.uk), where participants will be able to read further information on the study and view the participant information forms. If they decide they would be interested in taking part, then they complete a consent to contact questionnaire via a link in the website. This takes them to Qualtrics survey. Qualtrics is survey software licenced to be used by the University of East Anglia and meets their policies on security of data. This is standard practice at the University of East Anglia. When a potential participant completes the survey the lead researcher is informed by email. The lead researcher can then access this information from a Trust issued laptop and store it securely on a Trust hard drive or encrypted external drive. The data is then deleted from the Qualtrics platform. This will be done as quickly as possible so that the confidential data does not stay on this storage system longer than required. This information is password protected and only the Principal Investigator and Chief Investigator will have access to this.

When participants click on the consent to contact form, they are presented with a screen that asks if they have read the participant information form. A link is provided to this so they can read it before proceeding. Participants then complete an eligibility screen. No identifiable information is collected at this point. If the participant does not meet the eligibility criteria then they will not be able to proceed and a screen will thank them for their interest and provide them with contact details for the lead researcher. This is to stop gathering unnecessary identifiable information for participants who are not eligible for the study.

If participants are eligible, they will then be asked to provide consent to contact and consent to provide identifiable information. If they do not provide this they will be thanked and the survey will end. If they provide consent to contact then they will be asked their name, date of birth, contact telephone number, contact email, how they want to be contacted, their gender, whether they are under a community mental health team or not, the name of their lead professional (Care Co-ordinator, Lead Care Professional or GP), their GP and GP surgery. After this they are thanked by the survey and told that the lead researcher (PI) will be in contact within 10 working days. They will also be provided with contact information and the survey will end.

Following this the information will be received by the Principal Investigator and reviewed. An email will then be sent out thanking them for their interest and if all eligibility criteria are met an appointment for a phone call to discuss the research will be offered this will be no sooner than 72 hours following the email. This email will also contain copies of the participant information sheet, the consent form and a link to the electronic consent form. A copy of this email is enclosed in this application. The participant can also choose to receive a phone call to arrange this appointment as well. If the participant has requested a hard copy of the participant information form and consent form, then this will be sent out by 1st class post at the same time.

The participant will be offered the opportunity to suggest another time for the phone call to discuss consent if the suggested time is not suitable. If the study is full or the participant does not meet the eligibility criteria and email informing them of this will be sent and they will be thanked for their interest. Their information will then be deleted.

The telephone call to discuss the research and gain consent will approximately 30 minutes and will allow time for the research to be discussed in detail, confirm eligibility and to allow for consent to be discussed. If the participant consents this will be noted in the research log as verbal consent. The participant will then be asked to fill in the consent form. The participant will have the choice of doing this electronically via a Qualtrics Survey (link provided in preceding email) or via hard copy and returning it in a prepaid registered envelope, contained within the information pack. A provisional interview date will be set at a convenient time in the future. This will remain provisional until the electronic or hard copy consent form has been received. If the electronic or hard copy consent form has not been received at least three days before the interview then the Principal Investigator will make telephone contact with participant to see if they still want to take part and to arrange for consent to be returned and for a suitable interview date to be arranged so that electronic or hard copy consent has been gained. Once consent has been received a letter will be sent to the participant’s Lead Care Professional or GP informing them of their involvement. This will include opportunities for the professional to ask questions about the research. Only after consent has been received and professionals informed will the interview proceed.

Inclusion / exclusion

Inclusion:
- Aged 18 years or older
- Participant has received care from secondary mental health team within the host trust
- Participant agrees for Lead Care Professional or GP to be informed of involvement in the research
- Participant has received one to one individual therapy from a Clinical Psychologist in last 24 months
- Participant engaged in 8 or more individual therapy sessions with the Clinical Psychologist
- Participant is able to understand written and spoken English

Exclusion:
- Participant is currently in hospital or subject to Mental Health Act conditions, including Community Treatment orders.
- Participant received therapy from a Clinical Psychologist whilst subject to Mental Health Act conditions or whilst in psychiatric hospital.
- Participant is currently undertaking any form of structured one to one or group therapy with a Clinical Psychologist, Psychotherapist, Assistant Psychologist, Psychological Wellbeing Practitioner, or Counsellor.
- The participant’s current Lead Care Professional is the Clinical Psychologist who delivered their therapy.
- The participant does not have capacity to consent or the cognitive ability to take part in the study.

Consent
Participant information and consent sheets were developed using templates and guidance from the Health Research Authority (2017). Information sheets include details about the research, methodology, confidentiality, time commitment, contact details of primary researchers, potential benefits, reimbursement, data use, possible outcomes of the research, and how the results will be disseminated. Furthermore, in line with General Data Protection Regulation (European Union, 2017) the type of data collected is explicitly stated along with how it will be stored, used, and destroyed when no longer needed. Participant information sheets and consent forms will be sent by email or post at least 72 hours prior to the contact to discuss consent. Participant information sheets are also available through the

research website (www.researching-power.co.uk). Postal information packs will also contain a prepaid recorded delivery envelope to return consent forms. During the telephone call to discuss the research and to gain consent, verbal consent will be gained and noted in the research log. Following this, the participant will be offered the opportunity to provide written consent electronically (via online Qualtrics Survey) or with a paper copy that will be obtained via secure return post. Once written consent is obtained this will be noted in the research log and the interview will proceed. The interview will not proceed until written or electronic consent is obtained. Capacity to consent will be assumed as participants are over 18 years old, however, the initial telephone discussion will allow for capacity to be assessed, and anyone lacking capacity, according to the Mental Capacity Act (2005), will not be recruited. Participants who lose capacity after initial consent will be removed from the study and their Lead Care Professional or GP informed.

References:

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Mental Capacity Act. (2005). London: Her Majesty's Stationary Office. Retrieved from http://legislation.gov.uk/

Risks, burdens and benefits

Reflecting on previous therapy and the relationship as well as discussing experiences of mental distress may be distressing to some participants. Participants will be informed of this prior to taking part in the study. Should this occur then the participant will be reminded of their right to withdraw as well as being offered emotional support and signposting to statutory and third sector agencies. The participant’s Lead Care Professional will be informed that they are taking part in the research and the participant will be supported to access support from them as well. The interviewer is trained to provide emotional support to participants and will check current wellbeing before and after interview. A full debrief of the study will be provided after the interview.

COVID-19 related risks will be mitigated by all contacts being conducted remotely by telephone or video link, therefore reducing the need for participant to researcher contact. Participants will be encouraged to utilise the online consent forms so as to reduce the need for them to leave home to post the consent forms. However, this will be at the discretion of the participant and options for postal return of consent forms will be provided and postage will be paid for by the research team.

No potential benefits will be withheld. All participants will receive a £10 Amazon voucher for taking part. Other potential benefits include feeling empowered through contributing to research and feeling heard, as well as a therapeutic benefit of reflecting on therapy. The overall results of the study will be shared with participants once written up.

Burdens include the amount of time needed to conduct the interview, which is will include approximately 90 minutes for the interview session and around 30 minutes for gaining consent and giving participants information. The researchers will attempt to minimise this where possible to make sure the benefits outweigh the costs.

Confidentiality

The minimum amount of identifiable information will be collected and access to this will be restricted to the research team. This will include, names, dates of birth, contact addresses, telephone numbers, and email addresses. Other non-identifiable information that will be collected is participants’ ethnicity, employment status, gender, sexuality and whether they have a disability. Participants will have the right not to provide this information if they wish. Paper information will be stored in a locked filing cabinet in a locked office at the UEA. Electronic data will be stored on an encrypted memory stick. Participant contact details and identifiable information will be stored on a secure Trust issued laptop, which is password protected and encrypted to NHS security standards. This laptop will be stored in line with NHS and local Trust policy. Interview data will be kept on a password protected computer and immediately anonymised after transcription. The PI (Oliver Farrar) will be responsible for the transcriptions of the interviews, with no other parties being involved. Interviews will be conducted over a secure video link and interviews will be recorded on to an encrypted recording device. Published data, including interview quotes, will be anonymised as to be unidentifiable. Confidentiality is assumed, unless explicit consent is gained, however, this would be overridden if researchers were significantly concerned about risk (British Psychological Society, 2014). In this case, the Lead Care Professional or GP may be contacted to provide support and to help manage risk or in extreme cases emergency services or local safeguarding teams, but researchers would aim to discuss this with participants in the first instance.

Participants will be clearly informed, both in participant information sheets and by the Principal Investigator, that data will be anonymised as to be non-identifiable in the write up and subsequent publications.

Due to contacts being conducted remotely by phone or video link the researcher will be in a private office either on an [redacted] or at home. Participants will be encouraged to choose a private and quiet location for the interview.

To contextualise some of the structural power operations within the therapeutic relationship, participants will be asked the assumed age, assumed gender, assumed sexuality, assumed ethnicity and whether they assumed the Clinical Psychologist they saw had a disability. Participants will not be directly asked the name of the Clinical Psychologist which may help them to speak freely about their experiences. In the event of disclosure of concerns concerning malpractice or risk, information will be sought and handled using local and national guidance. An outline of a protocol for dealing with this is attached in the supporting documentation. This possibility will be discussed prior to the interview as part of informed consent.

References:

British Psychological Society. (2014). BPS Code of Human Research Ethics (2nd ed.). https://www.bps.org.uk/news-and-policy/bps-code-human-research-et hics-2nd-edition-2014

Conflict of interest
At the end of the study participants will be offered a full debrief and the opportunity to ask any questions about the research or their participation. They will also be offered a summary of the research when available, which will be posted or emailed to the participant. An opportunity for a phone call to discuss this with the Principal Investigator will also be offered.

It will be made clear to the participants that their involvement in the study will not affect the care they receive from the service or the NHS either at the time or in the future. They will also be informed that if they decide to take part but then withdraw from the study then this will not affect their care either.

The Principal Investigator conducting the research is a Trainee Clinical Psychologist who during the research may be on clinical placement within the host trust. As part of his clinical training he is supervised by Clinical Psychologists. There is a small chance that the Principal Investigator may interview a participant who has worked with a Clinical Psychologist whom he has previously worked with or may work with in the future. The researcher will not ask for identifying information about the Clinical Psychologist from the participant, unless significant concerns about the practice of the Clinical Psychologist are raised during the interview, in which case relevant local and national policies and professional guidance will be followed and acted on accordingly. Should the participant inadvertently disclose the name of the Clinical Psychologist they are working with, this will be treated with the same confidentiality as other information provided in the interview. Confidentiality will be discussed explicitly with the participant and opportunities to ask questions will be offered. Should the participant be concerned that the interviewer (PI) knows the Clinical Psychologist they are discussing and explicitly asks if he knows the Clinical Psychologist, then the interviewer (PI) will answer honestly, and ask the participant if they are happy to continue, as well as reminding the participant about confidentiality processes the research follows and that no identifiable information will be reported. The participant will always have the right to withdraw at any point as well as having the option of removing their data three days following the interview. Professional, trust and national guidance will be followed throughout and a position of candour will be taken by the research team in the unlikely event that such concerns are raised.

No further conflicts of interest have been identified.

3. PURPOSE AND DESIGN OF THE RESEARCH

A7. Select the appropriate methodology description for this research. *Please tick all that apply*:

☐ Case series/ case note review
☐ Case control
☐ Cohort observation
☐ Controlled trial without randomisation
☐ Cross-sectional study
☐ Database analysis
☐ Epidemiology
☐ Feasibility/ pilot study

☐ Laboratory study

☐ Metanalysis

☑ Qualitative research

☐ Questionnaire, interview or observation study

☐ Randomised controlled trial

☐ Other (please specify)

A10. What is the principal research question/objective? *Please put this in language comprehensible to a lay person.*

How do NHS service users experience power in therapeutic relationships with Clinical Psychologists?

A11. What are the secondary research questions/objectives if applicable? *Please put this in language comprehensible to a lay person.*

N/A

A12. What is the scientific justification for the research? *Please put this in language comprehensible to a lay person.*

This study will address the gaps in empirical evidence surrounding the experience of power in therapeutic relationships between Clinical Psychologists and NHS service users. Addressing this will support NHS stakeholders in the development and application of policy and practice and also strengthen the theoretical base. Furthermore, addressing this gap will help inform the practice of Clinical Psychologists and help service users in the NHS navigate these complex power dynamics in individual therapy more effectively.

There are over 13,000 practicing Clinical Psychologists currently in the United Kingdom (Health and Care Professions Council, 2019). Clinical Psychologists support service users in different ways, often indirectly by working with other staff, systems or families. Clinical Psychologists may also support some service users directly by offering therapy themselves. Whether working indirectly or directly in therapy and within this therapeutic relationship, both must navigate complex power dynamics within their therapeutic relationships and within the NHS. However, current understandings of power, and especially within the therapeutic relationship, remain at the theoretical and philosophical level, opposed to the empirical level. This is an oversight as power can influence processes and outcomes in therapy and can have significant consequences if misused.

Part of the difficultly of developing an empirical base to research power is due to the multiple theoretical, political and psychological conceptualisations of it throughout history. These understandings have developed from two general perspectives, structural theories, that view power as embedded in social structures of society (see Hindess, 1996 for a review), and postmodern theories, whereby power is seen and used in a variety of dynamic relational processes (see Foucault, 1980). However, from assimilating these multiple perspectives it is apparent that power operations are important and pervasive in all structures and relationships.

Recent psychological efforts to understand the influence of power are evident in the Power Threat Meaning Framework (Johnstone & Boyle, 2018). This examines the operation of power at biological, coercive, legal, economic, ideological and interpersonal levels, and the subsequent effects on individuals' experiences of distress. However, this framework does not claim to fully account for all operations of power, especially the more 'positive' uses of power (Johnstone & Boyle, 2018). Indeed, much of the literature around power focuses on the negative operations of power (Proctor, 2017), and often just at the abstract and philosophical level, and not the empirical level. Developing more robust literature on 'positive' applications of power, such as positive collective power (Arendt, 1968) or nutrient power (May, 1998), could support greater understanding of its use in routine clinical practice, particularly within the therapeutic relationship.

The relationship between therapist and service user has been shown to be the most stable predictor of positive therapy outcomes (Horvath, Del Re, Flückiger & Symonds, 2011), and as such forming and maintaining therapeutic relationships is something that has been extensively empirically researched (Norcross, 2010). Much of the literature focuses on the experiences of clinicians forming these relationships (Levitt, Pomerville & Surace, 2016) and less attention is paid to the experiences of the service users. This is misguided, as the less privileged are often more acutely aware of the operation of power (Fiske, 1993).

Different psychological approaches pay different attention to power in their theory and delivery (DeVaris, 1994). For example, in Cognitive Behavioural theory minimal attention is paid to power outside of the formation of collaborative relationships (Spong & Hollanders, 2003), whilst Rogerian theory puts empowerment more centrally. However, in most schools of psychology power is primarily addressed in terms of the therapeutic relationship and not the structural power context and the effects this has on therapeutic relationships (Proctor, 2017) and seldom explored in terms of the service user perspective (Levitt et al., 2016).

Furthermore, the scant literature looking at service users' experiences of therapeutic relationships primarily comes from outside the UK and the NHS. This provides arguable validity for use in the context of the NHS as the NHS is a unique public health context, being highly politicised and one of the few international health systems free at the point of access (Benbow, 2018). Founded following the Second World War on the principles of universality, equity of access, quality, and being paid for by central funding makes the NHS highly susceptible to political and economic power influences (Benbow, 2018). If we accept that power processes are pervasive in both structures and relationships, then these influences become important when thinking about their effects on policy and practice within the NHS, and the development of therapeutic relationships.

Despite acknowledgement of the importance of therapeutic relationships and that power is a significant and inevitable factor in these relationships (Proctor, 2017) one would expect direct empirical attention to this. However, almost no research has focussed on understanding the experience and role of power in therapeutic relationships, and none from the perspective of the service user (Levitt et al., 2016).

Therefore, this study will attempt to answer the question: How do NHS service users experience power in therapeutic relationships with Clinical Psychologists?

References:

Benbow, D. I. (2018). "With Great Power Comes Great Responsibility": Democracy, the Secretary of State for Health and Blame Shifting Within the English National Health Service. International Journal of Health Services, 48(3), 461-481.

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Health and Care Professions Council. (2019). Number of registered practitioner psychologists March 2019. Retrieved from https://www.hcpc-uk.org/resources/

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Horvath, A. O., Del Re, A. C., Flückiger, C., & Symonds, D. (2011). Alliance in individual psychotherapy. Psychotherapy, 48(1), 9-16.

Johnstone, L. & Boyle, M. with Cromby, J., Dillon, J., Harper, D., Kinderman, P., Longden, E., Pilgrim, D. & Read, J. (2018). The Power Threat Meaning Framework: Towards the identification of patterns in emotional distress, unusual experiences and troubled or troubling behaviour, as an alternative to functional psychiatric diagnosis. Leicester: British Psychological Society.

Levitt, H. M., Pomerville, A., & Surace, F. I. (2016). "A qualitative meta-analysis examining clients' experiences of psychotherapy: A new agenda": Correction to Levitt, Pomerville, and Surace (2016). Psychological Bulletin, 142(10), 1067–1067. https://doi.org/10.1037/bul0000079

May, R. (1998). Power and innocence: A search for the sources of violence. London: WW Norton & Company.

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Spong, S. and Hollanders, H. (2003). Cognitive Therapy and Social Power. Counselling and Psychotherapy Research, 3(3), 216 – 222.

A13. Please summarise your design and methodology. *It should be clear exactly what will happen to the research participant, how many times and in what order. Please complete this section in language comprehensible to the lay person. Do not simply reproduce or refer to the protocol. Further guidance is available in the guidance notes.*

A qualitative approach, Interpretive Phenomenological Analysis (IPA, Smith, Flowers & Larkin, 2013) will be used to answer the research question. This exploratory question is concerned with a particular experience of individuals (psychological therapy) in a specific context (the NHS) and IPA's grounding in phenomenology (the study of lived experience), hermeneutics (interpretation of meaning) and ideography (examination of the 'particular') should support answering this. For these reasons IPA was chosen over other qualitative approaches.

IPA does not seek to make empirical generalisations but is concerned with the detailed examination of human lived experienced and understanding the meanings that people impress upon it. Ideography, which is concerned with the 'particular', does not eschew generalisations (Harré, 1979) but locates them within the 'particular' and explores them with caution (Smith et al, 2013), creating dialogue between the particular and the psychological literature. This means that this approach can be suitable for not only answering the research question, but also developing the literature base around power in therapeutic relationships.

The study will involve 8-10 purposively sampled and eligible participants who will been seen remotely or by telephone on two occasions. The total time needed by participants will be approximately two hours, which will include a 30 minute phone call to discuss the research and gain consent, and a 90 minute video link session which will include a 60 minute semi structured interview to gather data, as well as providing time to debrief and answer questions that the participant may have.

References:
Harré, R. (1979). Social being. Oxford: Blackwell.

Smith, J. A., Flowers, P., & Larkin, M. (2012). Interpretative Phenomenological Analysis: Theory, Method and Research. London: SAGE Publications.

Overview of procedure:
In short, each participant will experience the following process once consent to contact has been gained:

1.Participants will receive information about the study through advertising or recommendation by involved professionals. They will be directed to the research website (https://www.researching-power.co.uk/) to review the participant information sheets and provide consent to contact. Consent forms will then be sent via email or post.

2.The Principal Investigator will telephone the participant to discuss the research and procedure. Here verbal consent will be gained, and the interview arranged. This will take approximately 30 minutes.

3.The participant will return the consent form.

4.The participant will join a secure video link with the Principal Investigator for approximately 90 minutes. The first 15 minutes will be to check in with the participant and go over the procedure, the next 60 minutes will be the interview, and the final 15 minutes will be the debrief. Following the interview, the participant will have three days in which they can have their data removed from the study. This will be the formal end of their involvement in the research.

5. A summary of the research will be sent out to the participant approximately 9-15 months following their interview and an opportunity to discuss the research via telephone with the Principal Investigator will be offered.

All contacts with participants will be facilitated remotely via telephone or video link to alleviate the risk of person to person transmission of the COVID-19 virus. The Principal Investigator will be responsible for all contacts and interviews in the research.

The exact process is detailed below:

Recruitment advertising
1. Following ethical approval recruitment literature will be provided to the PPL leads at the host Trust. This includes a recruitment poster, a recruitment email, a recruitment tweet, and a link to the study website which contains the full participant information sheet, a simplified visual representation of the participant information, and a link to questionnaire where the participant provides consent to contact and acts as an eligibility screen. All these documents are attached.

2. PPLs then distribute the advertising materials to secondary community mental health teams within the host trust, or provide consent for the Principal Investigator to pass these on to identified teams. These will be a range of secondary community adult mental health teams across the Trust and any other teams where eligible participants may be found. Furthermore, PPLs will place the recruitment poster on the trust website and issue a 'tweet' with details of the study. PPLs may distribute the recruitment materials to 3rd sector affiliates of the Trust and Peoples' Participation Team to recruit participants who are no longer under Trust services. The research team will not have access to any patient identifiable data until consent has been granted by participants. There will be no direct identification of potential

participants by 3rd sector organisations, just indiscriminate advertising, and as such these are not classed as Participant Information Centres (PICs).

3.Recruitment literature will include a link to the study website – www.researching-power.co.uk - (break down of this attached) which provides the participant with information on the study for them to review. This includes a basic visual representation of the participant information sheet, the formal participant information sheet, and a link for how to express interest in taking part and provide consent to contact. The participant will be asked to read this.

4.Should the potential participant still be interested there will be a link in the website to complete a consent to contact form. This will direct them to a Qualtrics Survey. Qualtrics is survey software licenced to be used by the University of East Anglia and meets their policies on security of data. This is standard practice at the University of East Anglia.

5.The following process then occurs:

i. When participants click on the consent to contact form, they are presented with a screen that asks if they have read the participant information form. A link is provided to this so they can read it before proceeding.

ii. Participants then complete an eligibility screen. No identifiable information is collected at this point. If the participant does not meet the eligibility criteria, then they will not be able to proceed and a screen will thank them for their interest and provide them with contact details for the lead researcher. This is to stop gathering unnecessary identifiable information for participants who are not eligible for the study.

iii. Once eligibility is confirmed they will be asked if they consent to being contacted by the research team and to providing their information. If they do not consent then they will not be able to proceed and provide identifiable information.

iv. If they provide consent to contact then they will be asked their name, date of birth, contact telephone number, contact email, how they want to be contacted, their gender (optional), whether they are under a community mental health team or not, the name of their lead professional (Care Co-ordinator, Lead Care Professional or GP), their GP and GP surgery. If they are unsure about the details of their associated professionals then they will have the option to leave this blank. The rationale for information outside of name and contact details being collected at this stage is as follows. Information about associated professionals is being collected so that these details are available immediately, so if support is needed during initial contact to discuss consent that there is professional contact for the researcher to pass any concerns to. For gender this is so that the participants are able to express their identified gender without the researcher making assumptions, giving the opportunity for appropriate pronouns to be used.

v. Participants will also be asked how they would like to be contacted and sent further information (including the consent form). They will have the choice of receiving information by email or post, and being initially contacted by email, phone or post to set up the first phone call to discuss the research and consent. It will be indicated that email and telephone take preference over postal forms of communication due to reducing the amount of contact that is necessary with others and thus reducing COVID-19 transmission risks for participants and researchers.

vi. Once submitted participants will be informed that the Principal Investigator will be in contact via email (or telephone), depending on preference to arrange an initial telephone conversation to obtain consent and to discuss the study.

6. The consent to contact is received by the Principal Investigator and the secure Qualtrics survey software notifies the lead researcher. This information is then immediately extracted from Qualtrics and stored securely on a trust issued laptop and servers and will not be made available outside of the research team. This will be recorded in the research log. The details are reviewed and if the participant appears suitable for the study, the Principal Investigator will email them with a suggested time for the initial telephone discussion about consent and to provide further information about the study. Information about how to arrange another time will be included (return email or by telephoning the Principal Investigator on their trust issued mobile telephone). This email will also contain the participant information sheet and consent form (both PDF and link to electronic consent form). The electronic consent form has been chosen as a method to gain written consent (the participant has to make a signature mark on it) that will reduce the COVID-19 related risks associated with postal correspondence (leaving the home to go to post box/post office, viral trace on the paper). This is to protect participants and researchers. This will be at least 72 hours before the phone call to discuss consent, so the participant is assured time to fully review the materials and come to an informed decision.

7.If the participant has requested paper copies of the information sheet and consent form, then these will be posted out at this time and contains a prepaid recorded envelope for return of the consent form.

Gaining informed consent

8.The Principal Investigator will then telephone the participant, using a Trust issued and secure mobile telephone, to discuss the research. This phone call will last approximately 30 minutes but can be extended if the participant requests it. The phone call will discuss the following points:

i. Introductions and thanks from the Principal Investigator.

ii. Brief eligibility check confirming that the participant meets the inclusion and exclusion criteria.

iii. Introduction and explanation of the research. This will include checking that the participant has been able to review the participant information documents. An overview of the research process and expectations will be given.

iv. Opportunity for the participant to answer any questions they may have about the research or process, with specific attention paid to confidentiality, their rights, and the potential difficulties of the research.

v. Review of the consent form with the participant, with space to answer any further questions.

vi. Confirmation if the participant wants to verbally consent to taking part in the research. This is recorded in the research log.

vii. If they consent, the participant is advised to sign the consent form at their earliest convenience. This is either done via the electronic link attached (this is a reproduction of the paper consent form) in the participant information email or by signing the paper copy sent out to them and returned via prepaid recorded mail. They will be informed that the interview will not be able to go ahead until this is received.

viii. A provisional interview date for approximately 2-4 weeks in the future will be set at a time that is during working hours and is convenient for the participant. The participant will be informed that if the consent form has not been received three days prior to the interview date that the Principal Investigator will contact them by telephone to check if they still want to be included in the study and to set an interview date that will allow time for the consent form to be completed. If the consent form is received before this time the researcher will not contact the participant prior to the scheduled interview.

ix. The researcher will inform the participant that he will send a letter to their Lead Care Professional and/or their GP to inform them of their participation in the research, informing them that the professional will be offered the opportunity to discuss the overall aims of the research. Consent for this is included and discussed as part of the informed consent process.

x. Details of how to access and join the secure online video platform Attend Anywhere which will be used for the interviews will be discussed and what technology they will require to do this. Attend Anywhere is a secure video link platform that is used nationally by NHS services and the host trust. This meets the high levels of security demanded for confidential clinical work in the NHS. The participant will be advised to choose a quiet, confidential and comfortable space to complete the interview. The participant and researcher will also discuss individual and explicit contingencies for managing any potential technical difficulties and any emotional distress remotely. This will involve planning for what to do if they lose the connection or if the participant becomes distressed and needs further support. The participant will be informed that if they are late for their scheduled interview time then the Principal Investigator will call them 10 minutes after their appointment time to see if they need support accessing the online platform. The participant will be informed that if they do not attend the scheduled meeting that their Lead Care Professional or GP will be immediately informed of their non-attendance and will be asked to check on their welfare.

xi. A contact email address, info@researching-power.co.uk, will be provided to participants so they are able to contact the Principal Investigator to rearrange the interview or withdraw from the study. They will be informed that this email is only to be used for matters pertaining to the study and that all other issues should be directed to their Lead Care Professional or GP. They will be informed that this email address is only available during office hours (Monday – Friday, 9am – 5pm) and that it is not monitored outside of these hours. They will also be informed that any information not pertaining to the study will be communicated to their Lead Care Professional or GP.

xii. The participant will have a final opportunity to ask questions and will be thanked for their participation in the research.

9.Consent form returned by participant either electronically or via post. Electronic copies will be stored securely on a Trust issued laptop on a secure server. Paper copies will be stored in a locked cabinet in a locked office at the University of East Anglia.

Informing of involved professionals about participant taking part

10.The professional involved in their care will be contacted by telephone to inform them of the participants involvement in the research. This call will allow the research to get a suitable email address or postal address to pass on information about the study as well as details of the research team so they can get in contact if they have concerns. This information will be stored securely on a trust issued laptop or passcode protected trust issued mobile telephone.

11.Letter sent to participant's Lead Care Professional or GP with details of the research and copies of the participant information form and website details.
Interview

12.On the day of the interview the participant will sign into to the Trust's secure online video platform 'Attend Anywhere' from a comfortable, private and quiet location of their choosing. The researcher will be completing the interview from home, which is private and where confidentiality can be maintained, adhering to trust and NHS guidance on remote working. Here they will be transferred to Principal Investigator who will be waiting to greet them. The entire session will take around 90 minutes, with the first fifteen being dedicated to checking in with the participant, the second 60 minutes being the interview and the final 15 being the debrief. If the participant requests more time for discussion after the allotted time this will be accommodated. An interview schedule and topic guide has been provided in the attached documents. The following process will then be followed in the interview:

i. Greeting the participant and thanking them for their time.

ii. Checking in on their wellbeing prior to interview. This will include asking about how they are feeling today, if there is anything concerning them or worrying them and if they feel okay to complete the interview today. If there are concerns raised, then this will be discussed with the participant and support will be offered and options for further sources of support (including support from involved professionals) will be discussed.

iii. Confirmation of consent to take part in the interview checked.

iv. A brief outline of the interview and question themes will be given.

v. A brief review of agreed individual protocols for managing technical difficulties and emotional distress will be completed.

vi. The participant will be reminded that they are able to take breaks or withdraw at any point in the interview and also ask questions at any point.

vii. A final opportunity to ask any questions before the formal interview starts will be offered.

viii. Recording of the interview will start on the audio recording device and the interview will begin. This is a semi-structured interview and the following protocol, developed with service user support and experts by experience will be utilised. This will be approximately 60 minutes in length and will aim to capture rich detail of the participant's unique experience of therapy and power within the therapeutic relationship. Please see attached document which outlines interview themes.

ix. After the participant has indicated they are finished, and the researcher has no further questions, then the interview will be closed, and the audio recording stopped.

x. The participant will be thanked for their effort in the interview and the last part of the session will involve a full debrief. There is no deception in the research and as such the aims of the research will have been stated throughout. This is an opportunity to discuss any aspect of the research further.

xi. The researcher will check in on the participant's wellbeing following the interview. This could include questions about how they are feeling after the interview and if there was anything difficult that came up for them that they would like to discuss further. If there are concerns raised, then this will be discussed with the participant and support will be offered and options for further sources of support (including support from involved professionals) will be discussed.

xii. The participant will then be offered the opportunity to ask any questions about the interview.

xiii. The researcher will confirm if the participant is happy to use their data in the study. If they agree then they will then be informed that they have three days to decide if they want to remove their data. They will be advised to contact the researcher during this period to inform them of this, otherwise it will be assumed that they are happy for their data to be used. They will be explicitly informed that it may not be possible to remove their data after this period.

xiv. Additional optional demographic information will also be asked to support the analysis, this includes their ethnicity, sexuality, employment status (now and during therapy), whether they have a disability and an approximation of when they finished therapy. They will also be asked to provide details of what they assumed were the demographics of their Clinical Psychologist. They are informed that this is not to identify the Psychologist but to ascertain what their perceptions of their Psychologists demographics were. The study is not interested in the actual demographics of the Psychologist, but the participants perceptions, as this will indicate potential structural power operations that might be occurring and will be useful in analysis. They will be informed that this is completely optional. The assumed demographics of their psychologist that will be collected are assumed gender, age, ethnicity, sexuality, and disability.

xv. The participant will then be asked if they would like a summary of the findings of the research. If they request this, they will be offered for the summary to be sent by email or post. They will also be offered the opportunity to discuss this with the Principal Investigator by telephone if they wish. Details on how to arrange this will be provided on the summary.

xvi. The participant will be asked on how they would like to receive their £10 Amazon voucher in gratitude for participation. This will be immediately sent out after the interview by post or email depending on the participant’s preference.

xvii. The participant will be offered a final opportunity to ask any questions.

xviii. The participant will be thanked for their time and the interview session will be terminated.

Post interview

13.Immediately following the interview, the recording of the interview will be transferred to the secure and trust issued laptop and stored on a secure server. The handwritten notes made by the researcher will be copied and stored on the trust issued laptop and secure server. Once the notes are transferred on to the laptop the handwritten notes will be destroyed in line with Trust policy.

14.After the interview the Lead Care Professional or GP will be informed of the participant’s attendance of the interview and that no concerns were raised. If concerns were raised these would be discussed immediately with the professional. This will be by email (using an encrypted, trust issued email address) or telephone call.

15.Transcription of the interview verbatim with comments added to text of notable non-verbal utterances, pauses and hesitations. The transcript will then be immediately anonymised using pseudonyms. This will only be done by the Principal Investigator.

16.The transcriptions of the interviews will be entered into a qualitative data analysis software package (such as NVivo).

17.Supervision and debrief will provided by the academic supervisors at regular intervals (every two weeks) following interviews to support quality in the research.

18.Steps 4-16 will then be completed for the remaining participants. Recruitment, consent and interviews will likely run from July through to August with 4-5 participants being recruited and interviewed in July 2021 and the following 4-5 in August 2021. It is likely that these stages will run alongside on another, depending on the uptake and logistics of doing the interviews.

Data analysis

The transcripts will be analysed using the guidance from Smith et al. (2013) and following this, cases will be drawn together to create master themes for the cohort. This process will continually consider Yardley’s (2000) principles for quality in qualitative research. The analyst will comment on the power relationship inherent in data collection and his own preconceptions, attempting to ‘bracket off’ these and incorporate accurate reflections on this in analysis (Smith et al., 2013). This process will also be supported by frequent academic supervision and the use of reflexive diaries (which will be kept throughout the whole process). This process is likely to take 3-4 months (July 2021-October 2021).

The results will be written up as part of a doctoral thesis portfolio and submitted to the University of East Anglia for assessment. This process is likely to take 3-4 months including revisions.

Following submission, the Principal Investigator will be assessed via Viva Voce examination and this will include suggestions for corrections.

Once passed and if requested, a summary of the results will be sent to participants in their previously indicated preferred format and the opportunity for them to arrange a phone call with the Principal Investigator to discuss the results will be offered.

The research will then be prepared for publication and dissemination.

The study will then be closed down and all held data will be stored in the University of East Anglia Repository and all contact details of participants destroyed. This will all be done in line with university policy on retention of data.

A14-1. In which aspects of the research process have you actively involved, or will you involve, patients, service users, and/or their carers, or members of the public?

☑ Design of the research
☑ Management of the research
☑ Undertaking the research
☐ Analysis of results
☐ Dissemination of findings
☐ None of the above

Give details of involvement, or if none please justify the absence of involvement.
It has been important to incorporate lived experience throughout the development implementation, analysis and dissemination of this research. This is in order to properly address inherent power differentials between researcher and participant (Rose & Kalathil, 2019). This research has therefore maximised service user participation, despite a number of constraints. These include: time constraints of fulfilment of the Doctorate in Clinical Psychology, the pressures of the ongoing COVID-19 pandemic and its associated restrictions. This has been addressed from the outset by incorporating a member of the research team who has lived experience of mental health difficulties in the development and supervision of the research as well as involving consultants with lived experience in the development of the interview schedule.

References:
Rose, D., & Kalathil, J. (2019). Power, Privilege and Knowledge: the Untenable Promise of Co-production in Mental "Health." Frontiers in Sociology, 4(7), 1–11. https://doi.org/10.3389/fsoc.2019.00057

4. RISKS AND ETHICAL ISSUES

RESEARCH PARTICIPANTS

A15. What is the sample group or cohort to be studied in this research?

Select all that apply:

☐ Blood
☐ Cancer
☐ Cardiovascular
☐ Congenital Disorders
☐ Dementias and Neurodegenerative Diseases
☐ Diabetes
☐ Ear
☐ Eye
☐ Generic Health Relevance
☐ Infection
☐ Inflammatory and Immune System
☐ Injuries and Accidents

☑ Mental Health
☐ Metabolic and Endocrine
☐ Musculoskeletal
☐ Neurological
☐ Oral and Gastrointestinal
☐ Paediatrics
☐ Renal and Urogenital
☐ Reproductive Health and Childbirth
☐ Respiratory
☐ Skin
☐ Stroke

Gender:	Male and female participants
Lower age limit: 18	Years
Upper age limit:	No upper age limit

A17-1. Please list the principal inclusion criteria (list the most important, max 5000 characters).

-Aged 18 years or older.
-Participant has received care from secondary mental health team within the host trust.
-Participant agrees for Lead Care Professional or GP to be informed of involvement in the research.
-Participant has received one to one individual therapy from a Clinical Psychologist in last 24 months.
-Participant engaged in 8 or more sessions with the Clinical Psychologist in therapy.
-Participant is able to understand and converse in English.

A17-2. Please list the principal exclusion criteria (list the most important, max 5000 characters).

-Participant is currently in hospital or subject to Mental Health Act conditions, including Community Treatment orders.
-Participant received therapy from a Clinical Psychologist whilst subject to Mental Health Act conditions or whilst in psychiatric hospital.
-Participant is currently undertaking any form of structured one to one or group therapy with a Clinical Psychologist, Psychotherapist, Assistant Psychologist, Psychological Wellbeing Practitioner, or Counsellor.
-The participant's current Lead Care Professional is the Clinical Psychologist who delivered their therapy.
-The participant does not have capacity to consent or the cognitive ability to take part in the study.

RESEARCH PROCEDURES, RISKS AND BENEFITS

A18. Give details of all non-clinical intervention(s) or procedure(s) that will be received by participants as part of the research protocol. *These include seeking consent, interviews, non-clinical observations and use of questionnaires.*

Please complete the columns for each intervention/procedure as follows:

1. Total number of interventions/procedures to be received by each participant as part of the research protocol.
2. If this intervention/procedure would be routinely given to participants as part of their care outside the research, how many of the total would be routine?
3. Average time taken per intervention/procedure (minutes, hours or days)
4. Details of who will conduct the intervention/procedure, and where it will take place.

Intervention or procedure	1	2	3	4
Participant receives information about study. Received either through trust advertising (through website or twitter) or by being given advertising material by involved professional.	1	0	1 min	Participant will see it through trust website or twitter or involved clinician will pass on details.

Participant accesses research website to view participant information.	1	0	10 mins max	At participants' convenience at home through own computer, tablet or phone.
Participant completes consent to contact form and provides information.	1	0	5 mins	Participant will complete themselves online. At participants' convenience at home through own computer, tablet or phone.
Participant has phone call Principal Investigator to discuss research and consent	1	0	30 minss	Principal Investigator will conduct this over telephone.
Interview. Time at start and end for questions and debrief	1	0	90 mins	Lead researcher will conduct the interview over video call. Participant will be in private space of choosing and researcher will be at home (private and confidential).

A21. How long do you expect each participant to be in the study in total?

The participants are expected to be in the study for approximately 3-8 weeks. This is given as a maximum range as interviews would aim to be carried out 2 weeks following consent, however, to add flexibility for the participants and research team this timeframe is extended. This is from the initial consent being gained until the end of the interview. Following this the only contacts will be if the participant wants to withdraw their data or if they request the findings from the study, which will be provided after submission and passing of the research prior to publication.

A22. What are the potential risks and burdens for research participants and how will you minimise them?

For all studies, describe any potential adverse effects, pain, discomfort, distress, intrusion, inconvenience or changes to lifestyle. Only describe risks or burdens that could occur as a result of participation in the research. Say what steps would be taken to minimise risks and burdens as far as possible.

This question has been considered with the academic supervisory team and has weighed the potential risks against the potential benefits of the study carefully. A member of the supervisory team is an expert by experience as well as a researcher, and she has informed thinking around the perspective service users in this study.

Risks

It is possible that participants may find aspects of reflecting on previous incidents of therapy distressing or upsetting. This may bring up memories of the therapy or the potentially sensitive issues that they discussed during therapy, as well as any difficulties that they had during this time personally and with the professionals they were in contact with. In addition, participants may find it difficult and even triggering to reflect on their own mental health conditions / experiences of ill-health. All potential participants will be informed of these issues before providing informed consent to take part in the research. All participants will be offered time and space to discuss any concerns they may have with the Principal Investigator at any point during the study. The Principal Investigator conducting the interviews is trained and experienced in listening to distressing information and is aware of processes for obtaining additional mental health services for service users when required. Consent will be gained from participants to inform their Lead Care Professional (if they are still in contact with mental health services) within their care team and/or their GP of their involvement in the study as well as providing consent for them to be contacted in the event that concerns are raised. This could include concerns about participant safety or concerns about their mental health. Participants will be informed at regular intervals that they have the right to withdraw from the study and that if they do so it will not affect the care they receive from the service or the NHS or their receipt of the £10 Amazon voucher for participation. Should a participant become distressed at any point during the interview then the researcher will stop the interview and explore this with the participant. The participant will be asked if they want to continue with the interview or if they would like to discuss sources of support. This may include support from their Lead Care Professional or their GP. The participant may also be reminded of their right to withdraw as well as being signposted to statutory and third sector agencies for additional support. The interviewer will check in on the current emotional wellbeing of the participant prior to the interview and following the interview. If a participant discloses information to suggest that they or someone else is at risk of harm, then this will be discussed immediately with the participant. The Lead Care Professional at their service or GP will be informed immediately. If their Lead Care Professional is not available, then a duty member of staff will be informed of the concerns. The host trust community teams operate a duty system whereby a clinician is available during office hours to respond immediate concerns. In extreme situations or where there is imminent risk of harm then emergency services may be called in line with university, Trust and National guidance. Potential participants will be informed of this procedure prior to providing consent to being involved in the study. They will also be informed if this procedure needs to be put in place (providing that it doesn't place the participant under increased risk).

Risks pertaining to the COVID-19 pandemic have be considered and reduced in this study as far as reasonably possible. All contacts with participants and professionals will be undertaken remotely by either email, telephone, or video link. Where possible all consent and participant information sheets will be delivered electronically so as to decrease the risk of viral transmission through post and exposure to other people (such as going to the post office). Participants will be encouraged to use electronic versions of these forms but will have the option for hard copies delivered by post if they wish.

Burdens

The primary burden for the participant is the amount of time needed to take part in the informed consent process and the interview, approximately 30 and 90 minutes respectively. This time will be during typical working hours (Monday – Friday, 9am – 5pm) and this may place a burden on participants because of potentially needing to organise time off work or to arrange childcare.
Furthermore, additional time to read the literature about the study and provide consent to contact, will be needed. This will be approximately 20 minutes but can be completed at times that suit the participant.
The researchers have made efforts to streamline this process so that the minimal amount of time is needed by the participants and that the contacts are efficient. However, if participants request more time in either contact to discuss concerns this will be provided. All potential participants will be given clear information about what is expected from the study and they will be given the choice as to whether they take part or not. They will also be informed that they can withdraw at any point. In an attempt to reduce burden as far as possible the participants will be offered regular breaks if needed. Participants that take part in the study will be offered a £10 Amazon voucher for taking part, which will be given to participant (by post or email) following the interview. It will be explained to participants that due to financial constraints only those completing the interview will be eligible for the Amazon voucher.

A23. Will interviews/ questionnaires or group discussions include topics that might be sensitive, embarrassing or upsetting, or is it possible that criminal or other disclosures requiring action could occur during the study?

● Yes ○ No

If Yes, please give details of procedures in place to deal with these issues:

Participants will be reflecting on their experience of therapy during the interview and it is possible that reflecting on previous therapy and their therapeutic relationship may be distressing or embarrassing for some participants. Discussing their experience of therapy may also bring up sensitive topics at times during the interview. The Principal Investigator, who is conducting the research, is experienced in managing sensitive interviews with individuals who have used mental health services and is trained to recognise when individuals are distressed and to respond accordingly to their needs and wishes. All interviews will be delivered in a sensitive and flexible manner.

Should the participant appear to become distressed or embarrassed the researcher will respond to this and will give the participant time to discuss their concerns. He will ask if the participant is happy to proceed or whether they would like to discuss sources of support. This may include support from their Lead Care Professional or their GP. The participant may also be reminded of their right to withdraw as well as being signposted to statutory and third sector agencies for additional support. The interviewer will check in on the current emotional wellbeing of the participant prior to the interview and following the interview as standard.

If a participant discloses information to suggest that they or someone else is at risk of harm, then this will be discussed immediately with the participant. The Lead Care Professional at their service or GP will be informed immediately. If their Lead Care Professional is not available, then a duty member of staff will be informed of the concerns. The host trust community teams operate a duty system whereby a clinician is available during office hours to respond immediate concerns. In extreme situations or where there is imminent risk of harm then emergency services may be called in line with university, Trust and National guidance. Potential participants will be informed of this procedure prior to providing consent to being involved in the study. They will also be informed if this procedure needs to be put in place (providing that it doesn't place the participant under increased risk).

The participant will not be directly asked the name of the Clinical Psychologist they have seen for therapy in the interview, as this will most likely enable them to speak freely about their experiences. However, in the event of disclosures indicating malpractice or risk, identifiable information to enable appropriate action to be taken will be sought and the situation will be managed using local and national guidance and policies. This possibility and relevant processes will be discussed as part of informed consent. An outline of a protocol for dealing with this is attached in the supporting documentation.

Telephone contact between participants and the researcher will be conducted using a trust issued mobile phone. Should the participant wish to contact the researcher, for example to rearrange the interview or to withdraw from the study, then they will be provided with an email account to contact the Principal Investigator. If the participant wants to speak on the phone to the lead researcher then they will be asked to email the lead researcher who will call them back. All telephone contacts will be from a withheld number and the participant will be aware of this.

If a participant uses this email address to report to the Principal Investigator about any distress, they are experiencing then this will be reported to a professional at the service immediately. It will be made clear to participants that this email will only be checked during office hours (Monday Friday, 9am 5pm) and that any issues unrelated to the study should be directed towards their care team or GP.

The researcher will receive frequent supervision from the academic supervisory panel which includes the Chief Investigator, which will include discussion of how the content of the interviews have affected him and if support is required.

A24. What is the potential for benefit to research participants?

On completion of the study the participants will be offered a £10 Amazon voucher as a token of gratitude.

It is possible that the participants will gain some psychological benefit from the study, but this is not guaranteed and made clear in participant information sheets. For example, participants may feel empowered through contributing to research and feeling heard, as well as a therapeutic benefit of reflecting on therapy.

A26. What are the potential risks for the researchers themselves? *(if any)*

The research will be conducted remotely via secure video platform and as such there are no foreseeable COVID related risks for the researcher. Where possible consent will be gained remotely via email, so that the risk of the researcher having to go to the University to pick up consent forms is reduced.

There are potentially emotional risks for the researcher, such as hearing distressing information during the interview. The lead researcher conducting the interviews is trained and experienced in listening to distressing information. He has regular supervision and processes to safely reflect on difficult information as well as sources of support provided through the University and host trust.

RECRUITMENT AND INFORMED CONSENT

In this section we ask you to describe the recruitment procedures for the study. Please give separate details for different study groups where appropriate.

A27-1. How will potential participants, records or samples be identified? Who will carry this out and what resources will be used?*For example, identification may involve a disease register, computerised search of GP records, or review of medical records. Indicate whether this will be done by the direct healthcare team or by researchers acting under arrangements with the responsible care organisation(s).*

Potential participants are will be approached through advertising materials being passed to them by professionals at the host trust. The research team will not have access to patient information until the potential participant has provided consent to contact.

People Participation Leads (PPLs) and their staff will act as gatekeepers. PPLs sit on care group leadership teams and are imbedded in clinical teams having vast experience of working within the mental health service as well as lived experience of mental health. PPLs have be consulted to develop the recruitment and research strategy as active participation is important to this research as well as increasing the voice of people with lived experience in shaping the research.

PPLs will support recruitment in 3 ways:

- They will pass marketing materials directly to clinical teams where potential participants may be recruited. This will include a recruitment email that has a basic introduction to the study to support clinicians in identifying potential participants, the research flyer poster/flyer, contact details, and the participant information sheet. Clinicians will then pass on the contact details (website address) and flyer to potential participants who can access the research website to read further information and provide consent to contact.
- PPLs will provide permission for the research team to pass marketing materials directly to appropriate clinical teams in the trust. This will include sending out a recruitment email (as outlined above) and may involve making contact with clinical teams to discuss the research and support recruitment.

- PPLs will publish details of the research on their website, their newsletter, or via their twitter account. They will use the recruitment poster and the link to the website to do this. This will provide links to the research website where potential participants can read the participant information sheets and express interest in the study. PPLs may also pass on marketing materials to affiliated 3rd sector agencies, such as local charities that work with former service users of the host trust. 3rd sector advertisers will not actively identify participants, just distribute marketing material indiscriminately and as such are not defined as Participant Identification Centres (PICs).

No clinical records will be screened by the research team to identify potential participants as clinical teams will do this or potential participants will express their interest following a non-identifiable screening questionnaire.

A27-2. Will the identification of potential participants involve reviewing or screening the identifiable personal information of patients, service users or any other person?

○ Yes ● No

Please give details below:
Members of the research team will not screen identifiable personal information prior to consent to contact being provided. Professionals from the host trust will pass on details of the study. Participants will then read this and decide if they would like to participate via the research website. Before identifiable information is collected, they will have to complete an online eligibility screen, this is embedded into the consent to contact form and without confirming eligibility they will not be able to proceed with providing contact details, so as no unnecessary identifiable information is collected.

A28. Will any participants be recruited by publicity through posters, leaflets, adverts or websites?

● Yes ○ No

If Yes, please give details of how and where publicity will be conducted, and enclose copy of all advertising material (with version numbers and dates).
Yes. These materials will be passed or passed with permission to clinical teams or placed on the trust website, twitter account or newsletter by the PLL leads.

Website – www.-researching-power.co.uk – this is the main website for the project. It contains 4 main pages. A home page which thanks people for their interest and provides links to the other pages. A ‘about the research’ page; this contains a simplified visual representation of the study. A ‘taking part’ page; this contains further information, including the full participant information sheet and a link to screen for eligibility for the study and to express interest and provide consent to contact (more details in next section). Finally, there is a ‘contact’ page; this provides details of the research team and a contact email for the lead researcher. Please see attached PDF of the website.

Tweet – The gatekeepers have a twitter account ([redacted]) where the research may be advertised. The tweet will include a link to the research website and a very basic (140 character) summary. For example, “Would you like to take part in research to help better understand peoples’ experiences of therapy? A study is recruiting 8-10 people to talk about this. See www.researching-power.co.uk for more details”

Poster – A poster has been developed to aid recruitment. This includes a headline asking people if they want to take part in research, followed by a visual infographic highlighting the research, and contact details, which includes direction to the study website where participants can read more and express interest. This may be placed in clinical team areas to aid recruitment.

Newsletter – The gatekeeper put out a regular newsletter through their website and by email. A segment on the research may be included in this. This would include the study poster. The editorial team for newsletter may put brief details of the study taken from the website and recruitment poster in addition to the recruitment poster.

Email to clinical teams – this will not be distributed to the public but just clinical teams. It will highlight the key points of the research, the inclusion/exclusion criteria and contact details, as well as including the recruitment poster and participant information sheet. See attached copy of this email.

A29. How and by whom will potential participants first be approached?

Potential participants will be approached by members of the host trust. This will be either directly by clinicians working with them who have information about the study (provided to them with permission of the gatekeepers – the People Participation Leads) or through viewing advertising literature, again provided the gatekeepers.

Potential participants who are identified by members of their care team will be given details of the study by their care team. This will include details of how to access the research website, which contains full details of the study and allows participants to express interest. They may also pass on a copy of the research poster and/or the participant information sheet.

Participants may also be approached through trust advertising. This includes marketing the research on the trust website, the trust Peoples' Participation twitter account and through the trust newsletter. These routes will have links to the research website which will allow potential participants to read the participant information and express interest in the study.

Full details of the process are outlined below:

1.Following ethical approval recruitment literature will be provided to the PPL leads at the host Trust. This includes a recruitment poster, a recruitment email, a recruitment tweet, and a link to the study website which contains the full participant information sheet, a simplified visual representation of the participant information, and a link to questionnaire where the participant provides consent to contact and acts as an eligibility screen. All these documents are attached.

2.PPLs then distribute the advertising materials to secondary community mental health teams within the host trust, or provide consent for the Principal Investigator to pass these on to identified teams. These will be a range of secondary community adult mental health teams across the Trust and any other teams where eligible participants may be found. Furthermore, PPLs will place the recruitment poster on the trust website and issue a 'tweet' with details of the study. PPLs may distribute the recruitment materials to 3rd sector affiliates of the Trust and Peoples' Participation Team to recruit participants who are no longer under Trust services. Third sector affiliates will not directly approach participants, instead only indiscriminately distributing marketing materials and as such are not classified as Participant Identification Centres (PICs).

3.Recruitment literature will include a link to the study website (break down of this attached) which provides the participant with information on the study for them to review. This includes a basic visual representation of the participant information sheet, the formal participant information sheet, and a link for how to express interest in taking part and provide consent to contact. The participant will be asked to read this.

4.Should the potential participant still be interested there will be a link in the website to complete a consent to contact form. This will direct them to a Qualtrics Survey. Qualtrics is survey software licensed to be used by the University of East Anglia and meets their policies on security of data. This is standard practice at the University of East Anglia. The following process then occurs:

5.When participants click on the consent to contact form, they are presented with a screen that asks if they have read the participant information form. A link is provided to this so they can read it before proceeding.

i. When participants click on the consent to contact form, they are presented with a screen that asks if they have read the participant information form. A link is provided to this so they can read it before proceeding.

ii. Participants then complete an eligibility screen. No identifiable information is collected at this point. If the participant does not meet the eligibility criteria, then they will not be able to proceed and a screen will thank them for their interest and provide them with contact details for the lead researcher. This is to stop gathering unnecessary identifiable information for participants who are not eligible for the study.

iii. Once eligibility is confirmed they will be asked if they consent to being contacted by the research team and to providing their information. If they do not consent then they will not be able to proceed and provide identifiable information.

iv. If they provide consent to contact then they will be asked their name, date of birth, contact telephone number, contact email, how they want to be contacted, their gender (optional), whether they are under a community mental health team or not, the following is also optional: the name of their lead professional (Care Co-ordinator, Lead Care Professional or GP), their GP and GP surgery.

v. Participants will also be asked how they would like to be contacted and sent further information (including the consent form). They will have the choice of receiving information by email or post, and being initially contacted by email, phone or post to set up the first phone call to discuss the research and consent. It will be indicated that email and telephone take preference over postal forms of communication due to reducing the amount of contact that is necessary with others and thus reducing COVID-19 transmission risks for participants and researchers.

vi. Once submitted participants will be informed that the Principal Investigator will be in contact via email (or telephone), depending on preference to arrange an initial telephone conversation to obtain consent and to discuss the study.

6.The consent to contact is received by the Principal Investigator and the Qualtrics survey software notifies the lead researcher. This information is then immediately extracted from Qualtrics and stored securely on a trust issued laptop and servers and will not be made available outside of the research team. This will be recorded in the research log. The details are reviewed and if the participant appears suitable for the study, the Principal Investigator will email them with a suggested time for the initial telephone discussion about consent and to provide further information about the study. Information about how to arrange another time will be included (return email or by telephoning the researcher on their trust issued mobile telephone). This email will also contain the participant information sheet and consent form (both PDF and link to electronic consent form). The electronic consent form has been chosen as a method to gain written consent (the participant has to make a signature mark on it) that will reduce the COVID-19 related risks associated with postal correspondence (leaving the home to go to post box/post office, viral trace on the paper). This is to protect participants and researchers. This will be at least 72 hours before the phone call to discuss consent, so the participant is assured time to fully review the materials and come to an informed decision.

7.If the participant has requested paper copies of the information sheet and consent form, then these will be posted out at this time and contains a prepaid recorded envelope for return of the consent form.

A30-1. Will you obtain informed consent from or on behalf of research participants?

● Yes ○ No

If you will be obtaining consent from adult participants, please give details of who will take consent and how it will be done, with details of any steps to provide information (a written information sheet, videos, or interactive material). Arrangements for adults unable to consent for themselves should be described separately in Part B Section 6, and for children in Part B Section 7.

If you plan to seek informed consent from vulnerable groups, say how you will ensure that consent is voluntary and fully informed.

Yes.

All participants will provide full informed consent before the study starts. Following consent to contact the potential participants will be send a copy of participant information sheet (which is also available on the website) and the consent form to review. This will be by email or post. The participant will have at least 72 hours to review this before a telephone call from the lead researcher to discuss and obtain consent. Participant information and consent sheets were developed using templates and guidance from the HRA (2017) and with the supervisory team who are experienced in gaining consent for research. Information sheets include details about the research, methodology, confidentiality, time commitment, contact details of primary researchers, potential benefits, reimbursement, data use, possible outcomes of the research, and how the results will be disseminated. Furthermore, in line with General Data Protection Regulation (European Union, 2017) the type of data collected is explicitly stated along with how it will be stored, used, and destroyed when no longer needed.

Due to all research activities being conducted remotely by telephone or video link participants will return consent forms by prepaid recorded envelope or by completing an electronic form online through a link provided to a Qualtrics survey. These forms are identical.

The full details of this process are highlighted below:

1.The Principal Investigator will telephone the participant, using a Trust issued and secure mobile telephone, to discuss the research. This phone call will last approximately 30 minutes but can be extended if the participant requests it. The phone call will discuss the following points:

i. Introductions and thanks from the Principal Investigator.

ii. Brief eligibility check confirming that the participant meets the inclusion and exclusion criteria.

iii. Introduction and explanation of the research. This will include checking that the participant has been able to review the participant information documents. An overview of the research process and expectations will be given.

iv. Opportunity for the participant to answer any questions they may have about the research or process, with specific attention paid to confidentiality, their rights, and the potential difficulties of the research.

v. Review of the consent form with the participant, with space to answer any further questions.

vi. Confirmation if the participant wants to verbally consent to taking part in the research. This is recorded in the research log.

vii. If they consent, the participant is advised to sign the consent form at their earliest convenience. This is either done via the electronic link attached (this is a reproduction of the paper consent form) in the participant information email or by signing the paper copy sent out to them and returned via prepaid recorded mail. They will be informed that the interview will not be able to go ahead until this is received.

viii. A provisional interview date for approximately 2-4 weeks in the future will be set at a time that is during working hours and is convenient for the participant. The participant will be informed that if the consent form has not been received three days prior to the interview date that the Principal Investigator will contact them by telephone to check if they still want to be included in the study and to set an interview date that will allow time for the consent form to be completed. If the consent form is received before this time the researcher will not contact the participant prior to the scheduled interview.

ix. The researcher will inform the participant that he will send a letter to their Lead Care Professional and/or their GP to inform them of their participation in the research, informing them that the professional will be offered the opportunity to discuss the overall aims of the research. Consent for this is included and discussed as part of the informed consent process.

x. Details of how to access and join the secure online video platform Attend Anywhere which will be used for the interviews will be discussed and what technology they will require to do this. Attend Anywhere is a secure video link platform that is used nationally by NHS services and the host trust. This meets the high levels of security demanded for confidential clinical work in the NHS. The participant will be advised to choose a quiet, confidential and comfortable space to complete the interview. The participant and researcher will also discuss individual and explicit contingencies for managing any potential technical difficulties and any emotional distress remotely. This will involve planning for what to do if they lose the connection or if the participant becomes distressed and needs further support. The participant will be informed that if they are late for their scheduled interview time then the Principal Investigator will call them 10 minutes after their appointment time to see if they need support accessing the online platform. The participant will be informed that if they do not attend the scheduled meeting that their Lead Care Professional or GP will be immediately informed of their non-attendance and will be asked to check on their welfare.

xi. A contact email address, will be provided to participants so they are able to contact the Principal Investigator to rearrange the interview or withdraw from the study. They will be informed that this email is only to be used for matters pertaining to the study and that all other issues should be directed to their Lead Care Professional or GP. They will be informed that this email address is only available during office hours (Monday – Friday, 9am – 5pm) and that it is not monitored outside of these hours. They will also be informed that any information not pertaining to the study will be communicated to their Lead Care Professional or GP.

xii. The participant will have a final opportunity to ask questions and will be thanked for their participation in the research.

2.Consent form returned by participant either electronically or via post. Electronic copies will be stored securely on a Trust issued laptop on a secure server. Paper copies will be stored in a locked cabinet in a locked office at the University of East Anglia.

If you are not obtaining consent, please explain why not.

N/A

Please enclose a copy of the information sheet(s) and consent form(s).

A30-2. Will you record informed consent (or advice from consultees) in writing?

● Yes ○ No

A31. How long will you allow potential participants to decide whether or not to take part?

A period of at least 72 hours will be allowed for potential participants to read the information sheet and consent form before consent is established with the Principal Investigator. However, they will have had access to the research website and will have had longer to review this. 72 hours is from the participant expressing consent to contact.

A33-1. What arrangements have been made for persons who might not adequately understand verbal explanations or written information given in English, or who have special communication needs?*(e.g. translation, use of interpreters)*

No arrangements have been made for people who do not understand English. The study inclusion criteria states that participants must be able to speak and converse in English in order to take part in the study. This is due to the complexity of the issues being explored in the study (power in therapeutic relationships) and the difficulty of properly including people who are not fluent in English. Especially as the study will be delivered remotely.

A35. What steps would you take if a participant, who has given informed consent, loses capacity to consent during the study? *Tick one option only.*

● The participant and all identifiable data or tissue collected would be withdrawn from the study. Data or tissue which is not identifiable to the research team may be retained.

○ The participant would be withdrawn from the study. Identifiable data or tissue already collected with consent would be retained and used in the study. No further data or tissue would be collected or any other research procedures carried out on or in relation to the participant.

○ The participant would continue to be included in the study.

○ Not applicable – informed consent will not be sought from any participants in this research.

○ Not applicable – it is not practicable for the research team to monitor capacity and continued capacity will be assumed.

Further details:

The participant will need to have capacity to consent to the study. Should they lose this before or during the interview, then their data will be immediately removed. Should the participant lose capacity following the interview and the 3 day period after the interview, which is when their time in the study ends, then their data would not be removed, as they provided full consent when they had capacity and their time in the study has ended.

In the highly unlikely event that a participant has capacity during the interview but loses this in the 3 days after interview, and they or their lead care professional gets in contact with the team (as there is not a scheduled contact during that period, just the opportunity for the participant to contact the team if they want to remove their data), then their wishes will be taken into consideration as to whether the data was retained in the study or removed. Additional time for this would be considered for this and negotiated with the participant if possible.

Potential participants will be informed of this before giving consent to be included in the study. Their Lead Care Professional and/or GP would also be immediately informed should they lose capacity in the study as well as the details of this.

CONFIDENTIALITY

In this section, personal data means any data relating to a participant who could potentially be identified. It includes pseudonymised data capable of being linked to a participant through a unique code number.

Storage and use of personal data during the study

A36. Will you be undertaking any of the following activities at any stage (including in the identification of potential participants)?*(Tick as appropriate)*

☐ Access to medical records by those outside the direct healthcare team

☐ Access to social care records by those outside the direct social care team

☑ Electronic transfer by magnetic or optical media, email or computer networks

☐ Sharing of personal data with other organisations

☐ Export of personal data outside the EEA

☑ Use of personal addresses, postcodes, faxes, emails or telephone numbers

☑ Publication of direct quotations from respondents

☐ Publication of data that might allow identification of individuals

☑ Use of audio/visual recording devices

☑ Storage of personal data on any of the following:

  - ☑ Manual files (includes paper or film)
  - ☑ NHS computers
  - ☐ Social Care Service computers
  - ☑ Home or other personal computers
  - ☑ University computers
  - ☐ Private company computers
  - ☑ Laptop computers

Further details:

A37. Please describe the physical security arrangements for storage of personal data during the study?

Electronic data will be stored on an encrypted memory stick or on a secure password protected Trust issued laptop on encrypted servers. If it is necessary to send electronic data (e.g. to academic supervisor) via e¬mail then this will also be encrypted. It will be ensured that any encrypted data sent via e¬mail meets NHS data transfer standards. GDPR regulations and guidance will be followed throughout.

Personal contact details and other identifiable information will be stored on a secure trust laptop on encrypted NHS servers or an encrypted memory stick. Personal telephone numbers will be stored on the study mobile telephone which will be protected with a passcode. The personal details will be erased when they are no longer required.

If direct quotations are used in any future publications these will be anonymised.

An audio recording device (e.g. Dictaphone) will be used to record the interview. Immediately following the interview, the recording of the interview will be immediately transferred to the secure and trust issued laptop and stored on a secure server. It will be ensured that the recordings are erased from the device once loaded onto the computer. Following this the interviews will be transcribed and anonymised using pseudonyms. Following this the recordings of the interviews will be erased. The trust issued password protected computer used for this will be stored at the Principal Investigator’s home. This is due to COVID-19 pandemic and requirement of homeworking where possible within the trust. The computer will be stored in a locked room when not in use and the storage of it is in line with NHS and trust guidance.

A significant effort to keep files for this project electronic has been made. This is to reduce the need of the researcher and participants to travel to deliver or store documents during the COVID-19 pandemic. Paper files, which may include consent forms, will be stored in a locked cabinet at the University of East Anglia in a locked office. Paper notes made by the researcher during interviews will be scanned and uploaded to the trust issued secure password protected laptop and stored on trust servers. The paper notes will then be destroyed in line with NHS policy using confidential waste shredding services provided by the trust.

Passcodes will be used on home, university and laptop computers to ensure confidentiality. Only anonymised data will be stored on these computers.

A38. How will you ensure the confidentiality of personal data?*Please provide a general statement of the policy and procedures for ensuring confidentiality, e.g. anonymisation or pseudonymisation of data.*

All raw data (interview transcripts) will be anonymised using pseudonyms for participants. This will also be used for any other names the participant might mention in the interview or identifiable landmarks. This data will be stored separately from consent forms.

A40. Who will have access to participants' personal data during the study? *Where access is by individuals outside the direct care team, please justify and say whether consent will be sought.*

The Principal Investigator will have access to personal data. Potential participants will be informed of this before agreeing to take part in the study.

Storage and use of data after the end of the study

A41. Where will the data generated by the study be analysed and by whom?

Data will be analysed by the Principal Investigator on a password protected personal computer and a trust issued secure laptop. No personal details will be included in the data set for analysis. Personal details will not be used on the data set and pseudonyms will be used to ensure anonymisation. The data will not be exported outside of the UK.

A42. Who will have control of and act as the custodian for the data generated by the study?

	Title	Forename/Initials	Surname
	Dr	Gillian	Bowden
Post	Clinical Lecturer		
Qualifications	Doctorate in Clinical Psychology, BPS Diploma in Clinical Psychology, BA Psychology		
Work Address	Department of Clinical Psychology, Norwich Medical School University of East Anglia Norwich Research Park, Norwich		
Post Code	NR4 7TJ		
Work Email	g.bowden@uea.ac.uk		
Work Telephone	01603 591213		
Fax			

A43. How long will personal data be stored or accessed after the study has ended?

○ Less than 3 months

○ 3 – 6 months

● 6 – 12 months

○ 12 months – 3 years

○ Over 3 years

A44. For how long will you store research data generated by the study?

Years: 10

Months: 0

A45. Please give details of the long term arrangements for storage of research data after the study has ended.*Say where data will be stored, who will have access and the arrangements to ensure security.*

The anonymised raw data will be placed into storage by the University of East Anglia for 10 years after the study has ended (in line with NHS policy). These data will be accessed only by the Principal Investigator (student) and the Chief Investigator (academic supervisor). After 10 years all data will be destroyed.

INCENTIVES AND PAYMENTS

A46. Will research participants receive any payments, reimbursement of expenses or any other benefits or incentives for taking part in this research?

● Yes ○ No

If Yes, please give details. For monetary payments, indicate how much and on what basis this has been determined.
Each participant taking part in the study will receive a £10 Amazon voucher as a token of gratitude. This is in line with university policy. Participants who withdraw from the study after giving consent will still receive the voucher.

Reimbursement of travel expenses is not needed for this study as participants will be completing the contacts in their own home by telephone or video link. Phone calls to the participant will be made by researcher so no costs to the participant will be involved. The participant will use their internet access to take part in the study. If participants raise this as a barrier for taking part then the research team will seek funding from the University to support reimbursement for this.

If the participants request to complete the consent form by hand and return it by post they will be provided with a prepaid recorded envelope to do this.

A47. Will individual researchers receive any personal payment over and above normal salary, or any other benefits or incentives, for taking part in this research?

○ Yes ● No

A48. Does the Chief Investigator or any other investigator/collaborator have any direct personal involvement (e.g. financial, share holding, personal relationship etc.) in the organisations sponsoring or funding the research that may give rise to a possible conflict of interest?

○ Yes ● No

NOTIFICATION OF OTHER PROFESSIONALS

A49-1. Will you inform the participants' General Practitioners (and/or any other health or care professional responsible for their care) that they are taking part in the study?

● Yes ○ No

If Yes, please enclose a copy of the information sheet/letter for the GP/health professional with a version number and date.

A49-2. Will you seek permission from the research participants to inform their GP or other health/ care professional?

● Yes ○ No

It should be made clear in the participant's information sheet if the GP/health professional will be informed.

PUBLICATION AND DISSEMINATION

A50. Will the research be registered on a public database?

○ Yes ● No

Please give details, or justify if not registering the research.
No suitable register exists.

However, the research will be registered with the Research and Development Department at the local trust [redacted]

Registration of research studies is encouraged wherever possible.
You may be able to register your study through your NHS organisation or a register run by a medical research charity,

or publish your protocol through an open access publisher. If you are aware of a suitable register or other method of publication, please give details. If not, you may indicate that no suitable register exists. Please ensure that you have entered registry reference number(s) in question A5-1.

A51. How do you intend to report and disseminate the results of the study?*Tick as appropriate:*

☑ Peer reviewed scientific journals

☑ Internal report

☑ Conference presentation

☑ Publication on website

☑ Other publication

☐ Submission to regulatory authorities

☐ Access to raw data and right to publish freely by all investigators in study or by Independent Steering Committee on behalf of all investigators

☐ No plans to report or disseminate the results

☐ Other (please specify)

A52. If you will be using identifiable personal data, how will you ensure that anonymity will be maintained when publishing the results?

No identifiable data will be used in the write up of the study for either the University of East Anglia or a peer reviewed scientific journal. The results will be described in a way that the participants involved cannot be identified.

A53. How and when will you inform participants of the study results?

If there will be no arrangements in place to inform participants please justify this.
If requested, the participants will be sent a summary of the general results for the study as well as being offered the opportunity of a phone call with the Principal Investigator to discuss the study. Individual analysis of their interviews will not be available. However, the participants will be provided with a debrief at the end of the study whereby they can discuss their time in the study.

5. Scientific and Statistical Review

A54. How has the scientific quality of the research been assessed?*Tick as appropriate:*

☐ Independent external review

☐ Review within a company

☐ Review within a multi−centre research group

☑ Review within the Chief Investigator's institution or host organisation

☑ Review within the research team

☑ Review by educational supervisor

☐ Other

Justify and describe the review process and outcome. If the review has been undertaken but not seen by the researcher, give details of the body which has undertaken the review:
The study has been designed under the supervision of the primary academic supervisor and secondary supervisors at the University of East Anglia. The collaborator has also been involved in the design of the study and has provided clinical supervision when required. The study proposal has been reviewed by an independent member of staff at the University of East Anglia whereby it was rated as satisfactory. Suggested changes were discussed with the academic supervisors and these have been incorporated in the proposal as appropriate. Please see attached proposal, feedback and covering sheet for further information.

For all studies except non-doctoral student research, please enclose a copy of any available scientific critique reports, together with any related correspondence.

For non-doctoral student research, please enclose a copy of the assessment from your educational supervisor/ institution.

A59. What is the sample size for the research? *How many participants/samples/data records do you plan to study in total? If there is more than one group, please give further details below.*

Total UK sample size:	10
Total international sample size (including UK):	0
Total in European Economic Area:	0

Further details:

A60. How was the sample size decided upon? *If a formal sample size calculation was used, indicate how this was done, giving sufficient information to justify and reproduce the calculation.*

The sample size was decided on through consideration of Smith, Flowers and Larkin's (2013) guidance on suggested sample sizes for IPA. This should allow for rich data and of sufficient volume for analysis.

References:
Smith, J. A., Flowers, P., & Larkin, M. (2012). Interpretative Phenomenological Analysis: Theory, Method and Research. London: SAGE Publications.

A62. Please describe the methods of analysis (statistical or other appropriate methods, e.g. for qualitative research) by which the data will be evaluated to meet the study objectives.

The analysis is qualitative. It will follow the guidelines stated for Interpretative Phenomenological Analysis (IPA) suggested by Smith, Flowers and Larkin (2013).

Analysis will start anonymisation and verbatim transcription of interviews into a qualitative data analysis software (such as NVivo) with comments added to text of notable non-verbal utterances, pauses and hesitations.

Analysis in IPA is analytic in focus and pays attention to how the participant makes sense of their experience (Smith et al., 2013). The process is iterative and inductive, requiring reflexive engagement with the data. This research will use the steps outlined by Smith et al. (2013), however, this will be used as a guide, as IPA is an iterative process. These steps involve immersion in a single participant's data with specific attention to experience, concerns and understandings; initial noting, paying attention to descriptive, linguistic and conceptual comments; and the development of emergent themes and searching for connections across themes, with particular attention to convergence and divergence, commonality and nuance. Analytic devices suggested by Smith et al. (2013), including abstraction, polarisation, contextualisation, numeration and looking for function of themes, will support the 'dialogue' between the data, the analysist, and their psychological knowledge about what this might mean for participants in this context. This supports the development of a frame that illustrates the relationships between themes. After this has been completed the analysist moves on to the next case, repeating the aforementioned steps until all cases have been examined. Once all cases are analysed the final step involves drawing themes across all participants together and creating master themes for the cohort, looking for potency and connections or disparities between themes, and moving towards a theoretical conceptualisation of related themes. Furthermore, as noted above, the analyst will comment on the power relationship inherent in data collection and his own preconceptions, attempting to 'bracket off' these and incorporate accurate reflections on this in analysis (Smith et al., 2013). Supervision and reflexive diaries will support this.

Quality will be monitored using Yardley's (2000) principles, including, sensitivity to context (ideographic and phenomenological approach), commitment and rigour (transparent purposive sampling and regular supervision), transparency and coherence (use of reflexive diaries and clear process records, allowing for independent audit), and focus on impact and importance (discussed in introduction).

Member checking, that is the returning of analysis to the participants to check for consistency, is not going to be done in this study. This is routine in IPA and member checking is not in line with the analytic approach of IPA.

References:
Smith, J. A., Flowers, P., & Larkin, M. (2012). Interpretative Phenomenological Analysis: Theory, Method and Research.

London: SAGE Publications.

Yardley, L. (2000). Dilemmas in qualitative health research. Psychology and health, 15(2), 215-228.

6. MANAGEMENT OF THE RESEARCH

A63. Other key investigators/collaborators. *Please include all grant co−applicants, protocol co−authors and other key members of the Chief Investigator's team, including non-doctoral student researchers.*

Title Forename/Initials Surname

Post
Qualifications
Employer
Work Address

Post Code
Telephone
Fax
Mobile
Work Email

A64. Details of research sponsor(s)

A64-1. Sponsor

Lead Sponsor

Status:
○ NHS or HSC care organisation
● Academic
○ Pharmaceutical industry
○ Medical device industry
○ Local Authority
○ Other social care provider (including voluntary sector or private organisation)
○ Other

Commercial status: Non-Commercial

If Other, please specify:

Contact person

Name of organisation	University of East Anglia
Given name	Polly
Family name	Harrison
Address	University of East Anglia
Town/city	Norwich

Post code NR4 7TJ
Country United Kingdom
Telephone +44 (0) 1603 597948
Fax
E-mail researchsponsor@uea.ac.uk

Legal representative for clinical investigation of medical device (studies involving Northern Ireland only)
Clinical Investigations of Medical Devices that take place in Northern Ireland must have a legal representative of the sponsor that is based in Northern Ireland or the EU

Contact person

Name of organisation
Given name
Family name
Address
Town/city
Post code
Country
Telephone
Fax
E-mail

A65. Has external funding for the research been secured?

Please tick at least one check box.

☐ Funding secured from one or more funders
☐ External funding application to one or more funders in progress
☑ No application for external funding will be made

What type of research project is this?

● Standalone project
○ Project that is part of a programme grant
○ Project that is part of a Centre grant
○ Project that is part of a fellowship/ personal award/ research training award
○ Other

Other – please state:

A66. Has responsibility for any specific research activities or procedures been delegated to a subcontractor (other than a co-sponsor listed in A64-1) ? *Please give details of subcontractors if applicable.*

○ Yes ● No

A67. Has this or a similar application been previously rejected by a Research Ethics Committee in the UK or another

country?

○ Yes ● No

Please provide a copy of the unfavourable opinion letter(s). You should explain in your answer to question A6-2 how the reasons for the unfavourable opinion have been addressed in this application.

A68-1. Give details of the lead NHS R&D contact for this research:

	Title	Forename/Initials	Surname
	[redacted]	[redacted]	[redacted]

[redacted] [redacted]
[redacted] [redacted]
[redacted]
[redacted]
[redacted] [redacted]
[redacted] [redacted]
[redacted] [redacted]
[redacted]
[redacted]

Details can be obtained from the NHS R&D Forum website: http://www.rdforum.nhs.uk

A69-1. How long do you expect the study to last in the UK?

Planned start date: 01/03/2021
Planned end date: 30/09/2022
Total duration:
Years: 1 Months: 6 Days: 30

A71-1. Is this study?

○ Single centre
● Multicentre

A71-2. Where will the research take place? *(Tick as appropriate)*

☑ England
☐ Scotland
☐ Wales
☐ Northern Ireland
☐ Other countries in European Economic Area

Total UK sites in study

Does this trial involve countries outside the EU?
○ Yes ● No

A72. Which organisations in the UK will host the research?*Please indicate the type of organisation by ticking the box and give approximate numbers if known:*

☑ NHS organisations in England	1
☐ NHS organisations in Wales	
☐ NHS organisations in Scotland	
☐ HSC organisations in Northern Ireland	
☐ GP practices in England	
☐ GP practices in Wales	
☐ GP practices in Scotland	
☐ GP practices in Northern Ireland	
☐ Joint health and social care agencies (eg community mental health teams)	
☐ Local authorities	
☐ Phase 1 trial units	
☐ Prison establishments	
☐ Probation areas	
☐ Independent (private or voluntary sector) organisations	
☑ Educational establishments	1
☐ Independent research units	
☐ Other (give details)	
Total UK sites in study:	2

A73-1. Will potential participants be identified through any organisations other than the research sites listed above?

○ Yes ● No

A74. What arrangements are in place for monitoring and auditing the conduct of the research?

This research is sponsored by the University of East Anglia and the Principal Investigator (student) will be monitored through supervision with the primary academic supervisor (CI) and supervisory team. Regular research supervision will be provided, reflexive diaries will be kept, and audit trails will be used to monitor this.

A76. Insurance/ indemnity to meet potential legal liabilities

***Note:** in this question to NHS indemnity schemes include equivalent schemes provided by Health and Social Care (HSC) in Northern Ireland*

A76-1. What arrangements will be made for insurance and/or indemnity to meet the potential legal liability of the sponsor(s) for harm to participants arising from the management of the research? *Please tick box(es) as applicable.*

Note: Where a NHS organisation has agreed to act as sponsor or co-sponsor, indemnity is provided through NHS schemes. Indicate if this applies (there is no need to provide documentary evidence). For all other sponsors, please describe the arrangements and provide evidence.

☐ NHS indemnity scheme will apply (NHS sponsors only)

☑ Other insurance or indemnity arrangements will apply (give details below)

This study is being conducted as part of the Doctorate in Clinical Psychology at the University of East Anglia. The university is therefore responsible for the management of the research. The university has appropriate insurance policies in place to provide professional indemnity and public liability cover. Please refer to attached letter.

Please enclose a copy of relevant documents.

A76-2. What arrangements will be made for insurance and/ or indemnity to meet the potential legal liability of the sponsor(s) or employer(s) for harm to participants arising from the design of the research? *Please tick box(es) as applicable.*

Note: Where researchers with substantive NHS employment contracts have designed the research, indemnity is provided through NHS schemes. Indicate if this applies (there is no need to provide documentary evidence). For other protocol authors (e.g. company employees, university members), please describe the arrangements and provide evidence.

☐ NHS indemnity scheme will apply (protocol authors with NHS contracts only)

☑ Other insurance or indemnity arrangements will apply (give details below)

This study is being conducted as part of the Doctorate in Clinical Psychology at the University of East Anglia. The university is therefore responsible for the design of the research.

Please enclose a copy of relevant documents.

A76-3. What arrangements will be made for insurance and/ or indemnity to meet the potential legal liability of investigators/collaborators arising from harm to participants in the conduct of the research?

Note: Where the participants are NHS patients, indemnity is provided through the NHS schemes or through professional indemnity. Indicate if this applies to the whole study (there is no need to provide documentary evidence). Where non-NHS sites are to be included in the research, including private practices, please describe the arrangements which will be made at these sites and provide evidence.

☑ NHS indemnity scheme or professional indemnity will apply (participants recruited at NHS sites only)

☑ Research includes non-NHS sites (give details of insurance/ indemnity arrangements for these sites below)

NHS indemnity scheme will cover all participants who are recruited from and recieve services from the host trust.

Some participants will be recruited by advert (which will be put out by the host trust) and may not be under the host trusts services. Therefore, for these partcipants, the University of East Anglia will act as another research site and the work will be undertaken on behalf of the University and their Insurance.

Please enclose a copy of relevant documents.

A78. Could the research lead to the development of a new product/process or the generation of intellectual property?

○ Yes ○ No ● Not sure

PART C: Overview of research sites

Please enter details of the host organisations (Local Authority, NHS or other) in the UK that will be responsible for the research sites. *For further information please refer to guidance.*

Investigator identifier	Research site		Investigator Name	
IN1	● NHS/HSC Site ○ Non-NHS/HSC Site		Forename	Oliver
			Middle name	James Shearing
			Family name	Farrar
			Email	o.farrar@uea.ac.uk
	Organisation name	[redacted]	Qualification (MD...)	BSc Psychology
	[redacted]	[redacted]	Country	United Kingdom
	Post Code	[redacted]		
	[redacted]	[redacted]		
IN2	○ NHS/HSC Site ● Non-NHS/HSC Site		Forename	Oliver
			Middle name	James Shearing
			Family name	Farrar
			Email	o.farrar@uea.ac.uk
	Institution name	University of East Anglia	Qualification (MD...)	BSc Psychology
	Department name	Research and Enterprise Services		
	Street address	Norwich Research Park	Country	United Kingdom
	Town/city	Norwich		
	Post Code	NR4 7TJ		
	Country	United Kingdom		

PART D: Declarations

D1. Declaration by Chief Investigator

1. The information in this form is accurate to the best of my knowledge and belief and I take full responsibility for it.

2. I undertake to fulfil the responsibilities of the chief investigator for this study as set out in the UK Policy Framework for Health and Social Care Research.

3. I undertake to abide by the ethical principles underlying the Declaration of Helsinki and good practice guidelines on the proper conduct of research.

4. If the research is approved I undertake to adhere to the study protocol, the terms of the full application as approved and any conditions set out by review bodies in giving approval.

5. I undertake to notify review bodies of substantial amendments to the protocol or the terms of the approved application, and to seek a favourable opinion from the main REC before implementing the amendment.

6. I undertake to submit annual progress reports setting out the progress of the research, as required by review bodies.

7. I am aware of my responsibility to be up to date and comply with the requirements of the law and relevant guidelines relating to security and confidentiality of patient or other personal data, including the need to register when necessary with the appropriate Data Protection Officer. I understand that I am not permitted to disclose identifiable data to third parties unless the disclosure has the consent of the data subject or, in the case of patient data in England and Wales, the disclosure is covered by the terms of an approval under Section 251 of the NHS Act 2006.

8. I understand that research records/data may be subject to inspection by review bodies for audit purposes if required.

9. I understand that any personal data in this application will be held by review bodies and their operational managers and that this will be managed according to the principles established in the Data Protection Act 2018.

10. I understand that the information contained in this application, any supporting documentation and all correspondence with review bodies or their operational managers relating to the application:

    - Will be held by the REC (where applicable) until at least 3 years after the end of the study; and by NHS R&D offices (where the research requires NHS management permission) in accordance with the NHS Code of Practice on Records Management.
    - May be disclosed to the operational managers of review bodies, or the appointing authority for the REC (where applicable), in order to check that the application has been processed correctly or to investigate any complaint.
    - May be seen by auditors appointed to undertake accreditation of RECs (where applicable).
    - Will be subject to the provisions of the Freedom of Information Acts and may be disclosed in response to requests made under the Acts except where statutory exemptions apply.
    - May be sent by email to REC members.

11. I understand that information relating to this research, including the contact details on this application, may be held on national research information systems, and that this will be managed according to the principles established in the Data Protection Act 2018.

12. Where the research is reviewed by a REC within the UK Health Departments Research Ethics Service, I understand that the summary of this study will be published on the website of the Health Research Authority (HRA) together with the contact point for enquiries named below. Publication will take place no earlier than 3 months after the issue of the ethics committee's final opinion or the withdrawal of the application.

Contact point for publication*(Not applicable for R&D Forms)*

HRA would like to include a contact point with the published summary of the study for those wishing to seek further *information. We would be grateful if you would indicate one of the contact points below.*

○ Chief Investigator
○ Sponsor
○ Study co-ordinator
○ Student
○ Other – please give details
○ None

Access to application for training purposes *(Not applicable for R&D Forms)*

Optional – please tick as appropriate:

☐ I would be content for members of other RECs to have access to the information in the application in confidence for training purposes. All personal identifiers and references to sponsors, funders and research units would be removed.

This section was signed electronically by Dr Gillian Bowden on 03/08/2021 09:33.

Job Title/Post:	Lecturer
Organisation:	UEA
Email:	g.bowden@uea.ac.uk

D2. Declaration by the sponsor's representative

If there is more than one sponsor, this declaration should be signed on behalf of the co−sponsors by a representative of the lead sponsor named at A64-1.

I confirm that:

1. This research proposal has been discussed with the Chief Investigator and agreement in principle to sponsor the research is in place.

2. An appropriate process of scientific critique has demonstrated that this research proposal is worthwhile and of high scientific quality.

3. Any necessary indemnity or insurance arrangements, as described in question A76, will be in place before this research starts. Insurance or indemnity policies will be renewed for the duration of the study where necessary.

4. Arrangements will be in place before the study starts for the research team to access resources and support to deliver the research as proposed.

5. Arrangements to allocate responsibilities for the management, monitoring and reporting of the research will be in place before the research starts.

6. The responsibilities of sponsors set out in the UK Policy Framework for Health and Social Care Research will be fulfilled in relation to this research.

   Please note: *The declarations below do not form part of the application for approval above. They will not be considered by the Research Ethics Committee.*

7. Where the research is reviewed by a REC within the UK Health Departments Research Ethics Service, I understand that the summary of this study will be published on the website of the National Research Ethics Service (NRES), together with the contact point for enquiries named in this application. Publication will take place no earlier than 3 months after issue of the ethics committee's final opinion or the withdrawal of the application.

8. Specifically, for submissions to the Research Ethics Committees (RECs) I declare that any and all clinical trials approved by the HRA since 30th September 2013 (as defined on IRAS categories as clinical trials of medicines, devices, combination of medicines and devices or other clinical trials) have been registered on a publically accessible register in compliance with the HRA registration requirements for the UK, or that any deferral granted by the HRA still applies.

This section was signed electronically by Ms Polly Harrison on 30/07/2021 15:09.

Job Title/Post:	Contracts Officer
Organisation:	University of East Anglia
Email:	researchsponsor@uea.ac.uk

D3. Declaration for student projects by academic supervisor(s)

1. I have read and approved both the research proposal and this application. I am satisfied that the scientific content of the research is satisfactory for an educational qualification at this level.

2. I undertake to fulfil the responsibilities of the supervisor for this study as set out in the UK Policy Framework for Health and Social Care Research.

3. I take responsibility for ensuring that this study is conducted in accordance with the ethical principles underlying the Declaration of Helsinki and good practice guidelines on the proper conduct of research, in conjunction with clinical supervisors as appropriate.

4. I take responsibility for ensuring that the applicant is up to date and complies with the requirements of the law and relevant guidelines relating to security and confidentiality of patient and other personal data, in conjunction with clinical supervisors as appropriate.

Academic supervisor 1

This section was signed electronically by Dr Gillian Bowden on 03/08/2021 16:35.

Job Title/Post:	Lecturer
Organisation:	UEA
Email:	g.bowden@uea.ac.uk

Academic supervisor 2

This section was signed electronically by Dr Hannah Zeilig on 02/08/2021 14:19.

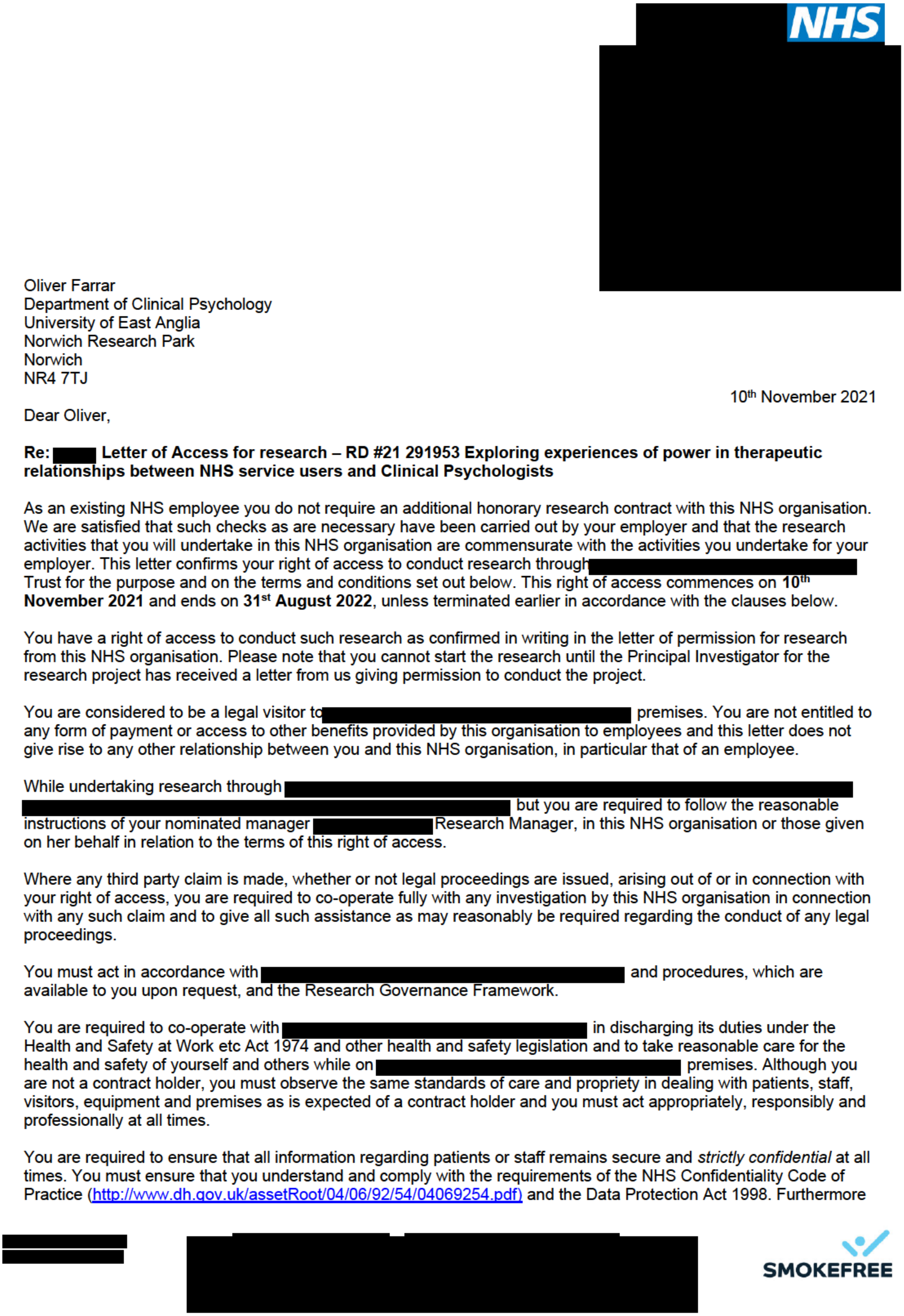
Job Title/Post:	Senior Research Fellow
Organisation:	University of the Arts
Email:	hannahzeilig@gmail.com

Academic supervisor 3

This section was signed electronically by Dr Corinna Hackmann on 02/08/2021 08:13.

Job Title/Post:	[redacted]
Organisation:	
Email:	[redacted]

Appendix J: Letter of access for host Trust



[redacted]
NHS

Oliver Farrar
Department of Clinical Psychology
University of East Anglia
Norwich Research Park
Norwich
NR4 7TJ

10th November 2021

Dear Oliver,

Re: [redacted] Letter of Access for research – RD #21 291953 Exploring experiences of power in therapeutic relationships between NHS service users and Clinical Psychologists

As an existing NHS employee you do not require an additional honorary research contract with this NHS organisation. We are satisfied that such checks as are necessary have been carried out by your employer and that the research activities that you will undertake in this NHS organisation are commensurate with the activities you undertake for your employer. This letter confirms your right of access to conduct research through [redacted] Trust for the purpose and on the terms and conditions set out below. This right of access commences on **10th November 2021** and ends on **31st August 2022**, unless terminated earlier in accordance with the clauses below.

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

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

While undertaking research through [redacted] but you are required to follow the reasonable instructions of your nominated manager [redacted] Research Manager, in this NHS organisation or those given on her behalf in relation to the terms of this right of access.

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

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

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

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

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

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

Your substantive employer is responsible for your conduct during this research project and may in the circumstances described above instigate disciplinary action against you.

We may terminate your right to attend at any time either by giving seven days' written notice to you or immediately without any notice if you are in breach of any of the terms or conditions described in this letter or if you commit any act that we reasonably consider to amount to serious misconduct or to be disruptive and/or prejudicial to the interests and/or business of this NHS organisation or if you are convicted of any criminal offence. Your substantive employer is responsible for your conduct during this research project and may in the circumstances described above instigate disciplinary action against you.

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

[redacted]

[redacted]

[redacted]
[redacted]

Appendix K: HRA ethical approval letter

Ymchwil Iechyd a Gofal Cymru
Health and Care Research Wales

NHS
Health Research Authority

Dr Gillian Bowden
Department of Clinical Psychology and
Psychological Therapies, School of Medicine
University of East Anglia
Norwich Research Park, Norwich
NR4 7TJ

Email: approvals@hra.nhs.uk
HCRW.approvals@wales.nhs.uk

16 August 2021

Dear Dr Bowden

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

Study title:	**Exploring experiences of power in therapeutic relationships between NHS service users and Clinical Psychologists**
IRAS project ID:	**291953**
Protocol	**291953**
number: REC	**21/NW/0114**
reference:	**University of East Anglia**
Sponsor	

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

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

How should I work with participating NHS/HSC organisations in Northern Ireland and Scotland?

HRA and HCRW Approval does not apply to NHS/HSC organisations within Northern Ireland and Scotland.

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

Please see IRAS Help for information on working with NHS/HSC organisations in Northern Ireland and Scotland.

How should I work with participating non-NHS organisations?
HRA and HCRW Approval does not apply to non-NHS organisations. You should work with your non-NHS organisations to obtain local agreement in accordance with their procedures.

What are my notification responsibilities during the study?

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

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

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

Who should I contact for further information?
Please do not hesitate to contact me for assistance with this application. My contact details are below.

Your IRAS project ID is **291953**. Please quote this on all correspondence.

Yours sincerely,

Kevin Ahmed
Approvals Manager

Email: approvals@hra.nhs.uk

Copy to: *Polly Harrison*

List of Documents

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

Document	*Version*	*Date*
Copies of materials calling attention of potential participants to the research [Email to clinical teams informing of recruitment to study]	v2.0	10 January 2021
Copies of materials calling attention of potential participants to the research [PDF Research flyer infographic]	v.2	06 June 2021
Copies of materials calling attention of potential participants to the research [Recuitment Email]	v.3	25 May 2021
Copies of materials calling attention of potential participants to the research [Website Page 1- home page (www.researching-power.co.uk)]	v.2	06 June 2021
Copies of materials calling attention of potential participants to the research [Website Page 2 - about the research - (www.researching-power.co.uk)]	v.2	06 June 2021
Copies of materials calling attention of potential participants to the research [Website Page 3 - taking part - (www.researching-power.co.uk)]	v.2	06 June 2021
Copies of materials calling attention of potential participants to the research [Website Page 4 - contact - (www.researching-power.co.uk)]	v.2	06 June 2021
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [Sponsor evidence of I&I cover]	v1.0	16 March 2021
GP/consultant information sheets or letters [Letter to LCP & GP Informing of Research]	v.2	25 May 2021
Interview schedules or topic guides for participants [Interview Protocol and topic guide]	v1	06 June 2021
IRAS Application Form [IRAS_Form_03082021]		03 August 2021
Letter from sponsor [Sponsor Insurance and Indemnity Cover Letter]	v1.0	16 March 2021
Letters of invitation to participant [Covering email for participant info and consentl]	v.2	25 May 2021
Letters of invitation to participant [Covering letter for participant information packl]	v.2	25 May 2021
Organisation Information Document [Organisation Information Document - IRAS Project ID: 291953]	v1.0	12 March 2021
Other [Sponsor evidence of professional indemnity]	v1.0	16 March 2021
Other [NEW DOCUMENT - Protocol for handling accusations against previous theraputic interventions]	v2	08 June 2021
Other [NEW DOCUMENT - Details of amendments made following Review from GM West Ethics Board 18th April 2021]	v.1	06 June 2021
Participant consent form [Participant Consent Form]	v.2	25 May 2021
Participant consent form [PDF qualtrics electronic participant consent form]	v3	25 May 2021
Participant information sheet (PIS) [Partcipant information sheetl]	v4	25 May 2021
Referee's report or other scientific critique report [Feedback from initial proposal/protocol from UEA internal reviewer]	v1.0	03 November 2020
Referee's report or other scientific critique report [List of updates from original thesis proposal / project protocol]	v1.0	21 November 2020
Research protocol or project proposal [Updated thesis proposal protocol l]	v3	06 June 2021
Schedule of Events or SoECAT [Schedule of Events for site]	v1.1	12 March 2021
Summary CV for Chief Investigator (CI) [CV Gillian Boweden - CI]	v1	17 November 2020

Summary CV for student [CV Oliver Farrar - Student PI]	v.2	05 July 2021
Summary CV for supervisor (student research) [CV Corinna Hackmann - Secondary Supervisor]	v1.0	12 March 2021
Summary CV for supervisor (student research) [CV Hannah Zeilig - Secondary Supervisor]	v1.0	12 March 2021
Summary, synopsis or diagram (flowchart) of protocol in non technical language [Research Flow Chart]	v1.0	10 January 2021

Information to support study set up

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

Types of participating NHS organisation	**Expectations related to confirmation of capacity and capability**	**Agreement to be used**	**Funding arrangements**	**Oversight expectations**	**HR Good Practice Resource Pack expectations**
There is only one participating NHS organisation therefore there is only one site type.	Research activities should not commence at participating NHS organisations in England or Wales prior to their formal confirmation of capacity and capability to deliver the study.	An Organisation Information Document has been submitted and the sponsor is not requesting and does not expect any other site agreement to be used.	No study funding will be provided to sites as per the Organisational Information Document	The Chief Investigator will be responsible for all research activities performed at study sites	No Honorary Research Contracts, Letters of Access or pre-engagement checks are expected for local staff employed by the participating NHS organisations. Where arrangements are not already in place, network staff (or similar) undertaking any of the research activities listed in the IRAS form (except for administration of questionnaires or surveys), would be expected to obtain an honorary research contract from one NHS organisation (if university employed), followed by Letters of Access for subsequent organisations. This would be on the basis of a Research Passport (if university employed) or an NHS to NHS confirmation of pre-engagement

					checks letter (if NHS employed). These should confirm enhanced DBS checks, including appropriate barred list checks, and occupational health clearance. For research team members only administering questionnaires or surveys, a Letter of Access based on standard DBS checks and occupational health clearance would be appropriate.

Other information to aid study set-up and delivery

This details any other information that may be helpful to sponsors and participating NHS organisations in England and Wales in study set-up.
The applicant has indicated that they do not intend to apply for inclusion on the NIHR CRN Portfolio.

Appendix L: Inclusion & Exclusion Criteria for the Empirical Paper

Table 1

Inclusion and exclusion criteria for the empirical study

Inclusion or Exclusion Criteria	Rationale
<u>Inclusion Criteria</u>	
Aged 18 years or older.	Primary reason for including adults only was that people under 18 are likely to have different structural power influences operating in therapy (parental responsibility operating on issues such as confidentiality and consent, school etc).
Participant has received care from secondary mental health team within the host trust.	Secondary services are being examined because of the likelihood of more intensive one to one psychological intervention and it also being the most utilised mental health sector (NHS digital, 2019), with over a million more people accessing secondary services compared to primary mental health services such as Improving Access to Psychological Therapies.
Participant agrees for Lead Care Professional or GP to be informed of involvement in the research.	This was a risk consideration as participants in secondary services are likely to have some element of risk. This allowed care co-ordinators and lead professionals to be aware of their involvement and as such provide a link if risk issues arose during the research.
Participant has received one to one individual therapy from a Clinical Psychologist in last 24 months.	The interview was asking detailed questions about the relationship with their therapist and as such having finished therapy recently would allow for better recall of aspects of the relationship. Clinical Psychologists were chosen to support homogeneity in the sample.
Participant engaged in 8 or more individual therapy sessions a Clinical Psychologist.	This was to make sure that there was time for therapeutic relationship to be established. Briefer interventions would likely not allow sufficient time for a therapeutic relationship to be established.
Participant is able to understand written and spoken English.	The scale of this project and resources available sadly did not allow for interpreters to be used. Furthermore, IPA as an approach requires relative homogeneity in the sample, and with the likely addition of an interpreter in the therapeutic relationship this would have added a unique dimension and dynamic (albeit

	interesting one) that may have dominated that participant's analysis.
Exclusion	
Participant is currently in hospital or subject to Mental Health Act (MHA) conditions, including Community Treatment orders.	Participants under any Mental Health Act conditions were excluded due to the legal and coercive structural power operating on them. The research team felt this would be better addressed in its own study and will be an area to consider in future research. Furthermore, the participant would likely be undergoing active treatment as well as being part of a group that is significantly smaller to those receiving care outside of MHA conditions.
Participant received therapy from a Clinical Psychologist whilst subject to Mental Health Act conditions or whilst in psychiatric hospital.	As above.
Participant is currently undertaking any form of structured one to one or group therapy with a Clinical Psychologist, Psychotherapist, Assistant Psychologist, Psychological Wellbeing Practitioner, or Counsellor.	This is so as not to interfere with their current therapeutic relationship.
The participant's current Lead Care Professional is the Clinical Psychologist who delivered their therapy.	This criterion was to protect the participant and the psychologist and make sure that the participant was able to speak freely in the interview.
The participant does not have capacity to consent or the cognitive ability to take part in the study.	The interview asked a number of abstract and conceptual questions which would require a certain level of abstract thinking skills as such those with reduced cognitive ability were excluded. Furthermore, participants without capacity to consent to the study were excluded to protect them.

Appendix M: Guidance for journal submission

Journal Guidance for 'Psychology and Psychotherapy: Theory, Research and Practice'

PAPTRAP AUTHOR GUIDELINES

Sections

1. SUBMISSION

Authors should kindly note that submission implies that the content has not been published or submitted for publication elsewhere except as a brief abstract in the proceedings of a scientific meeting or symposium.

Once the submission materials have been prepared in accordance with the Author Guidelines, manuscripts should be submitted online at http://www.editorialmanager.com/paptrap

Click here for more details on how to use **Editorial Manager**.

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

Data protection:

By submitting a manuscript to or reviewing for this publication, your name, email address, and affiliation, and other contact details the publication might require, will be used for the regular operations of the publication, including, when necessary, sharing with the publisher (Wiley) and partners for production and publication. The publication and the publisher recognize the importance of protecting the personal information collected from users in the operation of these services, and have practices in place to ensure that steps are taken to maintain the security, integrity, and privacy of the personal data collected and processed. You can learn more at **https://authorservices.wiley.com/statements/data-protection-policy.html**.

Preprint policy:

This journal will consider for review articles previously available as preprints. Authors may also post the submitted version of a manuscript to a preprint server at any time. Authors are requested to update any pre-publication versions with a link to the final published article.

2. AIMS AND SCOPE

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

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

3. MANUSCRIPT CATEGORIES AND REQUIREMENTS

- Articles should adhere to the stated word limit for the particular article type. The word limit excludes the abstract, reference list, tables and figures, but includes appendices.

Word limits for specific article types are as follows:

- Research articles: 5000 words
- Qualitative papers: 6000 words
- Review papers: 6000 words
- Special Issue papers: 5000 words

In exceptional cases the Editor retains discretion to publish papers beyond this length where the clear and concise expression of the scientific content requires greater length (e.g., explanation of a new theory or a substantially new method). Authors must contact the Editor prior to submission in such a case.

Please refer to the separate guidelines for **Registered Reports**.

All systematic reviews must be pre-registered.

Brief-Report COVID-19

For a limited time, the *Psychology and Psychotherapy: Theory, Research and Practice* are accepting brief-reports on the topic of Novel Coronavirus (COVID-19) in line with the journal's main aims and scope (outlined above). Brief reports should not exceed 2000 words and should have no more than two tables or figures. Abstracts can be either structured (according to standard journal guidance) or unstructured but should not exceed 200 words. Any papers that are over the word limits will be returned to the authors. Appendices are included in the word limit; however online supporting information is not included.

4. PREPARING THE SUBMISSION

Free Format Submission

Psychology and Psychotherapy: Theory, Research and Practice now offers free format submission for a simplified and streamlined submission process.

Before you submit, you will need:

- Your manuscript: this can be a single file including text, figures, and tables, or separate files – whichever you prefer. All required sections should be contained in your manuscript, including abstract, introduction, methods, results, and conclusions. Figures and tables should have legends. References may be submitted in any style or format, as long as it is consistent throughout the manuscript. If the manuscript, figures or tables are difficult for you to read, they will also be difficult for the editors and reviewers. If your manuscript is difficult to read, the editorial office may send it back to you for revision.
- The title page of the manuscript, including a data availability statement and your co-author details with affiliations. *(Why is this important? We need to keep all co-authors informed of the outcome of the peer review process.)* You may like to use this template for your title page.

Important: the journal operates a double-blind peer review policy. Please anonymise your manuscript and prepare a separate title page containing author details. *(Why is this important? We need to uphold rigorous ethical standards for the research we consider for publication.)*

- An ORCID ID, freely available at https://orcid.org. *(Why is this important? Your article, if accepted and published, will be attached to your ORCID profile. Institutions and funders are increasingly requiring authors to have ORCID IDs.)*

To submit, login at **https://www.editorialmanager.com/paptrap/default.aspx** and create a new submission. Follow the submission steps as required and submit the manuscript.

If you are invited to revise your manuscript after peer review, the journal will also request the revised manuscript to be formatted according to journal requirements as described below.

Revised Manuscript Submission

Contributions must be typed in double spacing. All sheets must be numbered.

Cover letters are not mandatory; however, they may be supplied at the author's discretion. They should be pasted into the 'Comments' box in Editorial Manager.

Parts of the Manuscript

The manuscript should be submitted in separate files: title page; main text file; figures/tables; supporting information.

Title Page

You may like to use **this template** for your title page. The title page should contain**:**

- A short informative title containing the major key words. The title should not contain abbreviations (see Wiley's best practice SEO tips);
- A short running title of less than 40 characters;
- The full names of the authors;
- The author's institutional affiliations where the work was conducted, with a footnote for the author's present address if different from where the work was conducted;
- Abstract;
- Keywords;
- Data availability statement (see Data Sharing and Data Accessibility Policy);
- Acknowledgments.

Authorship

Please refer to the journal's Authorship policy in the Editorial Policies and Ethical Considerations section for details on author listing eligibility. When entering the author names into Editorial Manager, the corresponding author will be asked to provide a CRediT contributor role to classify the role that each author played in creating the manuscript. Please see the **Project CRediT** website for a list of roles.

Abstract

Please provide an abstract of up to 250 words. Articles containing original scientific research should include the headings: Objectives, Design, Methods, Results, Conclusions. Review articles should use the headings: Purpose, Methods, Results, Conclusions.

Keywords

Please provide appropriate keywords.

Acknowledgments

Contributions from anyone who does not meet the criteria for authorship should be listed, with permission from the contributor, in an Acknowledgments section. Financial and material support should also be mentioned. Thanks to anonymous reviewers are not appropriate.

Practitioner Points

All articles must include Practitioner Points – these are 2-4 bullet point with the heading 'Practitioner Points'. They should briefly and clearly outline the relevance of your research to professional practice. (The Practitioner Points should be submitted in a separate file.)

Main Text File

As papers are double-blind peer reviewed, the main text file should not include any information that might identify the authors.

The main text file should be presented in the following order:

- Title
- Main text
- References
- Tables and figures (each complete with title and footnotes)
- Appendices (if relevant)

Supporting information should be supplied as separate files. Tables and figures can be included at the end of the main document or attached as separate files but they must be mentioned in the text.

- As papers are double-blind peer reviewed, the main text file should not include any information that might identify the authors. Please do not mention the authors' names or affiliations and always refer to any previous work in the third person.
- The journal uses British/US spelling; however, authors may submit using either option, as spelling of accepted papers is converted during the production process.

References

This journal uses APA reference style; as the journal offers Free Format submission, however, this is for information only and you do not need to format the references in your article. This will instead be taken care of by the typesetter.

Tables

Tables should be self-contained and complement, not duplicate, information contained in the text. They should be supplied as editable files, not pasted as images. Legends should be concise but comprehensive – the table, legend, and footnotes must be understandable without reference to the text. All abbreviations must be defined in footnotes. Footnote symbols: †, ‡, §, ¶, should be used (in that order) and *, **, *** should be reserved for P-values. Statistical measures such as SD or SEM should be identified in the headings.

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Although authors are encouraged to send the highest-quality figures possible, for peer-review purposes, a wide variety of formats, sizes, and resolutions are accepted.

Click here for the basic figure requirements for figures submitted with manuscripts for initial peer review, as well as the more detailed post-acceptance figure requirements.

Legends should be concise but comprehensive – the figure and its legend must be understandable without reference to the text. Include definitions of any symbols used and define/explain all abbreviations and units of measurement.

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Supporting information is information that is not essential to the article, but provides greater depth and background. It is hosted online and appears without editing or typesetting. It may include tables, figures, videos, datasets, etc.

Click here for Wiley's FAQs on supporting information.

Note: if data, scripts, or other artefacts used to generate the analyses presented in the paper are available via a publicly available data repository, authors should include a reference to the location of the material within their paper.

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- **Language:** Authors must avoid the use of sexist or any other discriminatory language.
- **Abbreviations:** In general, terms should not be abbreviated unless they are used repeatedly and the abbreviation is helpful to the reader. Initially, use the word in full, followed by the abbreviation in parentheses. Thereafter use the abbreviation only.
- **Units of measurement:** Measurements should be given in SI or SI-derived units. Visit the Bureau International des Poids et Mesures (BIPM) website for more information about SI units.
- **Effect size:** In normal circumstances, effect size should be incorporated.
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Also, check out our resources for **Preparing Your Article** for general guidance and the **BPS Publish with Impact infographic** for advice on optimizing your article for search engines.

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Except where otherwise stated, the journal operates a policy of anonymous (double blind) peer review. Please ensure that any information which may reveal author identity is blinded in your submission, such as institutional affiliations, geographical location or references to unpublished research. We also operate a triage process in which submissions that are out of scope or otherwise inappropriate will be rejected by the editors without external peer review. Before submitting, please read **the terms and conditions of submission** and the **declaration of competing interests**.

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The journal requires that clinical trials are prospectively registered in a publicly accessible database and clinical trial registration numbers should be included in all papers that report their results. Authors are asked to include the name of the trial register and the clinical trial registration number at the end of the abstract. If the trial is not registered, or was registered retrospectively, the reasons for this should be explained.

Research Reporting Guidelines

Accurate and complete reporting enables readers to fully appraise research, replicate it, and use it. Authors are encouraged to adhere to recognised research reporting standards.

We also encourage authors to refer to and follow guidelines from:

- Future of Research Communications and e-Scholarship (FORCE11)
- The Gold Standard Publication Checklist from Hooijmans and colleagues
- FAIRsharing website

Conflict of Interest

The journal requires that all authors disclose any potential sources of conflict of interest. Any interest or relationship, financial or otherwise that might be perceived as influencing an author's objectivity is considered a potential source of conflict of interest. These must be disclosed when directly relevant or directly related to the work that the authors describe in their manuscript. Potential sources of conflict of interest include, but are not limited to: patent or stock ownership, membership of a company board of directors, membership of an advisory board or committee for a company, and consultancy for or receipt of speaker's fees from a company. The existence of a conflict of interest does not preclude publication. If the authors have no conflict of interest to declare, they must also state this at submission. It is the responsibility of the corresponding author to review this policy with all authors and collectively to disclose with the submission ALL pertinent commercial and other relationships.

Funding

Authors should list all funding sources in the Acknowledgments section. Authors are responsible for the accuracy of their funder designation. If in doubt, please check the Open Funder Registry for the correct nomenclature: **https://www.crossref.org/services/funder-registry/**

Authorship

All listed authors should have contributed to the manuscript substantially and have agreed to the final submitted version. Authorship is defined by the criteria set out in the APA Publication Manual:

"Individuals should only take authorship credit for work they have actually performed or to which they have substantially contributed (APA Ethics Code Standard 8.12a, Publication Credit). Authorship encompasses, therefore, not only those who do the actual writing but also those who have made substantial scientific contributions to a study. Substantial professional contributions may include formulating the problem or hypothesis, structuring the experimental design, organizing and conducting the statistical analysis, interpreting the results, or writing a major portion of the paper. Those who so contribute are listed in the byline." (p.18)

Data Sharing and Data Accessibility Policy

Psychology and Psychotherapy: Theory, Research and Practice recognizes the many benefits of archiving data for scientific progress. Archived data provides an indispensable resource for the scientific community, making possible future replications and secondary analyses, in addition to the importance of verifying the dependability of published research findings.

The journal expects that where possible all data supporting the results in papers published are archived in an appropriate public archive offering open access and guaranteed preservation. The archived data must allow each result in the published paper to be recreated and the analyses reported in the paper to be replicated in full to support the conclusions made. Authors are welcome to archive more than this, but not less.

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In some cases, despite the authors' best efforts, some or all data or materials cannot be shared for legal or ethical reasons, including issues of author consent, third party rights, institutional or national regulations or laws, or the nature of data gathered. In such cases, authors must inform the editors at the time of submission. It is understood that in some cases access will be provided under restrictions to protect confidential or proprietary information. Editors may grant exceptions to data access requirements provided authors explain the restrictions on the data set and how they preclude public access, and, if possible, describe the steps others should follow to gain access to the data.

If the authors cannot or do not intend to make the data publicly available, a statement to this effect, along with the reasons that the data is not shared, must be included in the manuscript.

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Recognizing the importance of research transparency and data sharing to cumulative research, *Psychology and Psychotherapy: Theory, Research and Practice* encourages the following Open Research practices.

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Open Research Badges. In partnership with the non-profit Center for Open Science (COS), *Psychology and Psychotherapy: Theory, Research and Practice* offers all submitting authors access to the following three Open Research Badges— Open Materials, Open Data, and Preregistered Research Designs. We also award all qualifying authors Open Research Badges recognizing their contributions to the Open Research movement. The Open Research practices and associated award badges, as implemented by the Center for Open Science and supported by *Psychology and Psychotherapy: Theory, Research and Practice*, are the following:

The Open Materials Badge recognizes researchers who share their research instruments and materials in a publicly-accessible format, providing sufficient information for researchers to reproduce procedures and analyses of published research studies. A list of certified data repositories can be accessed at **re3data.org** or **fairsharing.org**. Guidelines about the use of data repositories can found at websites such as The Wellcome Trust (**https://wellcomeopenresearch.org/for-authors/data-guidelines**) and the Center for Open Science (**https://cos.io/**).

The Open Data Badge recognizes researchers who make their data publicly available, providing sufficient description of the data to allow researchers to reproduce research findings of published research studies. An example of a qualifying public, open-access database for data sharing is the Open Science Framework repository. Numerous other data-sharing repositories are available through various Dataverse networks (e.g., **http://dataverse.org**) and hundreds of other databases available through the Registry of Research Data Repositories (**http://www.re3data.org**). There are, of course, circumstances in which it is not possible or advisable to share data publicly. For example, there are cases in which sharing participant data could violate confidentiality. In these cases, the authors may provide an explanation of such circumstances in the Alternative Note section of **the disclosure form**. The information the authors provide will be included in the article's Open Research note.

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Authors will have an opportunity at the time of manuscript submission to inform themselves of this initiative and to determine whether they wish to participate. Applying and qualifying for Open Research Badges is not a requirement for publishing with *Psychology and Psychotherapy: Theory, Research and Practice*, but these badges are further incentive for authors to participate in the Open Research movement and thus to increase the visibility and transparency of their research. If you are interested in applying, please note that you will be asked to complete the Disclosure Form when submitting a revised manuscript.

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BPS members and open access: if the corresponding author of an accepted article is a Graduate or Chartered member of the BPS, the Society will cover will cover 100% of the APC allowing the article to be published as open access and freely available.

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Once the paper is typeset, the author will receive an email notification with full instructions on how to provide proof corrections.

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When the article is published online:

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- The link to the published article can be shared through social media.
- The author will have free access to the paper (after accepting the Terms & Conditions of use, they can view the article).
- For non-open access articles, the corresponding author and co-authors can nominate up to ten colleagues to receivea publication alert and free online access to the article.

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Measuring the Impact of an Article

Wiley also helps authors measure the impact of their research through specialist partnerships with **Kudos** and **Altmetric**.

9. EDITORIAL OFFICE CONTACT DETAILS

For help with submissions, please contact: Hannah Wakley, Associate Managing Editor (**papt@wiley.com**) or phone +44 (0) 116 252 9504.

Author Guidelines updated 28th August 2019

Appendix N: Interview protocol

Interview Protocol v1

IRAS Project ID: 291953

Project Title: Exploring Experiences of Power in Therapeutic Relationships Between NHS Service Users and Clinical Psychologists.

Research question: How do NHS service users experience power in therapeutic relationships with Clinical Psychologists?

Pre interview (00:00) – not recorded

i. Greeting the participant and thanking them for their time.
ii. Checking in on their wellbeing prior to interview. This will include asking about how they are feeling today, if there is anything concerning them or worrying them and if they feel okay to complete the interview today. If there are concerns raised, then this will be discussed with the participant and support will be offered and options for further sources of support (including support from involved professionals) will be discussed.
iii. Confirmation of consent to take part in the interview checked.
iv. A brief outline of the interview and question themes will be given. 1. Overview of therapy and understanding of power 2. Relational Power in the therapeutic relationship 3. Structural power factors outside of therapy that affect the relationship
v. A brief review of agreed individual protocols for managing technical difficulties and emotional distress will be completed.
vi. The participant will be reminded that they are able to take breaks or withdraw at any point in the interview and also ask questions at any point.
vii. A final opportunity to ask any questions before the formal interview starts will be offered.
viii. Recording of the interview will start on the audio recording device and the interview will begin.

Semi Structured Interview (00:15) – recorded audio

This is the formal interview. Questions in bold are core questions. Questions beneath are ideas for prompts and further exploration and are used to guide the interviewer's thinking.

Overview of therapy and understanding of power (00:15)

1. **Would you like to share a little about how you came to therapy?**
   - How long have you had the difficulties you worked on in therapy?

  - How did the conversation about therapy first start?
  - Have you had multiple therapists?
  - What choices did you have about therapy?
2. **What does power mean to you?**
   - Is it something you have ever considered?
   - What does it mean to you to be a powerful person? What does it mean to be disempowered?
   - How would you describe someone/thing having power over you or you having power over someone/thing?
   - How, overall does power affect you?

Relational Power in the therapeutic relationship (00:30)

3. **Can you tell me what it was like first meeting with your psychologist?**
   - How would you describe how you first felt?
   - What was the first meeting like and how did you feel?
   - Was this in person or remotely? How did that affect things?
4. **Can you tell me about your relationship with your psychologist?**
   - What was it like speaking to them? Did you use the same language?
   - How do you think they saw your relationship?
5. **Did your feelings towards your psychologist or relationship change over the time you spent in therapy?**
   - What do you think contributed to the change in how you felt?
   - Did anything happen to make the change?
   - How do you feel about them now?
6. **Were there times when the relationship between you and your therapist felt more or less equal?**
   - What did this look like? What happened to make you feel this?
   - How did this impact on how you felt?

Structural power factors outside of therapy that affect the relationship (00:50)

7. **How do you think you are different from your psychologist**?
   - Age, gender, race, socioeconomic, sexuality etc
   - Did these factors get spoken about?
   - What did this mean for you?
8. **What things outside of the therapy room affected your relationship with your psychologist? ------- How did that affect you/the relationship?**
   - Probes: Structure of NHS, other professionals, other important systems (family, friends, colleagues), ideology, stigma, social pressure/norms
9. **Did you and your therapist think about these things?**
   - What did you do? What did they do?
   - Were there things you felt you couldn’t talk about regarding your relationship? Was there anything you felt your psychologist could not talk about

10. **Is there anything else you would like to say about your relationship with your psychologist?**

General prompts/probes:

1. Can you tell me more about X?
2. Could you clarify what you mean by X to make sure I have understood properly?
3. What did that mean for you?
4. What do you think would have been different if X didn't happen?

11. Is there anything I haven't asked that you would have expected or wanted me to ask?

Post-Interview (01:15) – not recorded

ix. After the participant has indicated they are finished, and the researcher has no further questions, then the **interview** will be closed, and the audio recording stopped.

x. The participant will be thanked for their effort in the interview and the last part of the session will involve a full debrief. There is no deception in the research and as such the aims of the research will have been stated throughout. This is an opportunity to discuss any aspect of the research further.

xi. The researcher will check in on the participant's wellbeing following the interview. This could include questions about how they are feeling after the interview and if there was anything difficult that came up for them that they would like to discuss further. If there are concerns raised, then this will be discussed with the participant and support will be offered and options for further sources of support (including support from involved professionals) will be discussed.

xii. The participant will then be offered the opportunity to ask any questions about the interview.

xiii. The researcher will confirm if the participant is happy to use their data in the study. If they agree then they will then be informed that they have three days to decide if they want to remove their data. They will be advised to contact the researcher during this period to inform them of this, otherwise it will be assumed that they are happy for their data to be used. They will be explicitly informed that it may not be possible to remove their data after this period.

xiv. Additional optional demographic information will also be asked to support the analysis, this includes their ethnicity, sexuality, employment status (now and during therapy), whether they have a disability and an approximation of when they finished therapy. They will also be asked to provide details of what they assumed the demographics of their Clinical Psychologist was. They are informed that this is not to identify the Psychologist but to ascertain what their perceptions of their Psychologists demographics were. The study is not interested in the actual demographics of the Psychologist, but the participants perceptions, as this will indicate potential structural power operations that might be occurring and will be useful in analysis. They will be informed that this is completely optional. The assumed demographics of their psychologist that will be collected are assumed gender, age, ethnicity, sexuality, and disability.

xv. The participant will then be asked if they would like a summary of the findings of the research. If they request this, they will be offered for the summary to be sent by email or post. They will also be offered the opportunity to discuss this with the chief investigator by telephone if they wish. Details on how to arrange this will be provided on the summary.

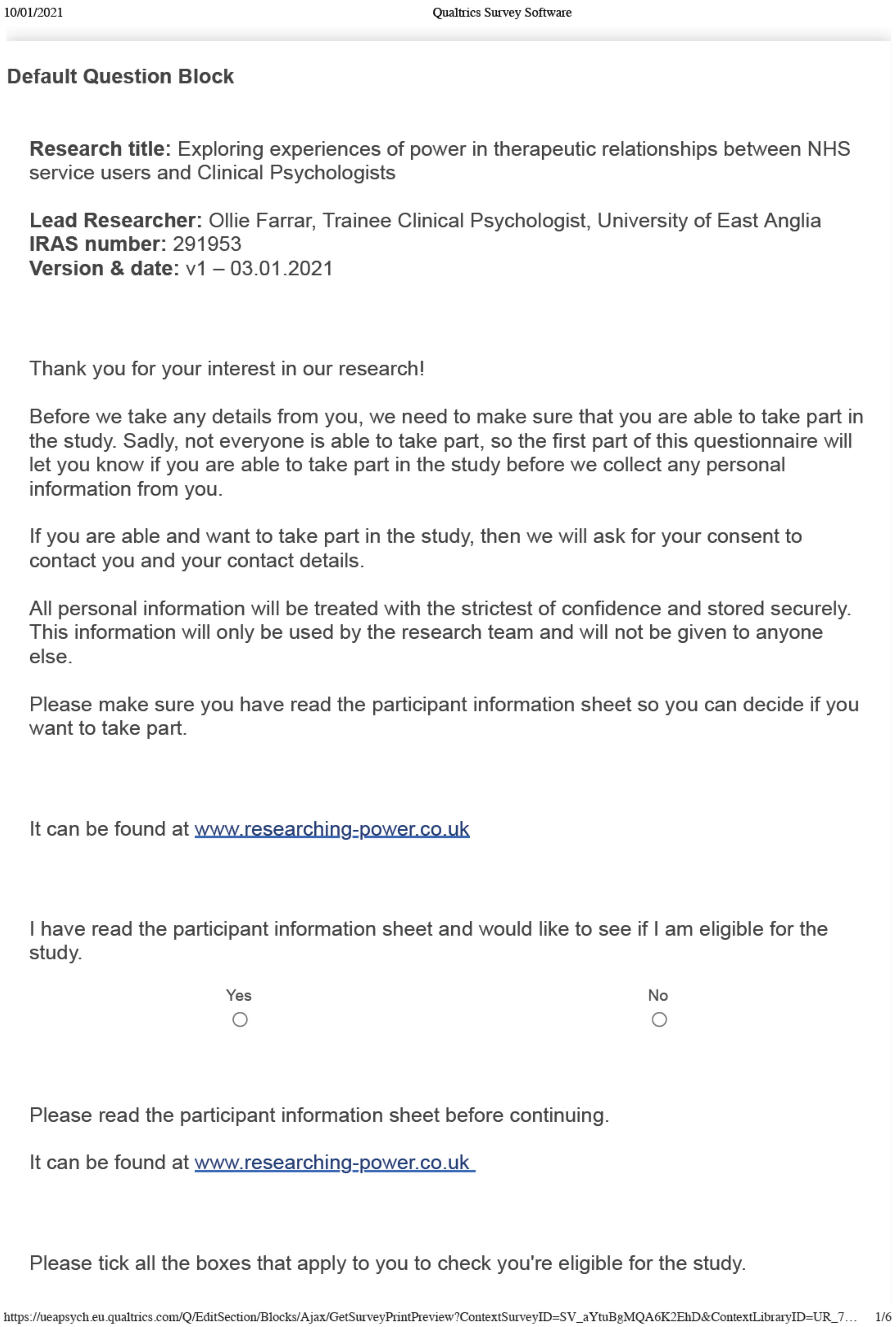
xvi. The participant will be asked on how they would like to receive their £10 Amazon voucher in gratitude for participation. This will be immediately sent out after the interview by post or email depending on the participant's preference.

xvii. The participant will be offered a final opportunity to ask any questions.

xviii. The participant will be thanked for their time and the interview session will be terminated.

End of interview (Total time - 01:30/90 minutes)

Appendix O: Electronic consent to contact form



10/01/2021 Qualtrics Survey Software

Default Question Block

Research title: Exploring experiences of power in therapeutic relationships between NHS service users and Clinical Psychologists

Lead Researcher: Ollie Farrar, Trainee Clinical Psychologist, University of East Anglia
IRAS number: 291953
Version & date: v1 – 03.01.2021

Thank you for your interest in our research!

Before we take any details from you, we need to make sure that you are able to take part in the study. Sadly, not everyone is able to take part, so the first part of this questionnaire will let you know if you are able to take part in the study before we collect any personal information from you.

If you are able and want to take part in the study, then we will ask for your consent to contact you and your contact details.

All personal information will be treated with the strictest of confidence and stored securely. This information will only be used by the research team and will not be given to anyone else.

Please make sure you have read the participant information sheet so you can decide if you want to take part.

It can be found at www.researching-power.co.uk

I have read the participant information sheet and would like to see if I am eligible for the study.

Yes	No
○	○

Please read the participant information sheet before continuing.

It can be found at www.researching-power.co.uk

Please tick all the boxes that apply to you to check you're eligible for the study.

https://ueapsych.eu.qualtrics.com/Q/EditSection/Blocks/Ajax/GetSurveyPrintPreview?ContextSurveyID=SV_aYtuBgMQA6K2EhD&ContextLibraryID=UR_7… 1/6

☐ 1. I am aged 18 or over.

☐ 2. I can speak and understand English.

☐ 3. I am not currently doing any form of psychological therapy or this therapy is due to finish in the next month. (This includes group or individual therapy working directly with a professional - E.g. CBT, CAT, Counselling)

☐ 4. I have am or have been under the care of an NHS Mental Health Team in the [redacted]

☐ 5. I have received one to one psychological therapy in the last 2 years.

☐ 6. My therapy has been with a Clinical Psychologist. (If you are unsure, tick the box and we will help you find out - if you do not tick the box then you will not be able to proceed)

☐ 7. This therapy was for 8 or more sessions.

☐ 8. I am not currently in Psychiatric Hospital or under a Community Treatment Order.

☐ 9. My therapy was not completed when in Psychiatric Hospital or under a Community Treatment order.

☐ 10. I am happy and able to meet via video link with the researcher using a personal computer, tablet or phone for the interview.

☐ 11. I am happy for the researcher to contact the person in charge of my care to let them know I am taking part in the research. This is either your Care Co-ordinator or Lead Care Professional if you are being supported by a mental health team. If you are no longer under the care of a mental health team then we will contact your GP.

☐ 12. My Care Co-ordinator or Lead Care Professional did not deliver my therapy. (If you are unsure, tick the box and we will help you find out - if you do not tick the box then you will not be able to proceed)

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

○ [redacted]

Thank you for your answers. Your responses indicate that you are able to take part in this study.

If you are happy for us to contact you to discuss the study further then please fill in the following form. You are not committing to taking part at this point, but you are letting us know that we can contact you to discuss it further and to allow us to provide you with additional information. Please answer all the questions as they will need to be answered to proceed.

I consent to give the research team my information and allow them to contact me.

○ Yes

○ No

[redacted]

[redacted]

[redacted]

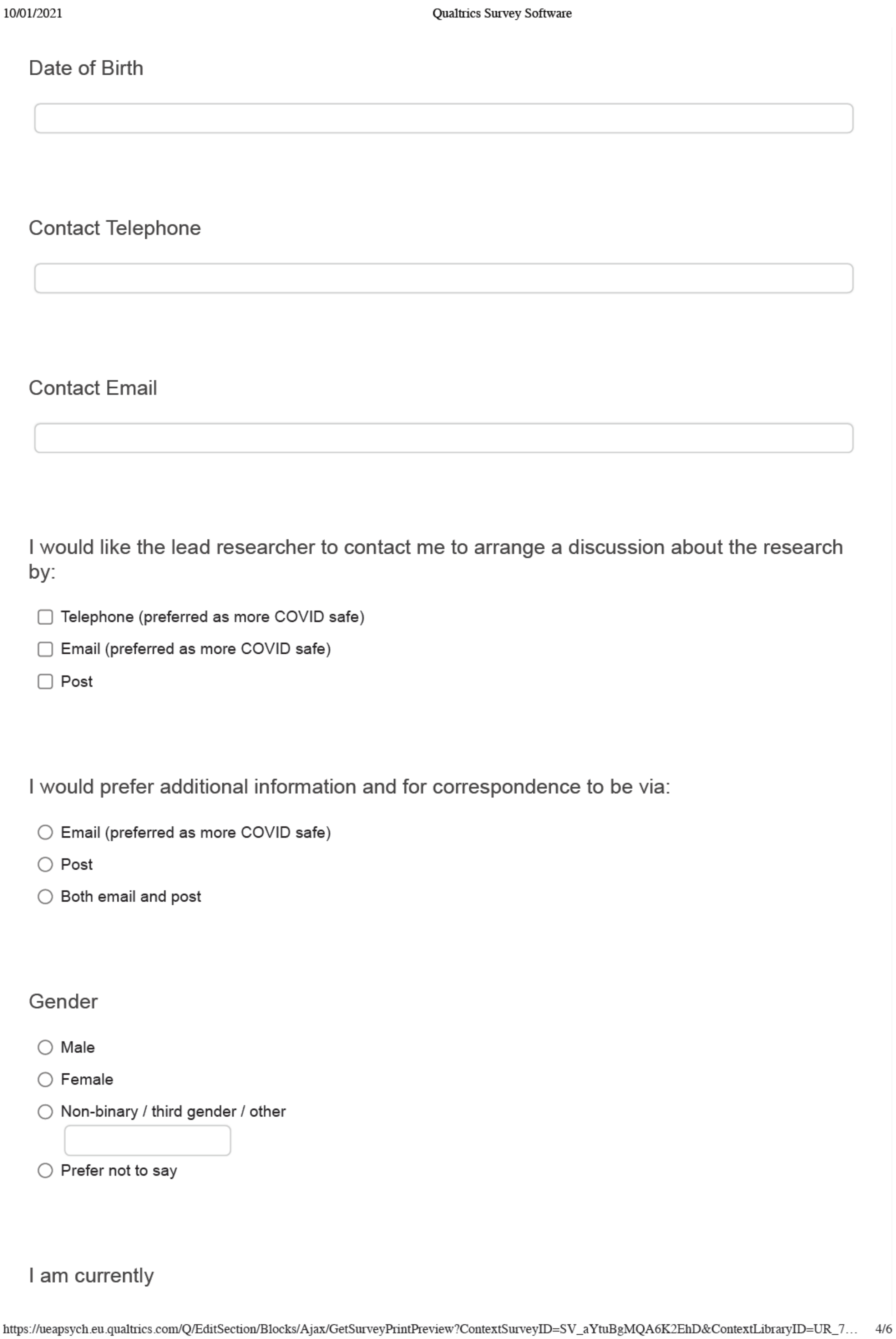
[redacted]

Thank you again for your interest!

○ Finish Survey

First name

Surname



Date of Birth

Contact Telephone

Contact Email

I would like the lead researcher to contact me to arrange a discussion about the research by:

☐ Telephone (preferred as more COVID safe)
☐ Email (preferred as more COVID safe)
☐ Post

I would prefer additional information and for correspondence to be via:

○ Email (preferred as more COVID safe)
○ Post
○ Both email and post

Gender

○ Male
○ Female
○ Non-binary / third gender / other
○ Prefer not to say

I am currently

○ Being supported by a Community Mental Health Team in [redacted]
○ I used to be supported by a Community Mental Health Team in [redacted] and now am discharged

If you are under a Community Mental Health Team what is the name of your Care Co-ordinator or the Lead Professional involved in your care? (if known)

Name of current or past Mental Health Team(s) at [redacted]? (if known)

GP name? (if known)

GP Surgery? (if known)

Thank you for completing the form!

The lead researcher (Ollie Farrar) will make initial in contact with you within 10 working days to arrange to discuss the research.

If there is significant demand to take part in the research then we may not be able to invite you to the study, but we will let you know as soon as possible if this is the case.

If you need to contact the research team in the meantime, please email info@researching-power.co.uk

Thank you so much for taking the time to fill in this form and for taking an interest in our research.

All the best,

Ollie Farrar
Trainee Clinical Psychologist
University of East Anglia

Appendix P: Participant information sheet

IRAS Project ID: 291953

Version 4, 25.05.2021

[redacted]

Ethics Reference Number (IRAS): 291953

PARTICIPANT INFORMATION SHEET

Study Title:
Exploring Experiences of Power in Therapeutic Relationships Between NHS Service Users and Clinical Psychologists.

Why have I been given this information sheet?

Thank you for taking the time to look at this information about the research we are doing. We are inviting you to take part in our research. Please have a good look at the following information and carefully think if you would like to take part. It is completely up to you whether or not you take part and taking part or not will not affect your care w [redacted] [redacted] or any other NHS care provider.

Why are we doing this research?

We are looking at better understanding the relationship between people who use NHS mental health services and Clinical Psychologists, who provide talking therapy. We are interested in how people experience working with their therapist. We are especially interested in ‘power’ in the relationship. We think that learning more about how people experience power will help us understand the relationship that people have in therapy better and allow us to think about how to do things better.

Why have I been asked to take part?

We are asking if you want to take part because you have expressed an interest taking part in the research. We are looking for people who have completed therapy with a Clinical Psychologist on a one to one basis. We also ask that this Clinical Psychologist is not your current Lead Care Professional (the person in charge of your care in the team). We are looking for people who have completed therapy whilst being an adult (18 years or older) and who have used community mental health services, which is sometimes called ‘secondary services’. It does not matter what type of therapy you have had or what that therapy was to help you with, but we would like to speak with people who have seen a Clinical Psychologist for at least 8 sessions of therapy within the last 24 months.

We are looking for between 8 to 10 people that want to take part. The most important thing is that you are comfortable taking part and feel that speaking about your experience of therapy would be something you both wanted and felt able to do. We cannot invite people who are currently undertaking therapy or people who have completed therapy with someone who was not a Clinical Psychologist. If you are unsure about whether you completed your therapy with a Clinical Psychologist or not, we can help you find out. We also cannot invite you if you received your therapy in hospital whilst detained under the Mental Health Act or when under a Community Treatment Order.

Who is organising and funding the research?

The researcher is Ollie Farrar, who is a Trainee Clinical Psychologist from the University of East Anglia (UEA) and is employed by [redacted]. The Chief Investigator for the project (the person in charge of the project overall) is Gillian Bowden, a Consultant Clinical Psychologist and Clinical Lecturer at the UEA.

The team also includes, Corinna Hackmann, a Clinical Psychologist working at [redacted] and Honorary Senior Research Associate at the UEA; and Hannah Zeilig who is a Visiting Research Fellow at the UEA, a senior research fellow at the University of the Arts London and who is also an expert by experience and lives with Bipolar.

Who has checked the study?

All research by the UEA in the NHS is looked at by another group of people, called the Health Research Authority (HRA). This is a national organisation that makes sure that all research that is done in the NHS is of good quality, abides by all the relevant laws and guidance, and is safe for everyone involved it in it. The North West – Greater Manchester West Research Ethics Committee has also reviewed this research on behalf of the HRA. They have said that this research meets their very strict criteria and is safe to do. We have also been given permission by [trust] to conduct the research in their organisation.

Do I have to take part?

No! It is entirely up to you! There is absolutely no pressure to take part and everyone involved will fully respect all decisions you make. There will be no changes made to any treatment, care or rights should you decide to take part or not. You do not have to give anyone a reason for not taking part if you do not want to. You can also change your mind at any point in the study.

What will happen if I take part?

The information on this sheet is to help you to make a decision as to whether you want to take part in the research. You will have seen it at least three days before you will need to make a decision as to whether you want to take part.

If you decide to take part, Ollie Farrar (the researcher) will contact you by telephone to answer any questions you might have about the research and to explain in more detail about what is involved. This will take roughly 30 minutes but can be longer if you have more questions.

If you decide you do want to take part you will be asked to sign a consent form to say you are happy to take part and that you have had the study explained to you. This will be done online through a link that we will send you. You can also chose to sign a paper copy of this form and post it back to us (using a prepaid, registered envelope) if you prefer.

Once you are happy with that we will arrange a time for an interview. This will likely be a few weeks later and take 90 minutes in total. You will meet with Ollie Farrar (the researcher), by a secure video link platform called Attend Anywhere. There will be time before and after the interview to discuss any concerns or questions you might have about the research. If you need a break at any point in the interview the you can take one whenever you need it.

Your safety will be the most important thing so we will discuss how we can do the interviews in a way that is in line with what the NHS advises and what you want. The audio (sound) from each interview will be securely recorded and stored (on a secure NHS computer) so that the research team can have a record of it and use what you both have discussed. Only the research team will have access to this recording and it will be transferred and stored securely on an NHS computer. Ollie Farrar (the researcher and interviewer) will transcribe (write down what was said) in the interview using the recording. Once this is done, the recording will be deleted, and the written transcript of the interview will be stored securely on an NHS computer. In the interview you will talk about your experiences of therapy with a Clinical Psychologist. There will be some questions that we ask everyone but for most of the interview you will be having general conversation about your experiences. You will not be asked to talk about anything that you do not want to discuss. There will also be opportunity to ask the interviewer questions.

After the interview the interviewer will check with you to make sure you are okay and whether you are still happy for us to use the data you collected together. You will be given three days following the interview to say if you do not want the data to be used and if you decide not to then you do not have to give a reason why you do not want it used. After this time, it might not be possible to remove your data from the study, but every effort would be made to do this and we would discuss this openly with you. Should you lose the ability to fully consent to the study before, during or in the three days after the interview then any information or data you have kindly given us would be removed and deleted. This is to protect you and to make sure you are giving information you are fully happy and able to give.

Once that is done your part in the research will be finished. You will be contacted after the study is written up to provide you with a copy of the results and offered the opportunity to discuss it by telephone, if that is your wish.

Where and when will the study be done?

The interviews will be conducted via secure video link so that you can do them at home or in a private place of your choosing. If you have any problems accessing a device to take part in the in the interviews, then we can work together to figure out an alternative that is most convenient for you.

How much of my time will it take?

The interview will be a maximum of 90 minutes, this includes time for questions and to check in with how you are feeling. The lead researcher will also call you before the interview to see if you want to take part and answer any questions you may have which will take around 30 minutes. The total expected time will be around two hours over two separate conversations.

How will we use the information about you?

We will need to use information about you for this research project.

This information will include the following:

- We will collect your name, date of birth, mailing address and contact details initially, as well of the name of the lead professional involved with your care, this is so we can contact you throughout the study. When the study is finished these details will be deleted. They will not be shared outside of the research team and will not be included in any of the final report or findings.
- Your age, gender, ethnicity, employment status, sexuality, whether or not you have a disability, will be collected to help us understand some of the differences between participants, however, it is your choice whether you tell us this.

- We will not ask for the name of the Clinical Psychologist that you have seen, nor will we inform them of you taking part in the research. However, if we are concerned about something to do with the Psychologist you saw then we might need to know their name. We would discuss this with you first.
- This researcher will ask you for information about the therapy you did. Particularly, what type of therapy (E.g., CBT), how many times you met with your therapist, and the type of location you would normally meet your therapist (E.g., online, home or in a clinic). The researcher may also ask you some questions about any assumptions you made about your therapist (E.g., their age or gender). You do not have to answer these questions if you don't want to.
- We will record the audio from the interview only. This will be the main source of data that we collect, and we will use this to complete the analysis. Any information in that might be used to identify you, your therapist, or the service you received your therapy in will not be shared outside of the research team and will be anonymised in the write up, so no one reading it would know who you are.
- If you decide to stop taking part in the study part way through, we will ask you if you would like to tell us why. It is up to you whether you tell us and is to help us see if we could do anything better.

People will use this information to do the research or to check your records to make sure the research is being done properly.

We will keep all information about you safe and secure.

Once we have finished the study, we will keep some of the data so we can check the results. We will write our reports in a way that no-one can work out that you took part in the study.

What are your choices about how your information is used?

- You can stop being part of the study at any time, without giving a reason, but we will keep information about you that we already have.
- We need to manage your records in specific ways for the research to be reliable. This means that we won't be able to let you see or change the data we hold about you.

Where can you find out more about how your information is used?

You can find out more about how we use your information

- at www.hra.nhs.uk/information-about-patients/
- our leaflet available from www.hra.nhs.uk/patientdataandresearch
- by sending an email to G.Bowden@UEA.ac.uk or info@researching-power.co.uk
- by ringing us on 01603 591213

What if I agree to take part then do not want to do the research anymore?

You are free to stop taking part at any time during the research without giving a reason. If you decide to stop, this will not affect your treatment or rights. You also have the right for your data to be removed from the study three days following the interview. After this time, it may not be possible to remove your data from the study, but we will discuss this with you.

Will anyone else know I'm doing this?

The people in our research team and your Lead Care Professional/GP will be aware you are taking part. We ask this so that they are aware of your involvement in the study and to help if you require any additional support when taking part in the study. We will only disclose what the study is investigating and not any of the details of the interview. However, we may have to tell someone else, which may include your GP, Lead Care Professional or the local safeguarding team, if you tell us something that suggests that you or someone else is at significant risk of harm. In the unlikely event that happens, we will do everything we can to involve you in this and discuss it with you first.

All information collected during the study will be treated as strictly confidential. The research team follow the EU General Data Protection Regulations Act 2018. All paper information, like paper consent forms, will be kept in a locked cabinet and locked office at the UEA. Any information about you will be kept on a computer will be stored on password protected and encrypted computer file or memory stick. We will change your name on the all the stored information as soon as reasonably possible and to make sure you cannot be identified. Only researchers at the University will be able to look at your personal information collected for the study.

When the research is written up and published all your data will be unidentifiable so that people reading will not know be able to know who you are.

Is there anything I should be worried about if I take part?

Your rights and wellbeing are our top priority and the research team will make sure that everyone involved in the study is kept safe, especially in light of the COVID-19 pandemic. For this reason, we will offer all the research to be completed online to all participants to make sure there is no risk of infection though close contact with the researcher as well as being sensitive to the additional strain that COVID-19 can put on people.

Sometimes talking about previous experiences can be upsetting and whilst we do not expect that the interviews will be upsetting, it is possible that you may feel this way. During the contacts we will discuss how you are feeling and whether you want to take part in the interview or call. Should you feel upset or distressed in any way then please let us know and you will be asked if you wish to continue and we will support you with whatever you decide to do. The researcher you will be speaking with is trained and experienced in providing support to people who are experiencing distress. They can also help you seek further support from your Lead Care Professional, GP or other mental health support agencies. We also ask for your consent to contact your Lead Care Professional or GP if we have any concerns during the study.

You will need to take some time to take part in the study. We will endeavour to keep this time to a minimum and hope that the benefits of taking part will outweigh this cost.

Will taking part help me?

This study is explicitly focused on understanding how people experience the relationship in therapy, and the findings of this are predicted to help inform service users, Clinical Psychologists and services how to work more effectively in therapy. However, there are no predicted benefits of taking part in the research, apart from a potential benefit of talking about and reflecting on your experience of therapy.

By taking part you will receive a £10 Amazon voucher for your time. This will be sent out to you by post or email after the interview. If you decide to withdraw from the study, you will still receive this voucher.

It is important to know that this is a research study, not a form of treatment for mental health problems. Therefore, if you are worried about your mental health or wellbeing, please speak to your GP or Lead Care Professional in your mental health team. Or you can contact either:

Samaritans – 24/7 confidential emotional support

Tel: 116 123

[redacted]**Mind Support Line**

Tel:[redacted]

[redacted]

Tel: [redacted]

[redacted] **Crisis line numbers,** [redacted]**:**

[redacted]

[redacted]

[redacted]

What happens when the study finishes?

Once all the interviews have been conducted the recordings of the interview will be typed up and analysed by the research team at the UEA. These findings will be written up and published.

What happens to the results of the research?

We plan to look at the information gathered from the study and share the results in presentations, publications and using social or national media. When we share the results, no one will be able to know you took part as we will make sure it is all anonymous and unidentifiable.

You will be asked if you want a copy of findings once the project is finished and ready to be published and if you do this will be sent out to you by post or email. You will also be able to discuss it with the researcher by phone if you wish.

Other researchers working on similar topics might ask to look at the results of our study as it could help them with their own research. Any results we share would all be anonymous.

Following UEA guidance, information collected during the study will be kept safely for at least 10 years following any publications before being destroyed.

What if there is a problem or something goes wrong?

If you are worried about anything relating to the research, please speak to someone from the research team and we will try our best to help you.

If you have a complaint about the research or researchers, please contact:

Professor Niall Broomfield, Head of the Department of Clinical Psychology and Psychological Therapies at the University of East Anglia.

Email: n.broomfield@uea.ac.uk Tel: 01603 591217

How can I find out more?

Please see our website for additional information:

www.researching-power.co.uk

You can contact the research team:

Oliver Farrar, Trainee Clinical Psychologist and Principal Investigator
Email: info@researching-power.co.uk or O.Farrar@UEA.ac.uk Tel: 01603 591213

Gillian Bowden, Consultant Clinical Psychologist, Clinical Tutor and Chief Investigator
Email: G.Bowden@UEA.ac.uk Tel: 01603 591213

What happens next?

Thank you for taking your time to read this information sheet. Please get in touch if you have any questions or want more information.

After giving you this information sheet, you will hear nothing from us for at least 72 hours (3 days). This is to make sure that you have time to read the information through and consider fully if you would like to take part. You will then be contacted by Ollie Farrar (the lead researcher) by telephone to discuss it further and to see if you want to take part.

If you decide that you would rather not take part in this study, you do not need to give a reason and no further contact will be made.

Thank you very much for considering this research,

Ollie Farrar

Principal Investigator

Appendix Q: Participant consent form

IRAS Project ID: 291953 Participant Consent form v.3 -25.05.2021

University of East Anglia

[redacted]

IRAS ID: 291953

Centre Number:

Study Number:

Participant Identification Number for this trial:

CONSENT FORM

Title of Project: Exploring Power in Therapeutic Relationships Between NHS Service Users and Clinical Psychologists.

Name of Researcher: Oliver Farrar

Please initial box

1. I confirm that I have read the information sheet dated.................... (version............) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected. ☐
3. I understand that relevant sections of data collected during the study, may be looked at by individuals from the University of East Anglia and from regulatory authorities or from the NHS Trust, where it is relevant to my taking part in this research. I give permission for these individuals to have access to my records. ☐
4. I give permission for my Lead Care Professional and/or GP to be informed of my participation in the research and given a copy of the 'participant information sheet'. I also confirm that they can be contacted with regards to any concerns that the researcher has. ☐
5. I confirm that I am 18 or more years old and have taken part in psychological therapy with a Clinical Psychologist for at least 8 one to one sessions within the last 24 months. ☐
6. I confirm that I did not receive psychological therapy whilst detained under the Mental Health Act or when under a Community Treatment Order and that I am not currently undergoing psychological therapy or counselling with a Clinical Psychologist, Psychological Therapist, Assistant Psychologist, Counsellor or Psychological Wellbeing Practitioner. ☐

7. I agree to take part in the above study. ☐

____________________	____________________	____________________
Name of Participant	Date	Signature
____________________	____________________	____________________
Name of Person taking consent	Date	Signature

Appendix R: Protocol for handling accusations against psychologists

Accusations against previous therapeutic interventions

Policies and Legal documents used to inform:

- Public Interest Disclosure Act 1998
- The Care Act 2014
- Serious Incident Framework – NHS Commissioning Board March 2015
- NHSE Patient Safety Strategy 2019
- British Psychological Society (BPS) Practice Guidelines 2017
- BPS Code of Ethics and Conduct 2018
- BPS Code of Human Research Ethics 2021
- Freedom to speak up policy July 2020 (HRP006)
- Patient Safety Incidents and Patient Safety Incident Investigation February 2021 – including the 'Patient Safety Checklist'
- Risk Management and Strategy Policy
- Safeguarding Vulnerable Adults Policy

Outline of procedure*

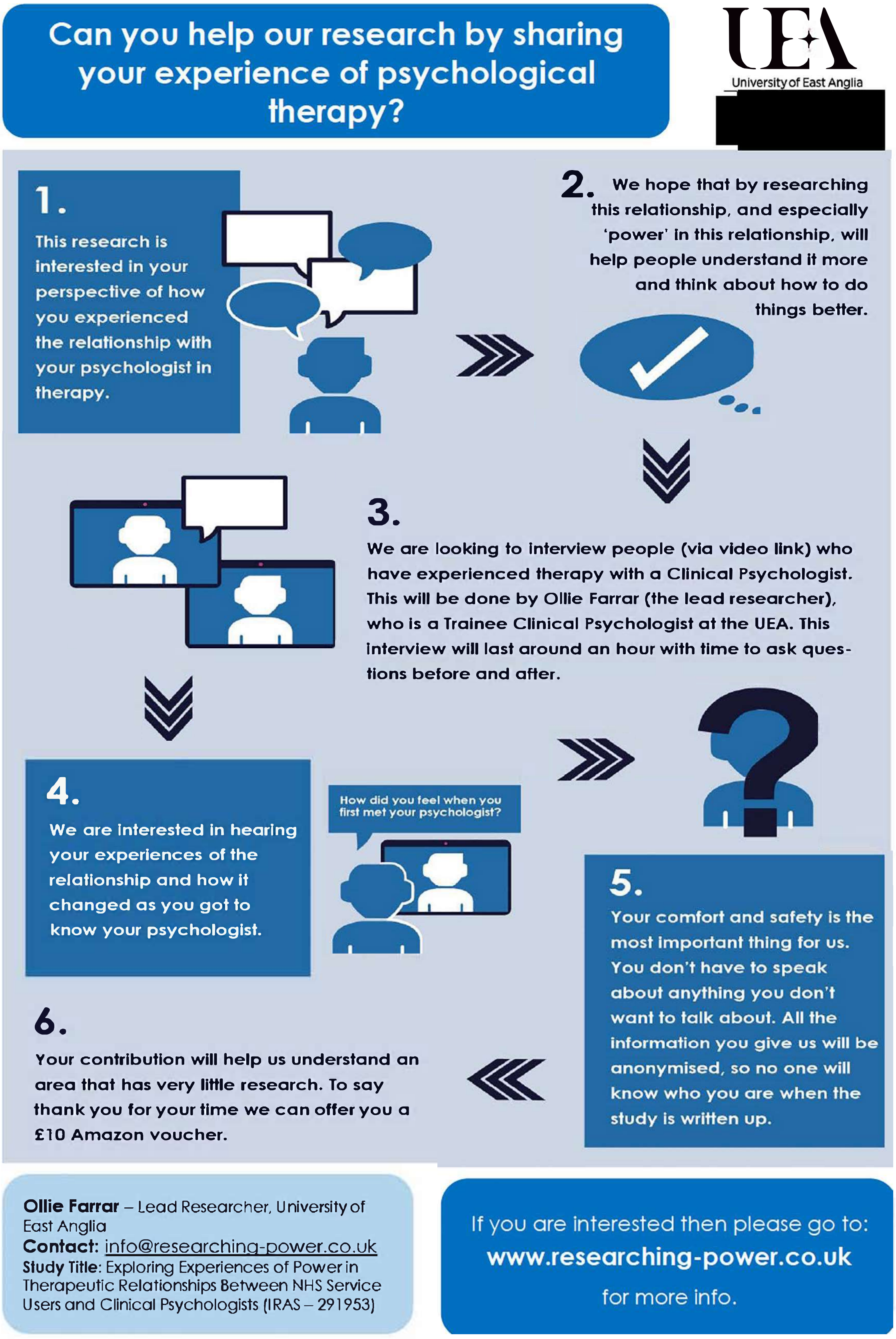
**All accusations will be treated individually and based on information available, the following is an outline for addressing concerns.*

1. Accusations and concerns against previous therapeutic inventions will treated very seriously if they occur during at any point in the research process.
2. Supporting the participant to feel safe is the primary concern of the researcher as well as to make sure their concerns are dealt with in a way that is respectful and provides protection and support.
3. Concerns may occur in several ways with either the participant raising concerns or the researcher having concerns about previous therapeutic interventions.
    a. If they are raised by the participant the interview will be halted and the participant will be encouraged to expand on their concerns and to establish if there is **risk of immediate harm**. If there is immediate risk of harm, the participant will be asked for details of the clinician involved and where the harm may be occurring and will be treated as any significant immediate risk incident informing the police and following the Trust's Patient Safety Incidents and Patient Safety Incident Investigation (PSII, February 2021) policy, which details how to respond and considers the process for speaking with all relevant Trust and external bodies (Safeguarding, HCPC etc).
    b. If concerns are suspected by the researcher the interview will be halted and the participant asked directly about this and if there is **any immediate risk of harm**. If there is immediate risk of harm the participant will be asked for details of the clinician involved and where the harm may be occurring and will be treated as any significant immediate risk incident informing the police and following the Trust's Patient Safety Incidents and Patient Safety Incident Investigation (PSII, February 2021) policy, which details how to respond and considers the process for speaking with all relevant Trust and external bodies (Safeguarding, HCPC etc).
4. If there is not immediate risk of harm, then further information will be sought to establish the nature of the of the concern and to discuss what the participant would like to happen, but within the agreed confidentiality agreement that they consented to. That is that

depending on the severity of the accusation and potential for further harm, that the researcher may have to disclose the information without the participants consent. However, the researcher and research team would want to do everything to support the participant to be part of this process. Should there be significant risk then the participant will be asked to disclose the name and team of clinician involved. They will be informed that the research team may have to get back in contact with them after this interview. If on further investigation (of the researcher's suspicions) there are not concerns, then the interview would be continued (but this discussed in supervision). The participant will always be asked if they want to continue and reminded that regardless of completion of the interview that they will receive the thank you gift voucher for taking part.

5. Following the ending of the call further guidance will be sought immediately from the supervisory team, who are very experienced at handling complaints and concerns at different levels. Dr Hackmann currently works in the trust as the Lead for and Dr Bowden has previously been a Lead Non-Medical Clinician and Lead Clinical Psychologist for the Trust. Interviews will be planned so that accessing supervisory support can be prompt, but that this will not impede action should it be warranted.
6. Should the disclosure be considered an immediate patient safety incident (or serious incident that caused significant or potential significant harm), then the Trust has clear guidance through their Patient Safety Incidents and Patient Safety Incident Investigation Policy (PSII, February 2021) as well as a checklist to follow. This considers all appropriate information sharing within the trust, safeguarding and other appropriate bodies.
7. Should the concern raised not be a serious patient incident then the trust has a policy for reporting suspected poor practice. This is the Freedom to Speak Up Policy and details exactly how concerns can be raised internally and externally of the Trust (including raising issues with professional governing bodies), as well as having a Freedom to Speak Up Guardian who can provide advice and support for this process.
8. The participant will be encouraged and supported to make a complaint through the Trust's complaints procedure for less serious concerns. The researcher will explain that if this is not resolved satisfactorily that they participant has the right to go to the Parliamentary and Health Service Ombudsman to have their complaint reviewed.

Appendix S: Research flyer



Can you help our research by sharing your experience of psychological therapy?

University of East Anglia

[redacted]

1. This research is interested in your perspective of how you experienced the relationship with your psychologist in therapy.

2. We hope that by researching this relationship, and especially 'power' in this relationship, will help people understand it more and think about how to do things better.

3. We are looking to interview people (via video link) who have experienced therapy with a Clinical Psychologist. This will be done by Ollie Farrar (the lead researcher), who is a Trainee Clinical Psychologist at the UEA. This interview will last around an hour with time to ask questions before and after.

4. We are interested in hearing your experiences of the relationship and how it changed as you got to know your psychologist.

5. Your comfort and safety is the most important thing for us. You don't have to speak about anything you don't want to talk about. All the information you give us will be anonymised, so no one will know who you are when the study is written up.

6. Your contribution will help us understand an area that has very little research. To say thank you for your time we can offer you a £10 Amazon voucher.

Ollie Farrar – Lead Researcher, University of East Anglia
Contact: info@researching-power.co.uk
Study Title: Exploring Experiences of Power in Therapeutic Relationships Between NHS Service Users and Clinical Psychologists (IRAS – 291953)

If you are interested then please go to:
www.researching-power.co.uk
for more info.

Would you like to take part in research?

Could you share your experience of talking therapy with us?

We are interested in hearing the perspectives of people who have had talking therapy with a Clinical Psychologist. We are especially interested in how you experienced this relationship.

- Are you 18 or older?
- Have you had 1:1 talking therapy with a Clinical Psychologist in the NHS?
- Would you be happy to to take part in an hour interview to talk about the relationship between you and your psychologist?
- We can offer a £10 Amazon voucher in thanks.

If you are interested in taking part then please go to

www.researching-power.co.uk

for more info.

Ollie Farrar – Lead Researcher, University of East Anglia
Contact: info@researching-power.co.uk
Study Title: Exploring Experiences of Power in Therapeutic Relationships Between NHS Service Users and Clinical Psychologists (IRAS – 291953)

[redacted]

Appendix T: Ontological and epistemological position statement

My Position Statement

My Ontology

1. Ontological positions are a spectrum, not absolutes.
2. I lean generally more to a relativist position. But not globally (radical). Therefore, see self as a local (Subtle) relativist.
3. Specifically, where I deviate is in terms of an individual's subjectivity, and their reality is 'real', not wanting to deny it in the classic equal equivalence arguments – not quite CR but defo not fully SC.
4. However, in many other areas I ascribe more relativist ontology (morals, ethics etc).

My Epistemology

1. Much more social constructionist in epistemology.
2. Reality described through contextualised & socially constructed discourses.
3. IPA is oft conducted in constructivist/interpretivist perspective (which is a softer form of SC opposed to CDA/FDA)
4. IPA is sympathetic to SC and acknowledgement that meaning making processes involve the speaker taking-up and mobilising certain discursive resources.
5. IPA hermeneutic interrogation leans more to empathy opposed to suspicion.

My Methodology

IPA

- IPA sees the person as an experiencing, meaning making, embodied and discursive agent.
- With IPA, it is not the case that the analysis is driven by theoretically derived categories.

Phenomenology

- Phenomena different to the experience – IPA Really focuses on the phenomena but specifically how this shed light on the Experience.
- A persons experience of the phenomena and how they make sense of it opposed to the phenomena (more global, less ideographic) itself.
- Attn to desire, wishes, feelings/EMOTIONAL QUALITY, motivations, belief systems and how they manifest (or not in beh and action).
- Looking at what appears, not what I am trying to fit it to.
- One has to access the phenomena and particularly the EXPERIENCE OF IT
- Exploring the phenomena and experience allows the research to resonate – which give credibility
- MEANING MEAKING INVOVLES DISCURIVE RESOURCES – trope etc

Hermeneutics

- Interpretation – links nicely with Heidegger interpretivist phenomenology
- Positions of empathy and suspicion
- *Empathy* tends to focus on the content of talk, and aims to reconstruct the speaker/author's experience in their own terms

- *Suspicion* takes a more critical view of language and the role of the speaker/author, and draws on external theoretical perspectives to deconstruct the social-structure of their talk (Smith et al., 2009; Sullivan, 2010)
- Less suspicion so not denying reality of participants – suspicion comes from perspective of curiosity
- Bridge between a constructivist and crit realist epistemology

Ideography

- The part and whole, single text/cohort, word/sentence
- Contextualised

My Analytic Resources

- MORE THAN ANYTHING DO NOT MISS THE EXPERIENCE AND BE FAITHFUL TO THE PHEONOMENA
- Attn to desire, wishes, feelings/EMOTIONAL QUALITY, motivations, belief systems and how they manifest (or not in beh and action).
- GEMS (interpretive tool) shining (brilliant utterance because true), suggestive gem (meaning harder to see – move round hermeneutic circle), secret gem (most elusive – small quiet part)shine light on someone's grasp of their world
- Moving between the part and whole on different analytical levels.
- Transitions/shifts, life stages.
- Discursive resources – tropes, common places, common sense
- Mindfulness as way of bridling and staying open
- Bridling and bracketing – awareness of reflexivity
- Descriptive commentary – important things that make up their lifeworld the things that matter (because you are trying to develop understanding of the meaning of these (objects, events, experiences in lifeworld)
- Linguistic comments – (pronoun use, repetition, tense, pause, laughter, metaphor, simile, Discursive devices
- Conceptual comments (overarching understanding of participants matters, moving away from explicit claims, dialogue with own reflections (Gadamerian dialogue?)
- Emergent themes – reduce volume of data THEMES are phrases that speak to psychological essence of the of the piece – BUT GROUNDED TO THE TEXT!

Quality in IPA

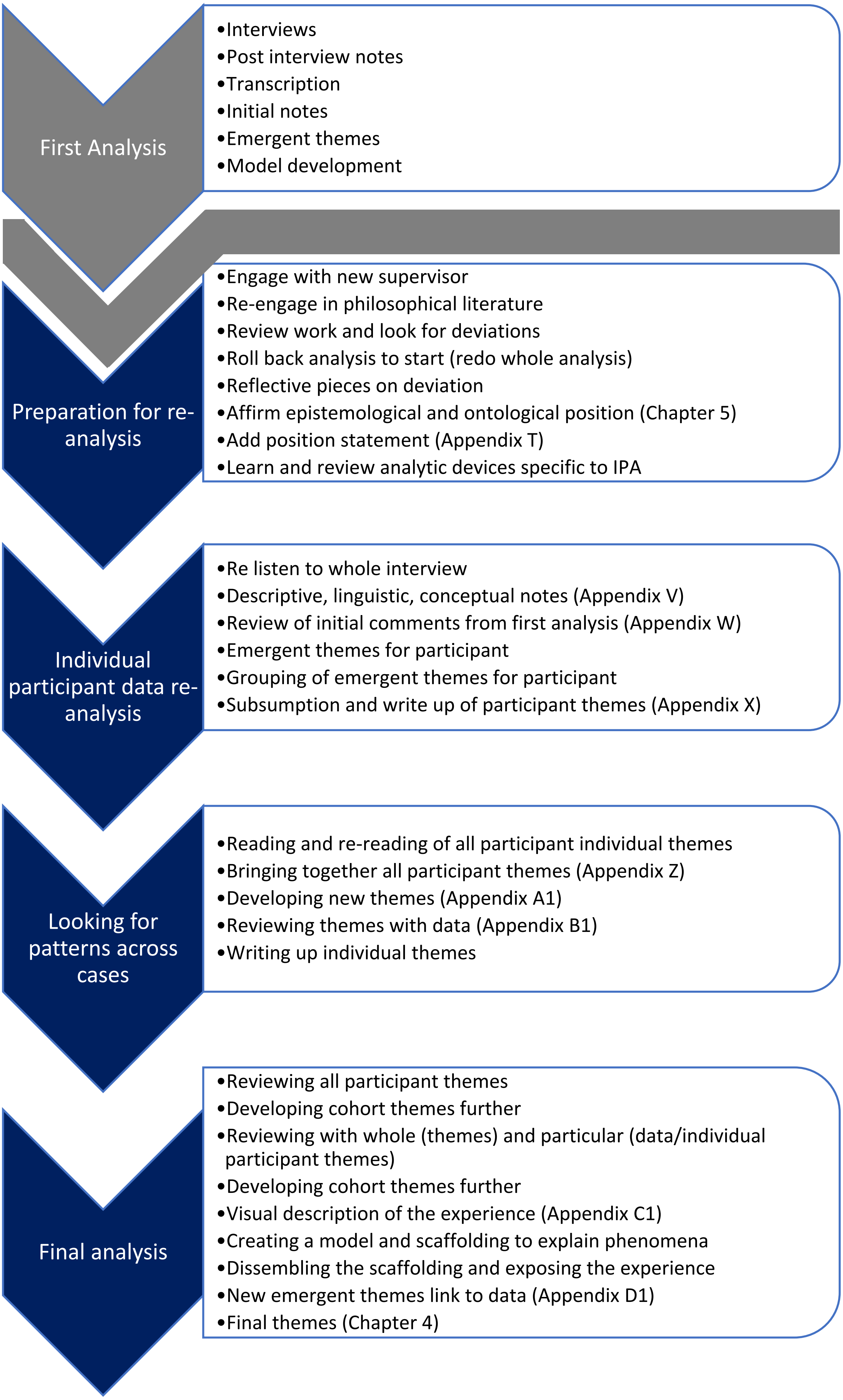
1. Compelling narrative of experience – (hermeneutics)
2. An experiential account (phenomenology)
3. Close analytic reading of the part/words (interpretive)
4. Attending to convergence and divergence (ideography)

My Reflexivity

- My Why for the research
    - Justice – highlighting that power operates, even when we think it isn't
    - Power is oft hidden elusive – opportunity to connect
    - Amplifying their voice and experience

  - TO LEAVE PEOPLE CHANGED FROM READING?
- Traps
  - Trying to create framework or guidance – if I am chasing that I'm not pay attn to the experience
  - Too much suspicion and tying experience to theory toooooooooo early!
  - NOT THE NATURE OF POWER IN THE TR BUT EXPERIENCES AND UNDERSTANDING OF IT.
  - Unbridled – running towards my assumptions.
  - Leaping to psychological formulation and missing the phenomena

Appendix U: Analysis flow chart



First Analysis

- Interviews
- Post interview notes
- Transcription
- Initial notes
- Emergent themes
- Model development

Preparation for re-analysis

- Engage with new supervisor
- Re-engage in philosophical literature
- Review work and look for deviations
- Roll back analysis to start (redo whole analysis)
- Reflective pieces on deviation
- Affirm epistemological and ontological position (Chapter 5)
- Add position statement (Appendix T)
- Learn and review analytic devices specific to IPA

Individual participant data re-analysis

- Re listen to whole interview
- Descriptive, linguistic, conceptual notes (Appendix V)
- Review of initial comments from first analysis (Appendix W)
- Emergent themes for participant
- Grouping of emergent themes for participant
- Subsumption and write up of participant themes (Appendix X)

Looking for patterns across cases

- Reading and re-reading of all participant individual themes
- Bringing together all participant themes (Appendix Z)
- Developing new themes (Appendix A1)
- Reviewing themes with data (Appendix B1)
- Writing up individual themes

Final analysis

- Reviewing all participant themes
- Developing cohort themes further
- Reviewing with whole (themes) and particular (data/individual participant themes)
- Developing cohort themes further
- Visual description of the experience (Appendix C1)
- Creating a model and scaffolding to explain phenomena
- Dissembling the scaffolding and exposing the experience
- New emergent themes link to data (Appendix D1)
- Final themes (Chapter 4)

Appendix V: Exemplar extract and initial noting

Transcript	Initial reflections	Descriptive notes	Lingusitic notes	Conceptual notes	Emergent themes
O: Okay so um yea should we just start with ummm I mean would you like to share a little bit about how you came to therapy Kate?					
K: Yea, umm so I think I first came to therapy when I was referred by the mental health crisis team at [general hospital].					
O: Yea					
K: ummm so I was going through a little bit of difficult time and I had been quite ill umm I have got problems with my kidney and I've been in and out of hospital since an operation3 I had [O:ohh] that had went wrong and I had just been feeling a bit down and feeling a bit suicidal4, so I took an overdose of sleeping tablets and so I went into hospital in [location] and then following my discharge I had the mental health crisis team there that came to talk to me and that's how I was referred to therapy [O: yea]. And they contacted me not long after by email and kind of arranged the appointment5	3 Physical health problems- plus a pandemic, make for a very understandable reason to be distressed. The operation as a trigger event	**I've been in and out of hospital since an operation3 I had [O:ohh] that had went wrong and I had just been feeling a bit down and feeling a bit suicidal4, so I took an overdose of sleeping tablets and so I went into hospital in [location] -** causation of medical negligence leading to MH crisis	**feeling a bit suicidal4, so I took an overdose of sleeping tablets and so I went into hospital in [location]** scene setting, feeling a bit suicidal so took an overdose - minimisation (avoid judgement?)	Operation that went wrong - impression of NHS?	**feeling a bit suicidal, so I took an overdose of sleeping tablets and so I went into hospital in [location]** scene setting, feeling a bit suicidal so took an overdose - minimisation (avoid judgement?)
	4 This is quite a minimised way of describing how you are feeling before attempting to take your life. I wonder if this speaks to how much is disclosed in interview?				**I've been in and out of hospital since an operation3 I had [O:ohh] that had went wrong and I had just been feeling a bit down and feeling a bit suicidal4, so I took an overdose of sleeping tablets and so I went into hospital in [location] -** causation of medical negligence leading to MH crisis
	5 Help coming at the point when it was needed, so she was seen and then after that they got in touch very shortly afterwards to arrange therapy. That never happens. I wonder what it speaks to in terms of outcomes, turns out a one-year waiting list, which is the norm, foster some sort of irritation/power with the system.				
O: okay thank you for sharing that with me. You said they contacted you by email, did you have any choices of the kind of therapy or service that you got from them?					
K: umm so at first they contacted me by email to let me know about arranging an appointment for like a triage telephone call. They did say that the initial triage would be by telephone umm I honestly can't remember if I had any options,6 umm, at that time I think it was just telephone to be honest, [yea] they might have offered a video call? Ummm but yea ummm on the initial triage which was telephone, I opted for the CBT by telephone,7 umm and yea that was kind of the course of therapy that I chose. I think it was just kind of recommended to me by the triage call I think they kind of worked out from there what would be the best course of therapy for me, so I just kind of went along with that, it seemed to be the best option at that time.8	6 No options being offered, she someone who isn't experienced in mental health treatment? I wonder what her knowledge of options could have been available was? Then I can imagine, in that early phase it's unlikely to have been at the forefront of the mind to get out, incredibly quickly. I wonder if she knew how quickly she was getting it question	**Ummm but yea ummm on the initial triage which was telephone, I opted for the CBT by telephone,7 umm and yea that was kind of the course of therapy that I chose. I think it was just kind of recommended to me by the triage call I think they kind of worked out from there what would be the best course of therapy for me, so I just kind of went along with that, it seemed to be the best option at that time -** just kind of went along with it, no choices offered.		Just kind of went along with it at the time, wanting to be helped? Feeling powerless? She had limited options or did not know where to go herself.	I just kind of went along with it' - indicates lack of choice

Transcript	Initial reflections	Descriptive notes	Lingusitic notes	Conceptual notes	Emergent themes
	7 Suggesting that there was a choice in terms of how the therapy was delivered but she went for telephone, or even other therapy options. I think it was pretty in the middle of the pandemic as well,	Seemed to be the best option at the time.			**Ummm but yea ummm on the initial triage which was telephone, I opted for the CBT by telephone,7 umm and yea that was kind of the course of therapy that I chose. I think it was just kind of recommended to me by the triage call I think they kind of worked out from there what would be the best course of therapy for me, so I just kind of went along with that, it seemed to be the best option at that time -** just kind of went along with it, no choices offered.
	8 Just kind of went along with it, it seemed like the best option at the time, that makes sense, something about not having much 'mental health experience' here maybe? Or is it something to do with personality? Like she just fairly compliant/acquiescent? I also think, this would have affected, there is the limited experience of being treated mental health, the preconceptions that brought into the room, and the room-need to look at how she viewed the NHS.				Just kind of went along with it at the time, wanting to be helped? Feeling powerless? She had limited options or did not know where to go herself.
O: [yea] okay doke yea and definitely that makes sense if that's what they kind of what they've yea recommended from the call with with that.					
K:Because when they kind of called me, I wasn't really sure I'd never really been in therapy before I didn't really know what I needed, so I just kind of went along with what they recommended, umm yea that sounded good at that time.9	9 See, she's never been into therapy before. Imagine how the other transcripts would have looked if these were the first times that people going into therapy, and they went straight in opposed to waiting for ages	Not really knowing what needed so went along with it.		Wonder if no prior experience impacted on this. With limited knowledge there is limited choice unless offered and explained.	**I didn't really know what I needed so I went along with it.**
O: Yea. Would you have done anything different with what you know now?		**Because when they kind of called me, I wasn't really sure I'd never really been in therapy before I didn't really know what I needed, so I just kind of went along with what they recommended, umm yea that sounded good at that time. -** inherent power in their opinion and expertise because of no prior knowledge or exp - not a bad thing			**Because when they kind of called me, I wasn't really sure I'd never really been in therapy before I didn't really know what I needed, so I just kind of went along with what they recommended, umm yea that sounded good at that time. -** inherent power in their opinion and expertise because of no prior knowledge or exp - not a bad thing
K: No I don't think so, cos at that time it was really helpful for me. So I don't think I would have done anything different. No.10	10 Suggest that she is very happy with therapy, or just doesn't know what could have been different,.... Was good essay acquiescence/compliant again by wonder if I'm getting pulled into thinking that because from other experiences and from other interviewees this just isn't the norm?	helpful experience at the time		It's hard to think of the lack of choice when the outcome was faviourable for her - **No I don't think so, cos at that time it was really helpful for me. So I don't think I would have done anything different**.	It's hard to think of the lack of choice when the outcome was faviourable for her - **No I don't think so, cos at that time it was really helpful for me. So I don't think I would have done anything different**.
O: Okay thank you and you said you had umm CBT was there anything that you were particularly focused on in the CBT?					

Transcript	**Initial reflections**	**Descriptive notes**	**Lingusitic notes**	**Conceptual notes**	**Emergent themes**
K: Yea ummm so it was CBT for mainly based around anxiety and worrying.11	11 This sounds very bread-and-butter, and anxiety work is generally much less complicated than other stuff and generally has better outcomes.				
O: Yea					
K: And then just kind of getting away from that kind of headspace of worry about everything umm then overwhelming. An yea it focused on that really.		wanting to escape from worry, overwhelming	Headspace - metaphor, all consuming? / overhwleming	Escape from current emotional situation - indicates preoccupied with it most of the time **- And then just kind of getting away from that kind of headspace of worry about everything umm then overwhelming**.	Coming in and wanting Escape from that kind of headspace -
O: Yea, And you said that you found it helpful is that right, did I hear that right?					Escape from current emotional situation - indicates preoccupied with it most of the time **- And then just kind of getting away from that kind of headspace of worry about everything umm then overwhelming**.
K: Yea definitely **O: Yea**					
K: It was really helpful12	12 I have no problem believing this. She got a service quickly, she got better, she got back to doing what was doing, although there was a lockdown after this when her therapy finished think, there were a lot more freedoms than in the previous lockdown's people were better prepared to think about what keeps them good in this situation.	Really helpful therapy - **It was really helpful**	definitely - very certain in that		Really helpful therapy - **It was really helpful**
O: Did you meet the same person sort of … K: Yes soo umm so I think it was over 10 weeks , it might of been 12, I think ummm but it was the same person yea same person every week that I spoke to on the phone. **O: Lovely okay Brilliant. That's Really really helpful. Is there anything else which you wanna share kinda about your story journey going in to therapy or…** K: Ummm **O: Does that sort of cover it?**					
K: Ummm It think that pretty much covers it yea, that is kind of my first ever experience with therapy.13	13 She didn't have that kind of anx to get her story out		Spoke very calmly and clearly about her story, matter of fact (minimisation> little suicidal)	**First ever experience with therapy -** and a postive expeirence - important that first time was good. And specifically no poor experiences to relate it too	**First ever experience with therapy -** and a postive expeirence - important that first time was good. And specifically no poor experiences to relate it too
O: Yea K: And it was all kind of, it started very quickly,					
O: it started quickly?					**yea, there wasn't much waiting around it was just kind of like I literally came out of hospital on the Thursday and within the next week or 2 that I got the email and got triaged very quickly. -** the speed that it happened, no waiting, as it should be

Transcript	Initial reflections	Descriptive notes	Lingusitic notes	Conceptual notes	Emergent themes
K: yea, there wasn't much waiting around it was just kind of like I literally came out of hospital on the Thursday and within the next week or 2 that I got the email and got triaged very quickly. And yea kind of started from there14	14 Again therapy started so quickly			**yea, there wasn't much waiting around it was just kind of like I literally came out of hospital on the Thursday and within the next week or 2 that I got the email and got triaged very quickly. -** the speed that it happened, no waiting, as it should be	
O: I mean that's that's really quick.					
	15 Pushed it through? Does she acknowledge that was quick, also for someone who has limited experience of mental health services,				
K: Yea, yea I do remember it being quite quick, umm. But I don't whether that was anything to do with the fact that I was referred by the MH crisis team or anyone at the hospital had pushed it through. I'm not sure,15		quick from triage and crisis to therapy	pushed it through - refferal - indicates special treatment or urgency (makes diffs seen taken seriously?)	that feeling that things have been taken seriously? Someone pushed it through. Speaking that the liaison team had power to make things happen - someone or system advocating for her - must have been validating for her and her actions. **Yea, yea I do remember it being quite quick, umm. But I don't whether that was anything to do with the fact that I was referred by the MH crisis team or anyone at the hospital had pushed it through.**	being taken seriously - people advocating for her - validating
					that feeling that things have been taken seriously? Someone pushed it through. Speaking that the liaison team had power to make things happen - someone or system advocating for her - must have been validating for her and her actions. **Yea, yea I do remember it being quite quick, umm. But I don't whether that was anything to do with the fact that I was referred by the MH crisis team or anyone at the hospital had pushed it through.**
O: yea brilliant					
K: I don't remember there being much time to think worry about it, it just started it haha16	16 Just that time not to worry about it, to mull it over, initially someone who was anxious anyway, and a worrier, which could have been very different with a long wait.		laughter as if she would worry about it- or indicating that this was something she would normally worry about. **I don't remember there being much time to think worry about it, it just started it haha**		laughter as if she would worry about it- or indicating that this was something she would normally worry about. **I don't remember there being much time to think worry about it, it just started it haha**
O: Yea					

Transcript	Initial reflections	Descriptive notes	Lingusitic notes	Conceptual notes	Emergent themes
K: which was kinda best I think because it don’t really give you the time to kind of umm and arghh about it, you’re just kinda doing this and it is starting now hahaha. Okay so yea cos that I guess that that space to just sort of mull things over and sort of17	17 Mull it over, it's just starting.... Something to do, with that power, good power, of clinicians saying you are in a bad place, this is what you need, and here is, and are just getting swept up in that because it went well she can look back on it well, opposed to being pressured into it.	starting quickly, no chance to mull over.	**You're doing this** - externalising force (in self?) it's starting now. Who is saying that is it her internal mono or is it something external -sounds internal	Not having the chance to get worried about it - As if she thought about it it could be unpleasant or scary? **- which was kinda best I think because it don’t really give you the time to kind of umm and arghh about it, you’re just kinda doing this and it is starting now hahaha. Okay so yea cos that I guess that that space to just sort of mull things over and sort of Kind of may be put you off it, but I didn’t really have that chance. -** They were taking charge?	you're just kinda doing this and it's starting now - helpful push? **You're doing this** - externalising force (in self?) it's starting now. Who is saying that is it her internal mono or is it something external -sounds internal Not having the chance to get worried about it - As if she thought about it it could be unpleasant or scary? **- which was kinda best I think because it don’t really give you the time to kind of umm and arghh about it, you’re just kinda doing this and it is starting now hahaha. Okay so yea cos that I guess that that space to just sort of mull things over and sort of Kind of may be put you off it, but I didn’t really have that chance. -** They were taking charge?
O: Yea K: Kind of may be put you off it, but I didn’t really have that chance. **O: That’s really interesting. Roughly when did it start, when did this happen for you Kate?** K: Ummm, I can’t remember I think it was around October 2020, I think, yea, yea around October, I think.					
O: That’s right in the middle of the pandemic.18	18 Or is happening at this point in the country, because that's important, it was when things were had opened up over summer, eat out to help out, and stuff was starting to get serious again. Next month was another lockdown, Christmas cancelled, then long lockdown from Jan to when ever				
K: Yea					
O: Really tricky time. Good ummm, So can the shift focus a little bit, umm, next question is what does power mean to you?					
…					

Transcript	Initial reflections	Descriptive notes	Lingusitic notes	Conceptual notes	Emergent themes
K: I think it's more like someone having kind of the authority ummm and kind of ability to actually action something, umm, mmm yes, it's a tricky one, I think when someone kinda says power you think about someone who is high authority, makes all the decisions, yea.		power is is described as authority impacting on action/decision		**I think it's more like someone having kind of the authority ummm and kind of ability to actually action something, umm, mmm yes, it's a tricky one, I think when someone kinda says power you think about someone who is high authority, makes all the decisions, -** is in charge (authority) makes ALL the decsisions **- ummm, yea that kinda what I think of power is authority, the power to make decisions**	**I think it's more like someone having kind of the authority ummm and kind of ability to actually action something, umm, mmm yes, it's a tricky one, I think when someone kinda says power you think about someone who is high authority, makes all the decisions, -** is in charge (authority) makes ALL the decsisions **- ummm, yea that kinda what I think of power is authority, the power to make decisions**
O: Yes, its tricky concept isn't it? K: Yea it can be used in so many different contexts, ummm, yea that kinda what I think of power is authority, the power to make decisions19	19 Authority, having authority. Being able to action something, facilitating change? How people describe the power, does that give us clues as to how they experience power? Like authority, for Kate, I give feels pretty neutral compared to some of the others. Use different in many different contexts the power to make decision's, that file say that authority	power used in many different contexts		Power is contextual and reaches many contexts **- Yea it can be used in so many different contexts,**	Power is contextual and reaches many contexts **- Yea it can be used in so many different contexts,**
O: Yea K: And kind of unrestricted **O: Unrestricted?**					
K: Not really anything standing in your way, if you've got power there's not really much stopping you doing what you want.20	20 Goes a bit darker here, that unrestricted, the word standing in your way, which gives it a more unconsensual vibe. She was pretty unsure when she was describing this, hesitant almost, but this was something she hadn't really thought about before.	Powerful - not really anything standing in your way or doing what you want	hesitant in description of this	even if the other doesn't want it. **unrestricted** - they can do what they want…. Not standing in their way (even if the other doesn't want it) **Not really anything standing in your way, if you've got power there's not really much stopping you doing what you want.20**	powerful nothing standing in your way **unrestricted** - they can do what they want…. Not standing in their way (even if the other doesn't want it) **Not really anything standing in your way, if you've got power there's not really much stopping you doing what you want.20**
O: That sounds from the person the person who has that like quite a strong position, is that right? Umm yea, is it something you've ever really though of before?					

Transcript	Initial reflections	Descriptive notes	Lingusitic notes	Conceptual notes	Emergent themes
K: No not really, no hahaha, so ummm no I think ever been asked that to be honest, that’s just kind of what comes to mind.21	21 See she hasn't really thought of that before. I wonder, because she doesn't seem to have the trauma histories of others, ! Yeah because she is well educated, without the apparent trauma history and history of engaging with services, or even just having power act against hers not like a long term service user, mental health patient, could be a case of just not seeing power as something because it doesn't affect you. I guess that my risk, power not acting against me is white British male who is well	laughing, not really thinking about it		because not really thought about it before may mean not explictly felt those explict power ops that people from minoritised backgrounds may be more used to. **- No not really, no hahaha, so ummm no I think ever been asked that to be honest, that’s just kind of what comes to mind. -** gives impression not disempowered ghenerally	because not really thought about it before may mean not explictly felt those explict power ops that people from minoritised backgrounds may be more used to. **- No not really, no hahaha, so ummm no I think ever been asked that to be honest, that’s just kind of what comes to mind. -** gives impression not disempowered ghenerally
	educated, middle-class.....				
O: So if that’s what a powerful person like, what would someone who is disempowered what would they look like, what would you think that would be like?					
K: I think kind of the opposite of having power is being restricted and umm having a lot of people make decisions for you and you feeling kind of bound by those restrictions and not having much say in kinda what goes on, yea.22	22 Disempowered - lack of choice - restrictions - unheardI have a feeling that this thematically through all of them	no having power is ppl making decisions,	bound by those resitrictions - bound (tied up restrained) can't do anything,	**I think kind of the opposite of having power is being restricted and umm having a lot of people make decisions for you and you feeling kind of bound by those restrictions and not having much say in kinda what goes on, yea -** bound by restrictions, lack of choice, controlled	**I think kind of the opposite of having power is being restricted and umm having a lot of people make decisions for you and you feeling kind of bound by those restrictions and not having much say in kinda what goes on, yea -** bound by restrictions, lack of choice, controlled
O: thank you and ummm, and uhhh something you before you hadn’t thought about that much, how do you say think power affects you as a person?					
K: Ummm I think to some extent, … I’m not quite sure, I don’t really see myself as having a struggle with power at this point in my life, I can't really think of any examples to be honest			long pauses contemplative	**Ummm I think to some extent, … I’m not quite sure, I don’t really see myself as having a struggle with power at this point in my life, I can't really think of any examples to be honest-** sturggling to think of times disempowered = not so disempowered. Acknowledging it does to some extent but hard to grasp or understand because not acute	**Ummm I think to some extent, … I’m not quite sure, I don’t really see myself as having a struggle with power at this point in my life, I can't really think of any examples to be honest-** sturggling to think of times disempowered = not so disempowered. Acknowledging it does to some extent but hard to grasp or understand because not acute
O: That’s again, these are some really… This is the most abstract question.					
K: Yea I mean, at some stages in my life I guess I have struggled with, especially when, umm a couple years ago when I’ve been in and out of hospital and had all these doctors kind of making decisions for me, and I remember once they were telling me to have this operation and I really didn’t want it, ummm and thinking, telling them no, and yea23	23 Not that explicit knowledge of having feeling disempowered is this something to do with her privilege?	all of these doctors making decsions for me -	grouping the whole - all these doctors	**all these doctors making decsions for me** - clue to how she experiences power - a grouping of them	**all these doctors making decsions for me** - clue to how she experiences power - a grouping of them
	A medical setting coming up, doctor-patient power dynamic, always classic situation for power to be used, bubbly wealthy and most		telling me - no choice		

Transcript	Initial reflections	Descriptive notes	Lingusitic notes	Conceptual notes	Emergent themes
				this was something she had capacity to do - and indeed noticed it and pushed back, without being forced in to it.	historical experience of using own power in NHS - because in the end I said no and didn't give in.
				a couple years ago when I've been in and out of hospital and had all these doctors kind of making decisions for me, and I remember once they were telling me to have this operation and I really didn't want it, ummm and thinking, telling them no, and yea - ppl in power making decisions for her - able to tell them no - so aware but able to push back	**a couple years ago when I've been in and out of hospital and had all these doctors kind of making decisions for me, and I remember once they were telling me to have this operation and I really didn't want it, ummm and thinking, telling them no, and yea -** ppl in power making decisions for her - able to tell them no - so aware but able to push back
O: Yea					coercion - soft - **Kind of being felt like I was pushed, to be saying yes, I didn't want to, but**
K: Kind of being felt like I was pushed, to be saying yes, I didn't want to, but yea				coercion - soft - **Kind of being felt like I was pushed, to be saying yes, I didn't want to, but**	
O: Okay K: At the moment it not really…					
O: So that definitely sounds like a situation where one or the other had more power, who would you say in that example that you gave, where was, who was sort of holding the power in that?				**I think at the time I thought that they were, but now that I look back, I was, because in the end I said no and I didn't give in. - i**t took effort! Also she did not feel powerful at the time, uncomfortable to do perhaps. **- give in -** persuade persistence	**I think at the time I thought that they were, but now that I look back, I was, because in the end I said no and I didn't give in. - i**t took effort! Also she did not feel powerful at the time, uncomfortable to do perhaps. **- give in -** persuade persistence
K: I think at the time I thought that they were, but now that I look back, I was, because in the end I said no and I didn't give in.					
O: Yea. Was that difficult to do? To..					
K: Mmmm yea yea a little bit because I kind of took it on myself, doing my own research and think what are the benefits do they outweigh the positives and I just thought it's not worth going through that, or it could possibly make me worse, so I thought for what was maybe worse. I thought, No, you don't have the power, I do. I think they wanted they wanted to show they had power by, showing that they had all of this knowledge and kinda used that power to make me, persuade me to do what they wanted me to do.24	24 This is a good example of where someone takes back their power, the effort involved was quite a lot. Idea of being persuaded or pushed into the right way of thinking. You know even in a medical setting things should be collaborative,	Power demonstrated and held and bound in knowledge- something to be effortfully aquired **- Mmmm yea yea a little bit because I kind of took it on myself, doing my own research and think what are the benefits do they outweigh the positives and I just thought it's not worth going through that, or it could possibly make me worse, so I thought for what was maybe worse I thought**		**I thought, No, you don't have the power, -** a tipping point - her having this knowledge let her push back on it - (something she did not have pre therapy>)	Power demonstrated and held and bound in knowledge- something to be effortfully aquired **- Mmmm yea yea a little bit because I kind of took it on myself, doing my own research and think what are the benefits do they outweigh the positives and I just thought it's not worth going through that, or it could possibly make me worse, so I thought for what was maybe worse I thought**
				Holding knowledge is a form of power - and can force change - both sides for her on this (her using it and the Drs) - **No, you don't have the power, I do. I think they wanted they wanted to show they had power by, showing that they had all of this knowledge and kinda used that power to make me, persuade me to do what they wanted me to do**	**I thought, No, you don't have the power, -** a tipping point - her having this knowledge let her push back on it - (something she did not have pre therapy>)

Transcript	Initial reflections	Descriptive notes	Lingusitic notes	Conceptual notes	Emergent themes
		Pushing against power is effortful (do own research and weigh things up)			Pushing against power is effortful
O: Wow, thank you for sharing that, really good example of umm being in a position where sort of different people have different power at different times. Thanks. So I'm gonna move on a bit now to therapy what happened next with that. So I was wondering if you could tell me a little bit about what it first like meeting with your psychologist, so I know you met over the phone , so tell me a little about that, if you can…					Holding knowledge is a form of power - and can force change - both sides for her on this (her using it and the Drs) - **No, you don't have the power, I do. I think they wanted they wanted to show they had power by, showing that they had all of this knowledge and kinda used that power to make me, persuade me to do what they wanted me to do**
K: Ummm, I think it was over the phone, I don't think it was that, I wasn't really that nervous at first, I was quite optimistic, which I thought, I don't know if it was because this person can't see me but, it kind of, kind of rid of the anxiety of meeting someone new.		optimistic in the intial meeting but not nervous, over the phone, person cant see me		**Ummm, I think it was over the phone, I don't think it was that, I wasn't really that nervous at first, I was quite optimistic -** hope optimisitc	**Ummm, I think it was over the phone, I don't think it was that, I wasn't really that nervous at first, I was quite optimistic -** hope optimisitc
O: Yea				face to face vulnerabilty - not seeing the other person made it easier **- I don't know if it was because this person can't see me but, it kind of, kind of rid of the anxiety of meeting someone new.**	face to face vulnerabilty - not seeing the other person made it easier **- I don't know if it was because this person can't see me but, it kind of, kind of rid of the anxiety of meeting someone new.**
K: Umm even though obviously I was still talking to this person ummm, not sure I can, I think it made it a lot easier made me feel I could be a lot more open, because I just wasn't as nervous as I would be kind of meeting someone in person for the first time.25	25 So because she met the psychologist over the phone, should have that initial anxiety. She is the only person who did therapy over the phone, most people did it over zoom, with a bit face-to-face. I wonder what would drive the nervousness, I should have asked that, but didn't. By guessing removes all their way potentially be judged, or a layer of vulnerability, and I guess if she made the choice to do it on phone that was managing something for her, because it sounded like she had the option to do by video. What safety did doing it by phone bring?		contrast - meeting someone in person compared to phone	not meeting f2f meant there was less anxiety - judgement, fear of doing something wrong>>>??? **- Umm even though obviously I was still talking to this person ummm, not sure I can, I think it made it a lot easier made me feel I could be a lot more open, because I just wasn't as nervous as I would be kind of meeting someone in person for the first time**	not meeting f2f meant there was less anxiety - judgement, fear of doing something wrong>>>??? **- Umm even though obviously I was still talking to this person ummm, not sure I can, I think it made it a lot easier made me feel I could be a lot more open, because I just wasn't as nervous as I would be kind of meeting someone in person for the first time**
O: Did you expect to be nervous before the call?					
K: Umm I yea, I excepted to be a little bit nervous yea, yea, but um yea I feel like the therapist was very um calming and kind of made me, reassuring that everything was confidential and um that yea.		calming, reassuring the		confidentiality important >shame of what she was feeling going through reaching for help **- um yea I feel like the therapist was very um calming and kind of made me, reassuring that everything was confidential and um that y**	confidentiality important >shame of what she was feeling going through reaching for help **- um yea I feel like the therapist was very um calming and kind of made me, reassuring that everything was confidential and um that y**
O: That sounds like…					
K: I think she made me feel very comfortable in um in kind of what was going on and explaining how the process would work and kind of each session.26	26 Calming, reassuring, comfortable - this all links back to the SR, which is good and what I would expect	explained the process, clear structure / set the expectations up well **- I think she made me feel very comfortable in um in kind of what was going on and explaining how the process would work and kind of each session.**	process - as in there is expecations in it - is there power in process	clear process of therapy	explained the process, clear structure / set the expectations up well **- I think she made me feel very comfortable in um in kind of what was going on and explaining how the process would work and kind of each session.**
	confidential being a big theme for her - shame? Being treated differently?				

Transcript	**Initial reflections**	**Descriptive notes**	**Lingusitic notes**	**Conceptual notes**	**Emergent themes**
					process - as in there is expecations in it - is there power in process
O: Okay					
K: Yes that made me feel quite comfortable and just in her like explaining the process and how it works.27	27 The process, explaining the process and how it works. i wonder if this instilled some professional confidence in her, like they knew what they were doing, what she didn't know what was going on, M MMM, not sure, she did that was going on because she was explained it.			not mystified, clear explained	
O: Lovely, Um so you described feelings of comfort in that in that initial meeting, were there any other feelings that sort of that you, I know it's a while ago, anything that sort of stuck out or came up for you in that initial meeting in terms of emotions?					
K: Umm, I think a little bit of relief.		feeling of relief in intial meeting **- Umm, I think a little bit of relief. Um, if I'm honest. Kind of a relief that I finally some had someone who I could kind of open up to, that didn't know me,**			the relief - of being able to open up, not concealing/hiding **- Um, if I'm honest. Kind of a relief that I finally some had someone who I could kind of open up to, that didn't know me,**
O: Okay					
K: Um, if I'm honest. Kind of a relief that I finally some had someone who I could kind of open up to, that didn't know me,			if I am honest, as if should not be relieved (Shame)	the relief - of being able to open up, not concealing/hiding **- Um, if I'm honest. Kind of a relief that I finally some had someone who I could kind of open up to, that didn't know me,**	relief in having someone I could finally open up to (overcoming shame barriers)
O: Yea					
K: And that I could be completely open and honest with because, they wouldn't have any bias against me because they don't know me, not like family or friend you have to be considerate of their feelings before being completely open with them.		protecting of others not wanting to impact on others, stranger	no bias against me - people who know are biased	power operating with friends and family - judgement?	power operating with friends and family - judgement?
O: Okay				**And that I could be completely open and honest with because, they wouldn't have any bias against me because they don't know me, -** ppl in her life may have been biased against her - expecting this - judgment -	**And that I could be completely open and honest with because, they wouldn't have any bias against me because they don't know me, -** ppl in her life may have been biased against her - expecting this - judgment -
K: So I think it was that relief that I had someone to talk to that kind of my problems did not have an effect on them personally. Which a quite a big sense of relief.28	28 Relief - that feeling of being able or comfortable enough to talk			**because they don't know me, not like family or friend you have to be considerate of their feelings before being completely open with them**. - don't want to hurt the family frens	**because they don't know me, not like family or friend you have to be considerate of their feelings before being completely open with them**. - don't want to hurt the family frens - suffering alone

Transcript	Initial reflections	Descriptive notes	Lingusitic notes	Conceptual notes	Emergent themes
O: Okay. Yea, no that sounds quite a weight off almost.	anonymity - relief that it was someone that didn't know her, query shame, query not going to impact on them. For example family not taking on her problems, I wonder those going on in her family and the time, if they struggled? Whether it was shame-based?				
K: It definitely was it was just kind of I can't believe why I didn't do this sooner.29 [laugh]	29 Holding it for quite a while. Like someone who doesn't normally open up. Again relief.		laugh **- cant believe I didn't do this soone**r - she had been feeling this way for a long time?	had been considering it for a while? Part of what she said before	laugh - **cant believe I didn't do this soone**r - she had been feeling this way for a long time?
O: Okay yea. You sort of mentioned like confidentiality and worrying about people being biased against you…					
K: So in the first in the first meeting um confidentiality was mentioned and it made me feel very comfortable to know that it wouldn't be shared outside with people when it wasn't necessary.		reassured around confidentiality being very important to her - the importance of this worry about it impacting other treatment and shame??? **- So in the first in the first meeting um confidentiality was mentioned and it made me feel very comfortable to know that it wouldn't be shared outside with people when it wasn't necessary.**			reassured around confidentiality being very important to her - the importance of this worry about it impacting other treatment and shame??? **- So in the first in the first meeting um confidentiality was mentioned and it made me feel very comfortable to know that it wouldn't be shared outside with people when it wasn't necessary.**
O: What was kind of the worry around around that. Sort of being sort of um externally to that, people sort of hearing and understanding what was happening for you?					
K: Um, so I think I was kind of a bit worried when you go the doctors and you see GP and you know they are writing everything down on their computer and they can see everything.				**Um, so I think I was kind of a bit worried when you go the doctors and you see GP and you know they are writing everything down on their computer and they can see everything. -** wanting her privacy, as she sees Drs a lot which - shame vs privacy	**Um, so I think I was kind of a bit worried when you go the doctors and you see GP and you know they are writing everything down on their computer and they can see everything. -** wanting her privacy, as she sees Drs a lot which - shame vs privacy
O: Yea					
K: I didn't want the same thing to happen, kind of with the therapy, I was thinking you could actually see this. It turns out it is very difficult, not like everyone can access it, which yes is quite huge load off my mind.30	30 like, what was she worried about with what she might disclose. Doesn't feel like she was worried about something bad happening it was more emotional, but it wasn't fear of physical consequence but of how she would feel. But what was it? I circle back to shame. She later on talk about stigma?			worry around judgement from professionals seeing it	worry around judgement from professionals seeing it

Transcript	Initial reflections	Descriptive notes	Lingusitic notes	Conceptual notes	Emergent themes
				I didn't want the same thing to happen, kind of with the therapy, I was thinking you could actually see this. It turns out it is very difficult, not like everyone can access it, which yes is quite huge load off my mind - huge load - weighing down so the pressure of worry around this was great and i wonder if that had time to percolate would it have impacted her more?	**I didn't want the same thing to happen, kind of with the therapy, I was thinking you could actually see this. It turns out it is very difficult, not like everyone can access it, which yes is quite huge load off my mind** - huge load - weighing down so the pressure of worry around this was great and i wonder if that had time to percolate would it have impacted her more?
O: Yea, and was worrying that sort of professionals or what people saw outside that would see it. K: Ummm it was more like every single professional that I was see…		worry around other professionals seeing things.		reassured others profs couldn't see it - she sees a lot of professionals? **- Ummm it was more like every single professional that I was see…. [line dropped out]**	reassured others profs couldn't see it - she sees a lot of professionals? **- Ummm it was more like every single professional that I was see…. [line dropped out]**
O: Sorry you just dropped out there…Oh… Hello K: Hello **O: Oh yea you've come back, I just got up to say going to A&E…?**					
K: Sorry someone was ringing me but it wasn't important. Yea, So think it was just worrying that if went to A&E with a broken foot they'd be able to see all my mental health records which would be embarrassing. 31	31 Actually this is someone who spends a lot of time in contact with health professional's. People Constantly trawling her records. With kidney problems she is likely to be seeing healthcare professionals quite a lot. I think this is an important point that she is someone who is in contact with healthcare professionals quite a lot, but not mental healthcare professionals, is the power dynamic more more pronounced particularly as you are seeing doctors and consultants?		embarassing - trope MH stuff is embarassing	**Yea, So think it was just worrying that if went to A&E with a broken foot they'd be able to see all my mental health records which would be embarrassin**g. - her experiences are embarassing and shameful	**Yea, So think it was just worrying that if went to A&E with a broken foot they'd be able to see all my mental health records which would be embarrassin**g. **-** her experiences are embarassing and shameful
O: Okay so yea that kind of over-sharing… K: Kind of over sharing my information is what I was kind of a bit worried about. Obviously, I knew that it would never be shared beyond anyone that actually needed to know. **O: Do you think that, say if it was shared beyond people who needed to know that change that would change how people um either treat you or behave towards you?**					
K: Um yea, I think, yea I think so, yea I think I would depend on it's just, I think it actual feeling that I want that kind of discretion when it comes to sharing sensitive information.32	32 Yeah, just wanting her private stuff to stay private, if it doesn't make any difference to how you be treated, although if you get diagnosis of health anxiety you're gonna get treated a lot different, I have experiences of that in the physical health hospital which is shocking and potentially could bias me on this. Something about different peoples trustworthiness? Distrust of some people?	fear that people would treat different		alluding that sensitive stuff can be shared - that this is sensitive, painful etc, sort of beneath this is a shame I think - **Um yea, I think, yea I think so, yea I think I would depend on it's just, I think it actual feeling that I want that kind of discretion when it comes to sharing sensitive information**	alluding that sensitive stuff can be shared - that this is sensitive, painful etc, sort of beneath this is a shame I think - **Um yea, I think, yea I think so, yea I think I would depend on it's just, I think it actual feeling that I want that kind of discretion when it comes to sharing sensitive information**
O: Yea K: Just knowing that it wont be shared with people kind of people who don't need that information. **O: Yea**					

Transcript	Initial reflections	Descriptive notes	Lingusitic notes	Conceptual notes	Emergent themes
Okay **O: Yea**					
K: Im not sure if it would affect my how they treat me. It could it completely depends on who has kind of their hands on it and that's where the worry is that you don't know who.			vauge ness -	**Im not sure if it would affect my how they treat me. It could it completely depends on who has kind of their hands on it and that's where the worry is that you don't know who. -** there are some people who might missuse it.	**Im not sure if it would affect my how they treat me. It could it completely depends on who has kind of their hands on it and that's where the worry is that you don't know who. -** there are some people who might missuse it.
O: Yea K: Umnm					
O: Brilliant thank you that's really helpful to think about, um, so thinking more sort overall about your relationship with the psychologist you were working with, could you tell me a little bit about that relationship with the psychologist what was that like for you?					
K: Yea um I think it was quite a… definitely quite a trusting relationship, and I felt I was like listened to and ummm, almost a bit like a friendship but not like a very personal friendship. So I don't know it's kind of strange, but there would be times that where we would have a little bit of a laugh and yea it was just like chatting to someone, so felt quite comfortable and not not kind under pressure. Didn't feel like I was talking to a, I don't know someone who was a medical professional, it felt like I was talking to someone who was giving me advice or yea.33	33 Trusting	trusting experience, where listened to, like a friendship but not like a very personal friendship - **Yea um I think it was quite a… definitely quite a trusting relationship, and I felt I was like listened to and ummm, almost a bit like a friendship but not like a very personal friendship.**		informality is a form of equalising power and it sounds like this was actually felt by her - **So I don't know it's kind of strange, but there would be times that where we would have a little bit of a laugh and yea it was just like chatting to someone, so felt quite comfortable and not not kind under pressure. Didn't feel like I was talking to a, I don't know someone who was a medical professional, it felt like I was talking to someone who was giving me advice or yea**	trusting experience, where listened to, like a friendship but not like a very personal friendship - **Yea um I think it was quite a… definitely quite a trusting relationship, and I felt I was like listened to and ummm, almost a bit like a friendship but not like a very personal friendship.**
	like a friendship, but not like a personal one - I don't think this is sort of over attached, like the way she spoke about the psychologist wasn't like overly attached/loving, more than those just her best way of articulating that it was casual and nice.	little bit of laugh, chatting to someone, felt comfortable, not under pressure		The experience (thus power in the realtionship felt different) - **Didn't feel like I was talking to a, I don't know someone who was a medical professional, it felt like I was talking to someone who was giving me advice or yea.**	informality is a form of equalising power and it sounds like this was actually felt by her - **So I don't know it's kind of strange, but there would be times that where we would have a little bit of a laugh and yea it was just like chatting to someone, so felt quite comfortable and not not kind under pressure. Didn't feel like I was talking to a, I don't know someone who was a medical professional, it felt like I was talking to someone who was giving me advice or yea**
	Have a bit of a laugh - not being serious all the time, because of not knowing much about therapy, you could easily expect it to be quite formal serious crying all the time, then a couch, stereotypical.	didn't feel like talking to medical prof		why is that important	The experience (thus power in the realtionship felt different) - **Didn't feel like I was talking to a, I don't know someone who was a medical professional, it felt like I was talking to someone who was giving me advice or yea.**
	Not under pressure-comfortable-this is important, again pressure is type of power, power over, power onto.				
O: Is it is that is and tell if I have this completely wrong, sort of like less formal or…					

Transcript	Initial reflections	Descriptive notes	Lingusitic notes	Conceptual notes	Emergent themes
K: Oh yea that’s the word! yea definitely less formal than I expected it to be.		informal - **Oh yea that’s the word! yea definitely less formal than I expected it to be.**		**Oh yea that’s the word! yea definitely less formal than I expected it to be. -** expecations around formality from previous medical expeirences and power etc????	**Oh yea that’s the word! yea definitely less formal than I expected it to be. -** expecations around formality from previous medical expeirences and power etc????
O: Yea					
K: Just because I had never been to therapy before I didn’t know what to expect seen from tv show’s and just yea, completely unrealistic expectations. whereas when you get in there and it is not as scary as I expected it to be so it’s a lot more informal and there weren’t like set questions they would always be like, if you’re not comfortable to answer a questions then you don’t have to. And kinda take it at your own pace really, which was really nice.34	34 informal - again preconceptions alluded to it being more formal, usual stereotypes of TV shows, clipboard seriousness et cetera taking at your own pace- so that person centred, , flexible, this links to the SR if you're not comfortable to answer questions you don't have to - balancing power, feeling able to say no not what I expected - alluding to preconceptions you you Watch out - because I have quite firm views that therapy shouldn't feel formal, like therapists shouldn't be dressed in a suit, shouldn't use ridiculous language et cetera [FO(1]THIS IS BEING vs DOING….. I keep coming back to this, deformalizing therapy, building the relationship, creativity, comfort to be self	tv shows set up unrelaistic expectations - choice own pace		**Just because I had never been to therapy before I didn’t know what to expect seen from tv show’s and just yea, completely unrealistic expectations. whereas when you get in there and it is not as scary as I expected it to be so it’s a lot more informal and there weren’t like set questions they would always be like, if you’re not comfortable to answer a questions then you don’t have to. And kinda take it at your own pace really, which was really nice. -** societial expectations and displays of what therapy is impacting - think it wil be scary - why scared? **And kinda take it at your own pace really, which was really nice. -** empowering for her. #	**Just because I had never been to therapy before I didn’t know what to expect seen from tv show’s and just yea, completely unrealistic expectations. whereas when you get in there and it is not as scary as I expected it to be so it’s a lot more informal and there weren’t like set questions they would always be like, if you’re not comfortable to answer a questions then you don’t have to. And kinda take it at your own pace really, which was really nice. -** societial expectations and displays of what therapy is impacting - think it wil be scary - why scared? **And kinda take it at your own pace really, which was really nice. -** empowering for her. #
O: Really nice yea. And did your um did you sort of ahh use the same language, like as your therap as the psychologist you were working with like, kinda like more informal from what it sounds likes?					
K: Yea					
O: could you sort of understand each other?					
K: It was yea yea I mean it didn’t feel very formal. It did feel like I could just speak my mind, and kind of no one was judging me, I didn’t need to kind to explain things in a certain way that, it was just kind of get it off ya chest it doesn’t matter it doesn’t matter how you kind of explain it.35	35 no judgement -			**It was yea yea I mean it didn’t feel very formal. It did feel like I could just speak my mind, -** informality providing space for free speech, expression	**It was yea yea I mean it didn’t feel very formal. It did feel like I could just speak my mind, -** informality providing space for free speech, expression

Transcript	Initial reflections	Descriptive notes	Lingusitic notes	Conceptual notes	Emergent themes
	the freedom to make mistakes when explaining just to say youre feeling, not having to get it completely right	**no one was judging me**		**I didn't need to kind to explain things in a certain way that, it was just kind of get it off ya chest it doesn't matter it doesn't matter how you kind of explain it -** freedom of expression	**I didn't need to kind to explain things in a certain way that, it was just kind of get it off ya chest it doesn't matter it doesn't matter how you kind of explain it -** freedom of expression **no one was judging me**
O: Okay. Um did your feelings sort of towards your psychologist or just the relationship, did that change over time that you spent in therapy?					
K: Ummm no no, I don't think there was much change, in kind of the way that so ..		Stablitly and consistency in the relationship **- Um did your feelings sort of towards your psychologist or just the relationship, did that change over time that you spent in therapy?Ummm no no, I don't think there was much change, in kind of the way that so ..**			Stablitly and consistency in the relationship **- Um did your feelings sort of towards your psychologist or just the relationship, did that change over time that you spent in therapy?Ummm no no, I don't think there was much change, in kind of the way that so ..**
O: say that session K: okay					
O: so from say session 1 like when you just kind of speaking to first sort of introductions, when did you start to notice that that trusting, kind of started to develop?					
K: I think it was very early on and from what I can remember. Um I think it would just the initial kind of um reassurance and that kind of the information wouldn't be shared with anyone unnecessarily and that kind of talking about the goals of the sessions.		confidentiality being key **-** = trust **- I think it was very early on [felt trust]and from what I can remember. Um I think it would just the initial kind of um reassurance and that kind of the information wouldn't be shared with anyone unnecessarily and that kind of talking about the goals of the sessions.**			confidentiality being key **-** = trust **- I think it was very early on [felt trust]and from what I can remember. Um I think it would just the initial kind of um reassurance and that kind of the information wouldn't be shared with anyone unnecessarily and that kind of talking about the goals of the sessions.**
O: okay		Clear process and goals			Clear process and goals
K: I think it was very kind of early on. And if not kind of first triage then definitely from the first session I felt comfortable, and to kind of share how I was feeling.36	36 Straight in with the trust and very little change in the relationship, I guess a good experience in mental health services probably helped with this, take a while to trust awhile to see. It seems that the stuff which she was most concerned was attended to from the beginning	felt comfortable quickly **-** and without that would not be able to share feelings **- I think it was very kind of early on. And if not kind of first triage then definitely from the first session I felt comfortable, and to kind of share how I was feeling**		the not being in the room supporting this?	felt comfortable quickly **-** and without that would not be able to share feelings **- I think it was very kind of early on. And if not kind of first triage then definitely from the first session I felt comfortable, and to kind of share how I was feeling**
O: Were there any times where you felt there were things you weren't able to share or… K: umm … I can't remember, I think possibly, um, possibly, I can't really think of anything specific examples from that time period? I think there probably would have been certain things that wouldn't of been able to share, but possibly things that were not relevant, yea.37 **O: yea**	37 Not relevant stuff not sharing-				

Transcript	**Initial reflections**	**Descriptive notes**	**Lingusitic notes**	**Conceptual notes**	**Emergent themes**
K: kind of if I had an argument with someone and I was thinking, oh I hate them. I wouldn't mention that to my therapist because she wouldn't need to know. But nothing that was kind of really bothering me, and yea…38	38 I hate them - I don't think this is anything to do with power particularly more managing personal perceptions. This was quite discreet piece of work, and not very relational so it doesn't really seem like it's gonna be something they were gonna talk about anyway.			element of of image management - showing she did care about what the therapist thought of them - very subtle - **kind of if I had an argument with someone and I was thinking, oh I hate them. I wouldn't mention that to my therapist because she wouldn't need to know. But nothing that was kind of really bothering me, and yea**	element of of image management - showing she did care about what the therapist thought of them - very subtle - **kind of if I had an argument with someone and I was thinking, oh I hate them. I wouldn't mention that to my therapist because she wouldn't need to know. But nothing that was kind of really bothering me, and yea**
O: Okay no, I realise you know I'm asking you to sort of cast your mind back a fair distance as well and you know it's absolutely fine not to remember sort of lots and lots of different bits.					
K: I cant remember if there was anything in particular that I purposively didn't share, if it was it wouldn't have been anything that was major, that was something like make that makes me sound a bit petty, so not gonna mention it because it's not important, but nothing like really deep thoughts that kind of were important, nothing like that39.	39 suggestions about managing her image with the psychologist - deep thoughts that were kind of important, so able to talk about the stuff that is really important which is really important.	felt comfortable to share	disclaimer??	**: I cant remember if there was anything in particular that I purposively didn't share, if it was it wouldn't have been anything that was major, that was something like make that makes me sound a bit petty, so not gonna mention it because it's not important, but nothing like really deep thoughts that kind of were important, nothing like that -** makes me sound a little petty - again image management and care what they thought - minimises this because it wasn't relevant?	**: I cant remember if there was anything in particular that I purposively didn't share, if it was it wouldn't have been anything that was major, that was something like make that makes me sound a bit petty, so not gonna mention it because it's not important, but nothing like really deep thoughts that kind of were important, nothing like that -** makes me sound a little petty - again image management and care what they thought - minimises this because it wasn't relevant?
O: Okay it sounds like kind of like really therapy specific stuff was okay to talk about? K: Yea					
O: And just kind of wondering about some of those sort of thoughts, you used the word petty, petty stuff or when someone where you might feel a certain way towards someone like you hated them or something like that…					
K: Yea					
O: And and just interested in about, was that just because it wasn't relevant or because you were sort of not wanting to sort of let the therapist know that you know they you might have been feeling petty or that umm you had those kind of feelings towards someone else?					
K: I think it was more it wasn't relevant to the sessions really so she'd say like how are you feeling, if I just, say I had an argument with my mum or yea, I wouldn't mention it, because I wouldn't see it as relevant, yea.40	40 Again doesn't really seem like relational focus on the therapy. I guess have don't have to talk about everything in therapy			**I think it was more it wasn't relevant to the sessions really so she'd say like how are you feeling, if I just, say I had an argument with my mum or yea, I wouldn't mention it, because I wouldn't see it as relevant, yea -** quite focused on the focus of the sessions - what they were there to do - I wonder if the focusing on this is a form of very subtle silencing power> probably a reach	**I think it was more it wasn't relevant to the sessions really so she'd say like how are you feeling, if I just, say I had an argument with my mum or yea, I wouldn't mention it, because I wouldn't see it as relevant, yea -** quite focused on the focus of the sessions - what they were there to do - I wonder if the focusing on this is a form of very subtle silencing power> probably a reach
O: okay thank you. And sort of thinking back, now, about the person you were with, how do you feel about them now?					

Transcript	**Initial reflections**	**Descriptive notes**	**Lingusitic notes**	**Conceptual notes**	**Emergent themes**
K: Ummm, yea I feel like they really helped me with what was a very difficult time in my life, and I'm definitely grateful for the sessions we had and I think they helped me a lot and I use kind of the techniques that she taught, me still to this day, so there's like quite a lot of techniques she told me about, ways to manage worries and anxieties that I still use and still helps with day to day worries now.41	41 Positive therapeutic experience	helpful experience at the time, techniques travelling through to today		Her experience was of the technical stuff she took away and found helpful. Not the relational - **yea I feel like they really helped me with what was a very difficult time in my life, and I'm definitely grateful for the sessions we had and I think they helped me a lot and I use kind of the techniques that she taught, me still to this day, so there's like quite a lot of techniques she told me about, ways to manage worries and anxieties that I still use and still helps with day to day worries now**	Her experience was of the technical stuff she took away and found helpful. Not the relational - **yea I feel like they really helped me with what was a very difficult time in my life, and I'm definitely grateful for the sessions we had and I think they helped me a lot and I use kind of the techniques that she taught, me still to this day, so there's like quite a lot of techniques she told me about, ways to manage worries and anxieties that I still use and still helps with day to day worries now**
	grateful for the sessions - less the person guess this is further said that she speaks about the techniques and how she still uses the. I wonder if there be more focus on the relationship opposed to the techniques if they met face-to-face or by video				
O: Ah that sounds lovely sounds like it made a real real difference.					
K: Yea. So there's quite a lot of worksheets and things that she sent me and just ideas that were kind of like if you ever worried about something you need to write it down and kind of make a column worries that kind of do something you can do something about and worries that you cant do something about. And if there is something you can do about it then write down the options, then if there's nothing you can do about it, you just throw it away and that's kind of like really helps you in your mind to just throw it away. Stuff like that I still do and I think it has really helped me like having someone to talk about the examples and kind of help me with that technique.42	42 This is all really practical, opposed to relational. Explicit mention of a specific psychological technique-problem-solving.			**And if there is something you can do about it then write down the options, then if there's nothing you can do about it, you just throw it away and that's kind of like really helps you in your mind to just throw it away. Stuff like that I still do and I think it has really helped me like having someone to talk about the examples and kind of help me with that technique**. - the therapist was a vessel for the techniques - again move away from the relational (phone therapy?)	**And if there is something you can do about it then write down the options, then if there's nothing you can do about it, you just throw it away and that's kind of like really helps you in your mind to just throw it away. Stuff like that I still do and I think it has really helped me like having someone to talk about the examples and kind of help me with that technique**. - the therapist was a vessel for the techniques - again move away from the relational (phone therapy?)
O: Brilliant wow. Yea that sounds like that made a real impact.					
K: Yea yea					
O: Ummm so what… so thinking about the kind of relationship between you both um what did you learn about sort of, relationships from that experience of therapy with her?					

Transcript	Initial reflections	Descriptive notes	Lingusitic notes	Conceptual notes	Emergent themes
K: Umm, I'm not quite sure if I kind of learned anything about relationships. I think it was more that I learnt to kind of share my feelings with someone that I had never met before and there's quite a lot of benefits to doing so. Um kind of more than I had realised because I'd never had kind of gone through anything like that before.43	43 I think this comment speaks to trust and safety - that if stuff is disclosed and being able to talk safely there are positive benefits to it	**: Umm, I'm not quite sure if I kind of learned anything about relationships. I think it was more that I learnt to kind of share my feelings with someone that I had never met before and there's quite a lot of benefits to doing so. Um kind of more than I had realised because I'd never had kind of gone through anything like that before -** whilst nothing explict from the relationship she did learn it was okay to share feelings - so an aspect of the TR translating outside of the room.			**: Umm, I'm not quite sure if I kind of learned anything about relationships. I think it was more that I learnt to kind of share my feelings with someone that I had never met before and there's quite a lot of benefits to doing so. Um kind of more than I had realised because I'd never had kind of gone through anything like that before -** whilst nothing explict from the relationship she did learn it was okay to share feelings - so an aspect of the TR translating outside of the room.
O: Yea					
K: I think it just helped me just open up a bit more to someone I had not met, yea.				found it helpful opending up - having trust and safety in a stranger **- I think it just helped me just open up a bit more to someone I had not met, yea?**	found it helpful opending up - having trust and safety in a stranger - **I think it just helped me just open up a bit more to someone I had not met, yea?**
O: Has that changed how you've how you'd sort of open up to other people or how you um sort of work or operate in relationships, I know that sounds a bit clinical…					but not the actual relational - quite reserved when comes to personal relationships - hence the worry around confidentiality etc - I don't think so, I don't think so no. I'm still actually quite reserved when it comes to personal relationships I don't think its really helped much in that
K: I don't think so, I don't think so no. I'm still actually quite reserved when it comes to personal relationships I don't think its really helped much in that.44	44 Definite evidence of it not being a relational therapy	but not the actual relational - quite reserved when comes to personal relationships - hence the worry around confidentiality etc - I don't think so, I don't think so no. I'm still actually quite reserved when it comes to personal relationships I don't think its really helped much in that			
O: Yea okay lovely. Ummm were there ever any times sort of during therapy where the relationship felt more or less equal between you both?					
K: Umm not sure I think it's always been a bit one sided because it's, I'm the one in therapy and I'm telling you all this information and I don't know anything about you and so think its ever its ever kinda been equal, but yea it didn't feel like at the same time it didn't feel inequal. It didn't feel like I was kind of made to be put down or anything.45	45 What I'm trying to pull out out here is about power.	not feeling put down	I'm telling you (a therapist?)	**Umm not sure I think it's always been a bit one sided because it's, I'm the one in therapy and I'm telling you all this information and I don't know anything about you and so think its ever its ever been equa**l, - not equal in the relationship because you are having to give all this private and sensitive information **but yea it didn't feel like at the same time it didn't feel inequal. It didn't feel like I was kind of made to be put down or anything -** so not abusive - power can operate, but not harm - not disempowered. LATENT POWER	**Umm not sure I think it's always been a bit one sided because it's, I'm the one in therapy and I'm telling you all this information and I don't know anything about you and so think its ever its ever been equa**l, - not equal in the relationship because you are having to give all this private and sensitive information **but yea it didn't feel like at the same time it didn't feel inequal. It didn't feel like I was kind of made to be put down or anything -** so not abusive - power can operate, but not harm - not disempowered. LATENT POWER

Transcript	Initial reflections	Descriptive notes	Lingusitic notes	Conceptual notes	Emergent themes
	Was there wasn't any disclosure from the therapist, I wonder if this was helpful for her because actually she spoke about not wanting it to impact on someone. Must let that kind of impartial person. Didn't feel unequal, no explicit feelings being disempowered - put down or anything [FO(2]I'm telling you right now, reflecting the relationship?				
O: Yea					
K: Yea I never felt like, like I was less important or anything like that46.	46 Equity in the relationship			**Yea I never felt like, like I was less important or anything like that**. - Equity and parity in the TR	**Yea I never felt like, like I was less important or anything like that**. - Equity and parity in the TR
O: yea, that's sounds helpful.					
K: It's quite a difficult one , I don't really know kind of what what it is to be kind of equal. Haha		don't what it is to be kind of equal		**It's quite a difficult one , I don't really know kind of what what it is to be kind of equal. Haha -** or has not acutely and chronically felt the effects of not being equal in a relationship (no T)	
O: Yea, yea some of these questions a little… quite abstract, so there's no right or wrong answer that's all. You know it's just kind of your perspective on it. I was interested in um that sort of what you said of that one sidedness of you sort of giving… sort of telling everything and not hearing, not knowing or hearing anything about the person you are working with. Can you tell you me any more about that, what that sort of felt like or…					
K: Umm I don't.. From what I can remember it didn't really make a difference because obviously like I knew that that person was there to kind of listen and to help me.48	48 see below	wanted it to be one sided because that was their job - **Umm I don't.. From what I can remember it didn't really make a difference because obviously like I knew that that person was there to kind of listen and to help me**			wanted it to be one sided because that was their job - **Umm I don't.. From what I can remember it didn't really make a difference because obviously like I knew that that person was there to kind of listen and to help me**
			that person - didn't use she, dettachement from her?		**that person** - didn't use she, dettachement from her?
O: Yea					
K: So so I know that obviously an agenda of um yea kind of asking the questions and like giving me advice and help and yea I didn't really see it as kind of unfair, its just one of those things.47	47 Thinking about disclosure here - she speaks about the importance of being heard and I guess understood in order to be helped.		agenda -	just one of those things, acceptance that	
	Having a bit of structure being helpful as well as? Acquiescent?				
O: Yea, Yea, okay, how do you think you would have felt if the therapist you were working with, did share quite a lot of stuff with you?					

Transcript	Initial reflections	Descriptive notes	Lingusitic notes	Conceptual notes	Emergent themes
K: Ummm I think it would depend what it was. If it was kind of something like to share their own experiences not like there experiences in full detail but if they kind of shared, kind of methods of coping that worked for them, I think that would be really useful and if they were to kind of say this really worked for me and this is how I did it.I think that would be kind of helpful. But if they were just going on like, giving me their life story I don't think that would be helpful. Depends… It depends.. Kind of it could have been helpful,		could have used some personal experience to agument the technique explanation but did not want their life story - I guess she not seeking a seceure attachment here she is wanting tools for help - as it comes back to the techniques not the relationship - **Ummm I think it would depend what it was. If it was kind of something like to share their own experiences not like there experiences in full detail but if they kind of shared, kind of methods of coping that worked for them, I think that would be really useful and if they were to kind of say this really worked for me and this is how I did it.I think that would be kind of helpful. But if they were just going on like, giving me their life story I don't think that would be helpful.**			could have used some personal experience to agument the technique explanation but did not want their life story - I guess she not seeking a seceure attachment here she is wanting tools for help - as it comes back to the techniques not the relationship - **Ummm I think it would depend what it was. If it was kind of something like to share their own experiences not like there experiences in full detail but if they kind of shared, kind of methods of coping that worked for them, I think that would be really useful and if they were to kind of say this really worked for me and this is how I did it.I think that would be kind of helpful. But if they were just going on like, giving me their life story I don't think that would be helpful.**
O: Okay no that's a really really good point that. Kind of just two make sure I have understood that, that kind of sharing a bit about their experience of the work you are doing like of them using it… K: so kind of if it was relevant and they had a technique that worked for them. And they were kind of explaining that in how that was in relation to your problems and how that can help you. I think that be really useful. But it would have to be relevant to have any impact really	49 Over disclosure being a bad thing - taking focus of the participant, but this didn't happen in this relationship obviously			Again this not close relationship but enough - she wasn't saying im not telling her etc.	
	But actually some disclosure or even contextualisation of techniques, posted the abstract - because she's well educated that understanding of abstract concepts would be all right - but I wonder with those people who are less educated need some more context and that's where disclosure could be used more effectively?		I'm telling you - the therapist not her		
O: Of course yea. Okay brilliant, ummm, just I'll just pause for a second and we've been speaking for like half an hour, we await to keep carrying on, do you need a drink or anything like that, or… K: I'm fine yea. **O: Thank you so much you're doing an amazing job thinking about all of this and casting your mind back.** K: Yea. It's good to remember to bits of it, thinking these things do come back.50	50 Positive experience of being interviewed?				
O: Brilliant and does the pace feel alright in terms of sort of.. K: Yea **O: Yea okay, brilliant, so um ill move on then if that's alright? Um so how do you think that you are different from your psychologist?**					

Transcript	Initial reflections	Descriptive notes	Lingusitic notes	Conceptual notes	Emergent themes
K: Ummm, it's difficult I never really… I think to be honest I think we could be quite the same [laugh], um it's just that I don't have the information to kind of know. Um but I didn't really see us as different, so kind of first went into the sessions I didn't really think of my psychologist being very much different to myself. I thought, ummm kind of she's probably sat at home, just like I am and she works from home, so do I haha, we both been to university, um, so actually think we are more similar than different, I yea.			laugh - could be quite the same - as if they would not be.	being more similar balance of pwer - been to uni etc	
O: Okay so more similar than different		**Ummm, it's difficult I never really… I think to be honest I think we could be quite the same [laugh], um it's just that I don't have the information to kind of know. =** not knowing enough about them to make a judgement on their similaritys		**m but I didn't really see us as different, so kind of first went into the sessions I didn't really think of my psychologist being very much different to myself. I thought, ummm kind of she's probably sat at home, just like I am and she works from home, so do I haha, we both been to university, um, so actually think we are more similar than different, I yea -** similar in education levels - otherwise no real diffs, hard to see over the phone.	**but I didn't really see us as different, so kind of first went into the sessions I didn't really think of my psychologist being very much different to myself. I thought, ummm kind of she's probably sat at home, just like I am and she works from home, so do I haha, we both been to university, um, so actually think we are more similar than different, I yea -** similar in education levels - otherwise no real diffs, hard to see over the phone.
K: I think it would be different for everyone.51	51 Feels that she enquire identified with her psychologist, they sounded like they were similar ages et cetera I wonder if that had an impact on things. I wonder if that why this was such a good experience, forming the relationship was easy, was because she didn't see that much difference between them is not that being upset with not having the same overall quality-of-life as the other person. Where as some of the people who were interviewed, and fastly different lives to those professionals and mentioned it, like receiving benefits, et cetera				**Ummm, it's difficult I never really… I think to be honest I think we could be quite the same [laugh], um it's just that I don't have the information to kind of know. =** not knowing enough about them to make a judgement on their similaritys
	When she says that she doesn't have the information to kind of know - indicates that she was wanting some knowledge, specialist knowledge, that's like a positive piece of power so that knowledge and is expertise and blah blah blah				
O: Yea					
K: Ahh but yea, but yeah probably a bit similar, in terms of.. in terms of what I knew, but obviously thought I wouldn't know…					
O: Okay, so I guess that is tricker over the phone the phone cos you can't really see them.					

<u>**Transcript**</u>	<u>**Initial reflections**</u>	<u>**Descriptive notes**</u>	<u>**Lingusitic notes**</u>	<u>**Conceptual notes**</u>	<u>**Emergent themes**</u>
K: Yea, I do remember there was one time where I went to my GPs offices, and we were wearing the same jumper, so that make me laugh.52	52 She was participant who did therapy over the phone so never actually saw what her psychologist looked like. For people with difficulties which are more relational and trust based, for example people even experience multiple traumas, both outside of services and within services, being able to see them - thinking explicitly to the participant who wanted to see the sweat on someone's brow, that would have obviously been much more important!				
O: They got the memo. K: Yea, haha. It was her who pointed it out. But at at that point I saw her like every week, so I knew her.53	53 My Terrible attempt at humour				
O: Ok doke, haha, ummm, so in terms of like your age you know, sort of ahh do you think you were sort of similar in age or …. K: Ummm, yea, I mean its difficult, to tell over the phone from her voice it sounded like she was similar age to me, maybe a bit older, yea.		simlar ages			
O: And what did it kind of like mean for you to have someone that you were talking to felt quite the same? Like was that important?					
K: No. I don't think it would have made much of a difference. I don't think it really crossed my mind about the kind of how they are as a person. I think it was just at that point someone to talk to listen to as long as long as I trusted them then, their kind of personal background wasn't really important, and the fact that I don't really know much about them. But I still kind of trusted them and was having to talking to them and being completely open.54	54 I guess it not crossing her mind speaks to speak to it not being a problem. There is that personality or the fact they were well matched.	**No. I don't think it would have made much of a difference. I don't think it really crossed my mind about the kind of how they are as a person. I think it was just at that point someone to talk to listen to as long as long as I trusted them then, there kind of personal background wasn't really important, and the fact that I don't really know much about them. But I still kind of trusted them and was having to talking to them and being completely open.** - trusting them - who they were did not make a massive difference -		could still trust them without knowing much about them - what gave that trust (approach, professional presige??) - **I trusted them then, their kind of personal background wasn't really important, and the fact that I don't really know much about them. But I still kind of trusted them and was having to talking to them and being completely open.**	**No. I don't think it would have made much of a difference. I don't think it really crossed my mind about the kind of how they are as a person. I think it was just at that point someone to talk to listen to as long as long as I trusted them then, there kind of personal background wasn't really important, and the fact that I don't really know much about them. But I still kind of trusted them and was having to talking to them and being completely open.** - trusting them - who they were did not make a massive difference -
					could still trust them without knowing much about them - what gave that trust (approach, professional presige??) - **I trusted them then, their kind of personal background wasn't really important, and the fact that I don't really know much about them. But I still kind of trusted them and was having to talking to them and being completely open.**
	An officer she didn't know much about them Kind of trusted them, - feels like she did trust them, and trust being important to fully open up. This is to the SR.				

Transcript	Initial reflections	Descriptive notes	Lingusitic notes	Conceptual notes	Emergent themes
O: Yea. Okay umm so were there anythings outside the therapy, so obviously you weren't meeting together in the same room, things going on outside that affected your relationship with the psychologist?					
K: Ummm, I think the fact that it was during lockdown would probably make me a lot more open. Because I didn't really have anyone else to talk, to kind of during the day.		She was isolated and lonely - **Ummm, I think the fact that it was during lockdown would probably make me a lot more open. Because I didn't really have anyone else to talk, to kind of during the day.**		wanting that some connection with somone because was isolated (lived alone/lockdown) **- Ummm, I think the fact that it was during lockdown would probably make me a lot more open. Because I didn't really have anyone else to talk, to kind of during the day**. - if she had those normal networks would she have been less open	wanting that some connection with somone because was isolated (lived alone/lockdown) **- Ummm, I think the fact that it was during lockdown would probably make me a lot more open. Because I didn't really have anyone else to talk, to kind of during the day**. - if she had those normal networks would she have been less open
O: Okay K: Kind of being in 4 walls. So possibly that would have made me a bit more open to sharing a bit more. **O: Yea** K: And yea **O: Ok**			**Kind of being in 4 walls** - trapped		**Kind of being in 4 walls -** trapped
K: So yea I mean that's a big one the sort of the lockdowns that were happening. I think that kind of like if someone was working from home for however long and they get to talk to someone once a week they blurt everything.55	55 The limited options because of lockdown meaning properly made her more open. Starved for someone to talk to, she lived alone, she had a very solitary job working remotely. So actually the chance to speak to someone was welcomed.	**K: So yea I mean that's a big one the sort of the lockdowns that were happening. I think that kind of like if someone was working from home for however long and they get to talk to someone once a week they blurt everything. -** lockdown isolation making her more likely to talk.			**K: So yea I mean that's a big one the sort of the lockdowns that were happening. I think that kind of like if someone was working from home for however long and they get to talk to someone once a week they blurt everything. -** lockdown isolation making her more likely to talk.
O: Yeah, So at that particular time you weren't having much contact with sort of people at home? K: Ummm, I mean I'd ring my family and speak to them now and again, but yea not really. I don't have a job where I really speak to people so…56	56 Having someone to confide in when family wasn't an option?				
O: Yea K: It … laugh yea **O: Is it okay to ask about what kind of work you were doing at that time or?** K: Oh yea I still work for [name] university and work in the [xxxxxx] office and so yea its very much just admin based so we don't don't really speak to people. **O: Okay yea, So I guess, yea and end of 2020 kind of there was yea, there had been a long time of not sort of seeing many other people so.** K: Yea		lonely before - social isolation - some contact with family			
O: Being able to kind of talk at that point sounded helpful. Um what about sort of umm ahhh the people around you? Say like family or um or friends or colleagues, did you speak to them about going to therapy? K: Yea I did mention it to my dad, and a couple of friends but yea I didn't really go into much detail just mentioned it. **O: What was that like sort of telling other people about it?**					

Transcript	**Initial reflections**	**Descriptive notes**	**Lingusitic notes**	**Conceptual notes**	**Emergent themes**
K: Um it was fine and they have known I struggled with kind of anxiety anyway. So It seemed that they were relieved as I was ha, um yea, it kind of an achievement really, and they saw as that as well.57	57 Was able to disclose it to family in a couple of friends- which doesn't speak to it being stigmatised that module having lots of external power pressure either to not to do it.	achievement going to therapy		Postive reaction from family - implying a good social support network - and acceptance that she was getting help - **Um it was fine and they have known I struggled with kind of anxiety anyway. So It seemed that they were relieved as I was ha, um yea, it kind of an achievement really, and they saw as that as well. --** not the external stigma of seeking help	Postive reaction from family - implying a good social support network - and acceptance that she was getting help - **Um it was fine and they have known I struggled with kind of anxiety anyway. So It seemed that they were relieved as I was ha, um yea, it kind of an achievement really, and they saw as that as well. --** not the external stigma of seeking help
	They were relieved as well as, and saw it as an achievement to reach out for help.... Why was that an achievement? Again this is someone who is new to mental health services doesn't sound like there's much experience with				
O: So an achievement, did you see as that as well?					
K: Yea definitely yea yea so I saw it as me as actually taking steps to kind of help myself and yea.58	58 Taking agency in own recovery, which she was proud of/so is an achievement			**O: So an achievement, did you see as that as well? K:Yea definitely yea yea so I saw it as me as actually taking steps to kind of help myself and yea-** agency to help self - you have to help youself - courage?	**O: So an achievement, did you see as that as well? K:Yea definitely yea yea so I saw it as me as actually taking steps to kind of help myself and yea-** agency to help self - you have to help youself - courage?
O: Lovely sounds like there was a kind of supportive response? Is that… K: Yea definitely, yea.					
O: Was there any sort of sort less supportive responses or anything like that that happened externally?					
K: No no, nothing like that, I mean did briefly mention it to my line manager at work, she was very supportive and yea, no no negative responses at all .59	59 No experiences of negative disclosure. Which again would have impacted on the relationship that she had that prior to coming in	no experiences of judgement in those condifed in - supportive others - no negative consequences -**No no, nothing like that, I mean did briefly mention it to my line manager at work, she was very supportive and yea, no no negative responses at all .**			no experiences of judgement in those condifed in - supportive others - no negative consequences -**No no, nothing like that, I mean did briefly mention it to my line manager at work, she was very supportive and yea, no no negative responses at all .**
O: And sort of telling people at work can often quite tricky as well. K: Yea, I mean, I was lucky it was through the pandemic so the only person I really needed to mention it was my line manager, like people in the office would notice you would go off for an hour and they can be a bit nosey. It was lucky it was during the pandemic and no one really saw me, only my line manager knew yea, I didn't feel the need to share it with anyone else, I didn't really have any kind of close friends at work. You're just there to work.			be a bit nosey - trope?	**I didn't feel the need to share it with anyone else, I didn't really have any kind of close friends at work. You're just there to work**. - again had this been a different more exposed context then it may have been harder for her -	**I didn't feel the need to share it with anyone else, I didn't really have any kind of close friends at work. You're just there to work**. - again had this been a different more exposed context then it may have been harder for her -
O: Okay yea no, I can definitely see how that yea, would avoid some of those watercooler conversations. Yea yea, would it have been, do you think, it would have been different in terms of you being able to seek that help if you know it wasn't pandemic times? If you were.. Do you think that would have been different?					

Transcript	**Initial reflections**	**Descriptive notes**	**Lingusitic notes**	**Conceptual notes**	**Emergent themes**
K: No I don't think so, I think avoided talking about it to people who don't I know really know very well anyway, if anyone had noticed that I'd been gone from my desk for an hour, I would have made something up. Or say it's none of your business.60	60 Again this still seems to be that kind of keeping it to herself, not the same sort of openness that you sometimes see with people, particularly people who been in service is a long time and are used to telling their story?		concealed	shame?	
O: Yea					
K: But yea I don't think it would make a difference, but think that I can understand why a few people may be would.					
O: Mmm ok mmm any sort of in terms of kind wanting to keep, to easier like that, were there any worries around sort of other peoples perceptions or stigma from seeking help.					
K: Umm no, not so much stigma, but I just know there's quite a few nosy people in my office, so I just did not want to talk to them about it. Definitely not stigma.	61 No real worries around stigma - feels like things improved in the last 10 years and I guess that's true with lots more mental health visibility, however that is particularly for less stigmatised difficulties, so she was being treated for anxiety and worry, I wonder if she had an SMI or a PD diagnosis, I wonder if her perceptions would be the same? Is this an argument for not diagnosing people with serious mental health conditions? And instead exploring the story, the narrative?	**K: Umm no, not so much stigma, but I just know there's quite a few nosy people in my office, so I just did not want to talk to them about it. Definitely not stigma**. - not stigma in the office just ppl in each others business - private person			**K: Umm no, not so much stigma, but I just know there's quite a few nosy people in my office, so I just did not want to talk to them about it. Definitely not stigma**. - not stigma in the office just ppl in each others business - private person
O: Yea. Outside of your office in terms of more like general society there any worries around pressure or norms, like kind of….					
K: No I think it's kind of don't really think its much of an issue anymore, very much kind of improved over the past 10 years I've definitely felt it's not really stigmatised anymore, which definitely helped because. I don't think stigma was anything I was really worried about, if I'm honest.				**No I think it's kind of don't really think its much of an issue anymore, very much kind of improved over the past 10 years I've definitely felt it's not really stigmatised anymore, which definitely helped because. I don't think stigma was anything I was really worried about, if I'm honest**. - the lessening impact of ideological pressure around stigma etc.... for someone of her age it is more the norm and to be talked about	**No I think it's kind of don't really think its much of an issue anymore, very much kind of improved over the past 10 years I've definitely felt it's not really stigmatised anymore, which definitely helped because. I don't think stigma was anything I was really worried about, if I'm honest**. - the lessening impact of ideological pressure around stigma etc.... for someone of her age it is more the norm and to be talked about
O: Brilliant thank you, so sort of, it sounds like you were quite similar or felt similar to the person that you were working with, sort of…					
K: Yeah kind of the things that I knew.					
O: And in terms of like terms of stuff going on outside the of therapy room like with the pandemic or you know, family, friends that kind of thing. Did you and your therapist talk about how that might impact on the work you're doing or how you were getting on?					

Transcript	Initial reflections	Descriptive notes	Lingusitic notes	Conceptual notes	Emergent themes
K: Yea I do briefly remember, kind of making sure that you have enough access to support networks, and making sure that you've got family and friends to speak, to whether it be virtually or possibly in-person.62	62 The didn't seem to be lots of really difficult situations going on outside of therapy.... Although she might of just not said, but didn't feel like that. I guess having the security of the home, job, probably enough money will be enough to make this not problem. Support networks too.	**Yea I do briefly remember, kind of making sure that you have enough access to support networks, and making sure that you've got family and friends to speak, to whether it be virtually or possibly in-perso**n - her having a network not just relying on MH services			**Yea I do briefly remember, kind of making sure that you have enough access to support networks, and making sure that you've got family and friends to speak, to whether it be virtually or possibly in-perso**n - her having a network not just relying on MH services
O: So you had those kind of conversations… K: There's not a lot I can remember I think I made sure I like could contact someone that I wasn't just sat on my own. **O: And how do you like feel about you feel about the NHS in general? I know that's a big question.**					
K: umm yea, I think, yeah pretty good, yea from what I've experienced anyway, yea definitely.		good experiences with the NHS - **And how do you like feel about you feel about the NHS in general? I know that's a big question. - umm yea, I think, yeah pretty good, yea from what I've experienced anyway, yea definitely**.			good experiences with the NHS - **And how do you like feel about you feel about the NHS in general? I know that's a big question. - umm yea, I think, yeah pretty good, yea from what I've experienced anyway, yea definitely**.
O: yea I know I'm an NHS professional, that can be that can make it difficult to say.. ahh rubbish ..haha					
K: yeah but I would say 90% of my experience has been positive, and probably had a couple of people that I've really not gotten along with, yea, that's definitely doesn't really give a negative opinion.63	63 She had a good experience in the NHS, and that feels appropriate to say in this instance because she needed help and she got help at the point of need, as opposed to a year down the line on a waiting list in a community team. Just imagine the outcomes people of people were seen were able to be seen and get psychological and nursing help at the point of need, instead of entering the service in either a state of desperation, or the whole picture being completely different. Even in the cases where people just get better by themselves, it probably would still leave a bitter taste in their mouths	the good exp of NHS outweighed the bad **- yeah but I would say 90% of my experience has been positive, and probably had a couple of people that I've really not gotten along with, yea, that's definitely doesn't really give a negative opinion.**			the good exp of NHS outweighed the bad **- yeah but I would say 90% of my experience has been positive, and probably had a couple of people that I've really not gotten along with, yea, that's definitely doesn't really give a negative opinion.**
O: And I'm definitely not seeking all of the positive ones as well just good kind of balanced view. More than anything so don't worry because obviously that's something that is sort of live in power in the relationship here as well. K: Yea **O: Me being a professional with that too.**					
K: Yea64	64 Me trying to coax out a bit of the negative, just might have not been any.				
O: I wonder about sort of saying some of the times where you've not so good experiences of NHS professionals compared what the experience you had with your psychologist? What were the big differences in that for you?					

Transcript	**Initial reflections**	**Descriptive notes**	**Lingusitic notes**	**Conceptual notes**	**Emergent themes**
K: I think the big differences were, kind of I my negative experience there was a lack of understanding and like a lack of compassion as well. Whereas I definitely felt that with the therapist, I felt like she was very understanding, and quite sympathetic as well, and which I think makes all the difference when you are going through like a difficult time. I think that's the main thing that like made it a positive experience really.65	65 Where experience, not with therapist, were poor. - Lack of compassion	experiences of compassion, understanding - being the differences to when she has a disempowered/poor exp of NHS opposed to her experience - **I think the big differences were, kind of I my negative experience there was a lack of understanding and like a lack of compassion as well. Whereas I definitely felt that with the therapist, I felt like she was very understanding, and quite sympathetic as well, and which I think makes all the difference when you are going through like a difficult time. I think that's the main thing that like made it a positive experience really**			experiences of compassion, understanding - being the differences to when she has a disempowered/poor exp of NHS opposed to her experience - **I think the big differences were, kind of I my negative experience there was a lack of understanding and like a lack of compassion as well. Whereas I definitely felt that with the therapist, I felt like she was very understanding, and quite sympathetic as well, and which I think makes all the difference when you are going through like a difficult time. I think that's the main thing that like made it a positive experience really**
O: And when you say understanding what's that's wanting, again another slightly abstract question, what's it wanting to be understood?	lack of understanding - formulation and empathy and compassion being key				
K: So kind of your needs, feeling and kind of how to kind of manage them, is suppose, I come to therapist with an issue. And her kind of understanding and providing the solution is kind of her saying I understand because I've listened to you and I can offer you a solution, and these are my thoughts, and here's how we can help you.66	66 Also wanting the practical help, providing the solution-I guess they can only come with good understanding which again argues for more formulation-based approach animal person centred approach as opposed to diagnostic.	what she wants to be understood and solution provifing		Offering a solution/intervention is based in understanding and having been listened to - **So kind of your needs, feeling and kind of how to kind of manage them, is suppose, I come to therapist with an issue. And her kind of understanding and providing the solution is kind of her saying I understand because I've listened to you and I can offer you a solution, and these are my thoughts, and here's how we can help you**	Offering a solution/intervention is based in understanding and having been listened to - **So kind of your needs, feeling and kind of how to kind of manage them, is suppose, I come to therapist with an issue. And her kind of understanding and providing the solution is kind of her saying I understand because I've listened to you and I can offer you a solution, and these are my thoughts, and here's how we can help you**
O: Lovely. What if the person offering wasn't able to offer a solution?					
K: I mean it would still it would really depend; it wouldn't really mean they hadn't understood, but it could just be is that there is no solution, which is the case like most of the time, yea.					
O: Yea					
K: I mean as long as they can offer some sort of information, or advice how to help me deal with it.' Id say that I've been understood.67	67 Guess solutions don't always exist. But as long as they're being heard and understood, and can provide something, I guess it's better than nothing			she wanted advice and soltuions hence the technical aspects being important not the TR, - **I mean as long as they can offer some sort of information, or advice how to help me deal with it.' Id say that I've been understood.67**	she wanted advice and soltuions hence the technical aspects being important not the TR, - **I mean as long as they can offer some sort of information, or advice how to help me deal with it.' Id say that I've been understood.67**
O: Lovely, that bit, making sense of it?					
K: Yea, it's just explain like that show that they understand and they can kind of make sense of what you are saying, and yea, usually they can kind of offer you some reassurance, say this has helped people in the past.		**showing they understand** - offering reassurance - this has helped ppl in the past			**showing they understand** - offering reassurance - this has helped ppl in the past

Transcript	Initial reflections	Descriptive notes	Lingusitic notes	Conceptual notes	Emergent themes
O: Yea. Okay, and thinking about, just going back to the those kind of differences between good experiences and bad experiences, or not so good experiences with people, what's, um if you had any sort of advice for a clinician or a like a therapist for helping you someone you to have a the same good experience, compared to a bad, compared to a not so good one. What would you tell them?					
K: Ummm not quite sure. I think I would, I'd advise them to request a different person, ummm because obviously how my experience was a good one, and if they felt they weren't being understood or listened to and then just like reassuring them that like good help does exist, and that they just need to maybe try something else, or request a different psychiatrist.					
O: Lovely, similar kind of thing, what would you say you would be the most important thing that someone working the NHS can do to help with their relationship with a …. With Someone in therapy?					
K: Ummm. I would say its quite a difficult one, I would just say to try and… Take it at the patients pace and try and don't make them feel uncomfortable and reassuring them that they can share as much as they want to. And making them aware that it is completely confidential, yea, I think that's all they can do, be friendly and not make it too formal, and yea that that kind of thing.68	68 Comfort	**Ummm. I would say its quite a difficult one, I would just say to try and… Take it at the patients pace and try and don't make them feel uncomfortable and reassuring them that they can share as much as they want to. And making them aware that it is completely confidential, yea, I think that's all they can do, be friendly and not make it too formal, and yea that that kind of thing**. - her advice ffor what works- confidential , friendly, informal,			**Ummm. I would say its quite a difficult one, I would just say to try and… Take it at the patients pace and try and don't make them feel uncomfortable and reassuring them that they can share as much as they want to. And making them aware that it is completely confidential, yea, I think that's all they can do, be friendly and not make it too formal, and yea that that kind of thing**. - her advice ffor what works- confidential , friendly, informal,
	reassurance - particularly around choice with what they disclose confidentiality friendly and informal				
O: Fabulous suggestions, really really good, thank you, I'm gonna ask the opposite question, what would be a big no no, what would be the worst thing someone could do?					
K: I think kind of being unprepared, and not really, kind of going in don't really know what to ask and reading from a script essentially. Then the person might feel a bit like, it's too formal, and it's just a tick box exercise, and they are not really being heard so yea, I think yea, pretty much.69	69 This really speaks to source of professional competence and confidence.	Need to still be human and not treat as a process - too formal, tick box - so not understood - :: **I think kind of being unprepared, and not really, kind of going in don't really know what to ask and reading from a script essentially. Then the person might feel a bit like, it's too formal, and it's just a tick box exercise, and they are not really being heard so yea, I think yea, pretty much**			Need to still be human and not treat as a process - too formal, tick box - so not understood - :: **I think kind of being unprepared, and not really, kind of going in don't really know what to ask and reading from a script essentially. Then the person might feel a bit like, it's too formal, and it's just a tick box exercise, and they are not really being heard so yea, I think yea, pretty much**
	As well as the individualised approach-not just going through the motions, reading of the script				
O: So how we have language, how we use language…					

Transcript	Initial reflections	Descriptive notes	Lingusitic notes	Conceptual notes	Emergent themes
K: Yes very important, make it feel a little bit formal, so not to be too overwhelming I suppose.		formailty in language = overwhelming - **Yes very important, make it feel a little bit formal, so not to be too overwhelming I suppose.**			formailty in language = overwhelming - **Yes very important, make it feel a little bit formal, so not to be too overwhelming I suppose.**
O: Okay. Brilliant, And is there anything else you'd like to say about your relationship with your psychologist?					
K: Ummm, I don't think there's anything I can think of that I haven't already mentioned, but yea it just generally it was good relationship and that I felt that I could confide in her and it wasn't to formal, yea, quite a trusting relationship and also really helpful. Yeah.70	70 Again feeling able to talk and trust				
O: Lovely.Yes so there's lots of suggestions from my kind of summary, like what I've heard like that trust, being heard, being understood, sort of from an informal, sort of not check box /tick box is what really develop that relationship, and obviously really nice outcomes for you as well.					
K: Yea definitely.					
O: Brilliant is there anything that I haven't asked that you would have expected or wanted me to ask Kate?					
K: Um, not that I can think of, I mean wasn't kind of sure what kind of questions to expect kind of based on how did you get into therapy and your experience. It wasn't really anything specific that I thought you'd ask.					
O: Brilliant					
END					

Appendix W: Connections across themes for individual participant

minimising her distress?	Help at the right time/ only exp of therapy MH services - taken seriously	happy to go along with it	power as authority to make things happen	has not felt sig disempowered - so not considered - good NHS exp	being able to stand up to power - knowledge, courgae (still felt)	relief in being able to talk / not suffering in silence	before therapy - optimisitic	latent fear of being judged by profs	confidentiality and shame/embarrassment	power and safety in the processes	a relationship is not equal but doesn't have to feel unequal
feeling a bit suicidal, so I took an overdose of sleeping tablets and so I went into hospital in [location] scene setting, feeling a bit suicidal so took an overdose - minimisation (avoid judgement?)	**I've been in and out of hospital since an operation3 I had [O:ohh] that had went wrong and I had just been feeling a bit down and feeling a bit suicidal4, so I took an overdose of sleeping tablets and so I went into hospital in [location] -** causation of medical negligence leading to MH crisis	I just kind of went along with it' - indicates lack of choice	**I think it's more like someone having kind of the authority ummm and kind of ability to actually action something, umm, mmm yes, it's a tricky one, I think when someone kinda says power you think about someone who is high authority, makes all the decisions, -** is in charge (authority) makes ALL the decsisions **- ummm, yea that kinda what I think of power is authority, the power to make decisions**	because not really thought about it before may mean not explictly felt those explict power ops that people from minoritised backgrounds may be more used to. - **No not really, no hahaha, so ummm no I think ever been asked that to be honest, that's just kind of what comes to mind.** - gives impression not disempowered ghenerally	**all these doctors making decsions for me** - clue to how she experiences power - a grouping of them	the relief - of being able to open up, not concealing/hiding - **Um, if I'm honest. Kind of a relief that I finally some had someone who I could kind of open up to, that didn't know me,**	**Ummm, I think it was over the phone, I don't think it was that, I wasn't really that nervous at first, I was quite optimistic -** hope optimisitc	face to face vulnerabilty - not seeing the other person made it easier **- I don't know if it was because this person can't see me but, it kind of, kind of rid of the anxiety of meeting someone new.**	**I've been in and out of hospital since an operation3 I had [O:ohh] that had went wrong and I had just been feeling a bit down and feeling a bit suicidal4, so I took an overdose of sleeping tablets and so I went into hospital in [location] -** causation of medical negligence leading to MH crisis	explained the process, clear structure / set the expectations up well - **I think she made me feel very comfortable in um in kind of what was going on and explaining how the process would work and kind of each session.**	**Umm not sure I think it's always been a bit one sided because it's, I'm the one in therapy and I'm telling you all this information and I don't know anything about you and so think its ever its ever been equa**l, - not equal in the relationship because you are having to give all this private and sensitive information
Escape from current emotional situation - indicates preoccupied with it most of the time - **And then just kind of getting away from that kind of headspace of worry about everything umm then overwhelming**.	Really helpful therapy - **It was really helpful**	**Ummm but yea ummm on the initial triage which was telephone, I opted for the CBT by telephone,7 umm and yea that was kind of the course of therapy that I chose. I think it was just kind of recommended to me by the triage call I think they kind of worked out from there what would be the best course of therapy for me, so I just kind of went along with that, it seemed to be the best option at that time -** just kind of went along with it, no choices offered.	Power is contextual and reaches many contexts - **Yea it can be used in so many different contexts,**	**Ummm I think to some extent, … I'm not quite sure, I don't really see myself as having a struggle with power at this point in my life, I can't really think of any examples to be honest-** sturggling to think of times disempowered = not so disempowered. Acknowledging it does to some extent but hard to grasp or understand because not acute	historical experience of using own power in NHS - because in the end I said no and didn't give in.	power operating with friends and family - judgement?		not meeting f2f meant there was less anxiety - judgement, fear of doing something wrong>>>??? - **Umm even though obviously I was still talking to this person ummm, not sure I can, I think it made it a lot easier made me feel I could be a lot more open, because I just wasn't as nervous as I would be kind of meeting someone in person for the first time**	confidentiality important >shame of what she was feeling going through reaching for help - **um yea I feel like the therapist was very um calming and kind of made me, reassuring that everything was confidential and um that y**	process - as in there is expecations in it - is there power in process	**but yea it didn't feel like at the same time it didn't feel inequal. It didn't feel like I was kind of made to be put down or anything -** so not abusive - power can operate, but not harm - not disempowered. LATENT POWER
	First ever experience with therapy - and a postive expeirence - important that first time was good. And specifically no poor experiences to relate it too	Just kind of went along with it at the time, wanting to be helped? Feeling powerless? She had limited options or did not know where to go herself.	powerful nothing standing in your way	good experiences with the NHS - **And how do you like feel about you feel about the NHS in general? I know that's a big question. - umm yea, I think, yeah pretty good, yea from what I've experienced anyway, yea definitely**.	**a couple years ago when I've been in and out of hospital and had all these doctors kind of making decisions for me, and I remember once they were telling me to have this operation and I really didn't want it, ummm and thinking, telling them no, and yea -** ppl in power making decisions for her - able to tell them no - so aware but able to push back	laugh - **cant believe I didn't do this soone**r - she had been feeling this way for a long time?		**Um, so I think I was kind of a bit worried when you go the doctors and you see GP and you know they are writing everything down on their computer and they can see everything.** - wanting her privacy, as she sees Drs a lot which - shame vs privacy	reassured around confidentiality being very important to her - the importance of this worry about it impacting other treatment and shame??? - **So in the first in the first meeting um confidentiality was mentioned and it made me feel very comfortable to know that it wouldn't be shared outside with people when it wasn't necessary.**	Clear process and goals	**Yea I never felt like, like I was less important or anything like that**. - Equity and parity in the TR
	yea, there wasn't much waiting around it was just kind of like I literally came out of hospital on the Thursday and within the next week or 2 that I got the email and got triaged very quickly. - the speed that it happened, no waiting, as it should be	**I didn't really know what I needed so I went along with it.**	**unrestricted** - they can do what they want…. Not standing in their way (even if the other doesn't want it) **Not really anything standing in your way, if you've got power there's not really much stopping you doing what you want.20**	the good exp of NHS outweighed the bad - **yeah but I would say 90% of my experience has been positive, and probably had a couple of people that I've really not gotten along with, yea, that's definitely doesn't really give a negative opinion.**	coercision - soft - **Kind of being felt like I was pushed, to be saying yes, I didn't want to, but**			worry around judgement from professionals seeing it	confidentiality being key - = trust - **I think it was very early on [felt trust]and from what I can remember. Um I think it would just the initial kind of um reassurance and that kind of the information wouldn't be shared with anyone unnecessarily and that kind of talking about the goals of the sessions.**		wanted it to be one sided because that was their job - **Umm I don't.. From what I can remember it didn't really make a difference because obviously like I knew that that person was there to kind of listen and to help me**
	being taken seriously - people advocating for her - validating	**Because when they kind of called me, I wasn't really sure I'd never really been in therapy before I didn't really know what I needed, so I just kind of went along with what they recommended, umm yea that sounded good at that time. -** inherent power in their opinion and expertise because of no prior knowledge or exp - not a bad thing	**I think kind of the opposite of having power is being restricted and umm having a lot of people make decisions for you and you feeling kind of bound by those restrictions and not having much say in kinda what goes on, yea -** bound by restrictions, lack of choice, controlled		**I think at the time I thought that they were, but now that I look back, I was, because in the end I said no and I didn't give in. - i**t took effort! Also she did not feel powerful at the time, uncomfortable to do perhaps. **- give in -** persuade persistence			**I didn't want the same thing to happen, kind of with the therapy, I was thinking you could actually see this. It turns out it is very difficult, not like everyone can access it, which yes is quite huge load off my mind** - huge load - weighing down so the pressure of worry around this was great and i wonder if that had time to percolate would it have impacted her more?			**that person** - didn't use she, dettachement from her?
	that feeling that things have been taken seriously? Someone pushed it through. Speaking that the liaison team had power to make things happen - someone or system advocating for her - must have been validating for her and her actions. **Yea, yea I do remember it being quite quick, umm. But I don't whether that was anything to do with the fact that I was referred by the MH crisis team or anyone at the hospital had pushed it through.**	It's hard to think of the lack of choice when the outcome was faviourable for her - **No I don't think so, cos at that time it was really helpful for me. So I don't think I would have done anything different**.			Power demonstrated and held and bound in knowledge- something to be effortfully aquired - **Mmmm yea yea a little bit because I kind of took it on myself, doing my own research and think what are the benefits do they outweigh the positives and I just thought it's not worth going through that, or it could possibly make me worse, so I thought for what was maybe worse I thought**			reassured others profs couldn't see it - she sees a lot of professionals? - **Ummm it was more like every single professional that I was see…. [line dropped out]**			**Umm not sure I think it's always been a bit one sided because it's, I'm the one in therapy and I'm telling you all this information and I don't know anything about you and so think it's ever... it's ever been equal, but yea it didn't feel like at the same time it didn't feel inequal. It didn't feel like I was kind of made to be put down or anything**. - not equal but not inequal
	quick from triage and crisis to therapy	laughter as if she would worry about it- or indicating that this was something she would normally worry about. **I don't remember there being much time to think worry about it, it just started it haha**			**I thought, No, you don't have the power, -** a tipping point - her having this knowledge let her push back on it - (something she did not have pre therapy>)			**Yea, So think it was just worrying that if went to A&E with a broken foot they'd be able to see all my mental health records which would be embarrassin**g. - her experiences are embarassing and shameful			acknowledgement just how much of yourself you have to give up without receiving much (simlar) from the therapist - **Umm not sure I think it's always been a bit one sided because it's, I'm the one in therapy and I'm telling you all this information and I don't know anything about you and so think it's ever... it's ever been equal**
		you're just kinda doing this and it's starting now - helpful push?			Pushing against power is effortful			alluding that sensitive stuff can be shared - that this is sensitive, painful etc, sort of beneath this is a shame I think - **Um yea, I think, yea I think so, yea I think I would depend on it's just, I think it actual feeling that I want that kind of discretion when it comes to sharing sensitive information**			
		You're doing this - externalising force (in self?) it's starting now. Who is saying that is it her internal mono or is it something external -sounds internal			Holding knowledge is a form of power - and can force change - both sides for her on this (her using it and the Drs) - **No, you don't have the power, I do. I think they wanted they wanted to show they had power by, showing that they had all of this knowledge and kinda used that power to make me, persuade me to do what they wanted me to do**			**Im not sure if it would affect my how they treat me. It could it completely depends on who has kind of their hands on it and that's where the worry is that you don't know who. -** there are some people who might missuse it.			
		Not having the chance to get worried about it - As if she thought about it it could be unpleasant or scary? - **which was kinda best I think because it don't really give you the time to kind of umm and arghh about it, you're just kinda doing this and it is starting now hahaha. Okay so yea cos that I guess that that space to just sort of mull things over and sort of Kind of may be put you off it, but I didn't really have that chance. -** They were taking charge?						**I didn't need to kind to explain things in a certain way that, it was just kind of get it off ya chest it doesn't matter it doesn't matter how you kind of explain it -** freedom of expression **no one was judging me**			

anonyminity / privacy	trusting	undertanding / advice and solution	consistency	informal / not a medical prof	empowering choice?	caring what the therapist thought of them	wanting the technical over the relational - distance - on topic	similiarity to therapist	lonliness	good support and good reactions from others - no exp of judgment	stigma - preconceptions
	trusting experience, where listened to, like a friendship but not like a very personal friendship - **Yea um I think it was quite a… definitely quite a trusting relationship, and I felt I was like listened to and ummm, almost a bit like a friendship but not like a very personal friendship.**	experiences of compassion, understanding - being the differences to when she has a disempowered/poor exp of NHS opposed to her experience - **I think the big differences were, kind of I my negative experience there was a lack of understanding and like a lack of compassion as well. Whereas I definitely felt that with the therapist, I felt like she was very understanding, and quite sympathetic as well, and which I think makes all the difference when you are going through like a difficult time. I think that's the main thing that like made it a positive experience really**	Stablitly and consistency in the relationship - **Um did your feelings sort of towards your psychologist or just the relationship, did that change over time that you spent in therapy?Ummm no no, I don't think there was much change, in kind of the way that so ..**	informality is a form of equalising power and it sounds like this was actually felt by her - **So I don't know it's kind of strange, but there would be times that where we would have a little bit of a laugh and yea it was just like chatting to someone, so felt quite comfortable and not not kind under pressure. Didn't feel like I was talking to a, I don't know someone who was a medical professional, it felt like I was talking to someone who was giving me advice or yea**	**And kinda take it at your own pace really, which was really nice. -** empowering for her. #	element of of image management -showing she did care about what the therapist thought of them - very subtle - **kind of if I had an argument with someone and I was thinking, oh I hate them. I wouldn't mention that to my therapist because she wouldn't need to know. But nothing that was kind of really bothering me, and yea**	Her experience was of the technical stuff she took away and found helpful. Not the relational - **yea I feel like they really helped me with what was a very difficult time in my life, and I'm definitely grateful for the sessions we had and I think they helped me a lot and I use kind of the techniques that she taught, me still to this day, so there's like quite a lot of techniques she told me about, ways to manage worries and anxieties that I still use and still helps with day to day worries now**	**m but I didn't really see us as different, so kind of first went into the sessions I didn't really think of my psychologist being very much different to myself. I thought, ummm kind of she's probably sat at home, just like I am and she works from home, so do I haha, we both been to university, um, so actually think we are more similar than different, I yea -** similar in education levels - otherwise no real diffs, hard to see over the phone.	wanting that some connection with somone because was isolated (lived alone/lockdown) - **Ummm, I think the fact that it was during lockdown would probably make me a lot more open. Because I didn't really have anyone else to talk, to kind of during the day**. - if she had those normal networks would she have been less open	Postive reaction from family - implying a good social support network - and acceptance that she was getting help - **Um it was fine and they have known I struggled with kind of anxiety anyway. So It seemed that they were relieved as I was ha, um yea, it kind of an achievement really, and they saw as that as well. --** not the external stigma of seeking help	**Just because I had never been to therapy before I didn't know what to expect seen from tv show's and just yea, completely unrealistic expectations. whereas when you get in there and it is not as scary as I expected it to be so it's a lot more informal and there weren't like set questions they would always be like, if you're not comfortable to answer a questions then you don't have to. And kinda take it at your own pace really, which was really nice. -** societial expectations and displays of what therapy is impacting - think it wil be scary - why scared?
	felt comfortable quickly - and without that would not be able to share feelings - **I think it was very kind of early on. And if not kind of first triage then definitely from the first session I felt comfortable, and to kind of share how I was feeling**	Offering a solution/intervention is based in understanding and having been listened to - **So kind of your needs, feeling and kind of how to kind of manage them, is suppose, I come to therapist with an issue. And her kind of understanding and providing the solution is kind of her saying I understand because I've listened to you and I can offer you a solution, and these are my thoughts, and here's how we can help you**		The experience (thus power in the realtionship felt different) - **Didn't feel like I was talking to a, I don't know someone who was a medical professional, it felt like I was talking to someone who was giving me advice or yea.**		**: I cant remember if there was anything in particular that I purposively didn't share, if it was it wouldn't have been anything that was major, that was something like make that makes me sound a bit petty, so not gonna mention it because it's not important, but nothing like really deep thoughts that kind of were important, nothing like that -** makes me sound a little petty - again image management and care what they thought - minimises this because it wasn't relevant?	Clear process and goals	**Ummm, it's difficult I never really… I think to be honest I think we could be quite the same [laugh], um it's just that I don't have the information to kind of know. =** not knowing enough about them to make a judgement on their similaritys	**Kind of being in 4 walls** - trapped	**O: So an achievement, did you see as that as well? K:Yea definitely yea yea so I saw it as me as actually taking steps to kind of help myself and yea-** agency to help self - you have to help youself - courage?	**K: Umm no, not so much stigma, but I just know there's quite a few nosy people in my office, so I just did not want to talk to them about it. Definitely not stigma**. - not stigma in the office just ppl in each others business - private person
	No. I don't think it would have made much of a difference. I don't think it really crossed my mind about the kind of how they are as a person. I think it was just at that point someone to talk to listen to as long as long as I trusted them then, there kind of personal background wasn't really important, and the fact that I don't really know much about them. But I still kind of trusted them and was having to talking to them and being completely open. - trusting them - who they were did not make a massive difference -	she wanted advice and soltuions hence the technical aspects being important not the TR, - **I mean as long as they can offer some sort of information, or advice how to help me deal with it.' Id say that I've been understood.67**		**Oh yea that's the word! yea definitely less formal than I expected it to be.** - expecations around formality from previous medical expeirences and power etc????		**I think it was more it wasn't relevant to the sessions really so she'd say like how are you feeling, if I just, say I had an argument with my mum or yea, I wouldn't mention it, because I wouldn't see it as relevant, yea -** quite focused on the focus of the sessions - what they were there to do - I wonder if the focusing on this is a form of very subtle silencing power> probably a reach	**And if there is something you can do about it then write down the options, then if there's nothing you can do about it, you just throw it away and that's kind of like really helps you in your mind to just throw it away. Stuff like that I still do and I think it has really helped me like having someone to talk about the examples and kind of help me with that technique**. - the therapist was a vessel for the techniques - again move away from the relational (phone therapy?)		**K: So yea I mean that's a big one the sort of the lockdowns that were happening. I think that kind of like if someone was working from home for however long and they get to talk to someone once a week they blurt everything. -** lockdown isolation making her more likely to talk.	no experiences of judgement in those condifed in - supportive others - no negative consequences -**No no, nothing like that, I mean did briefly mention it to my line manager at work, she was very supportive and yea, no no negative responses at all .**	**No I think it's kind of don't really think its much of an issue anymore, very much kind of improved over the past 10 years I've definitely felt it's not really stigmatised anymore, which definitely helped because. I don't think stigma was anything I was really worried about, if I'm honest**. - the lessening impact of ideological pressure around stigma etc.... for someone of her age it is more the norm and to be talked about
	could still trust them without knowing much about them - what gave that trust (approach, professional presige??) - **I trusted them then, their kind of personal background wasn't really important, and the fact that I don't really know much about them. But I still kind of trusted them and was having to talking to them and being completely open.**	**showing they understand** - offering reassurance - this has helped ppl in the past		**It was yea yea I mean it didn't feel very formal. It did feel like I could just speak my mind,** - informality providing space for free speech, expression			**: Umm, I'm not quite sure if I kind of learned anything about relationships. I think it was more that I learnt to kind of share my feelings with someone that I had never met before and there's quite a lot of benefits to doing so. Um kind of more than I had realised because I'd never had kind of gone through anything like that before -** whilst nothing explict from the relationship she did learn it was okay to share feelings - so an aspect of the TR translating outside of the room.			**I didn't feel the need to share it with anyone else, I didn't really have any kind of close friends at work. You're just there to work**. - again had this been a different more exposed context then it may have been harder for her -	
				Need to still be human and not treat as a process - too formal, tick box - so not understood - :: **I think kind of being unprepared, and not really, kind of going in don't really know what to ask and reading from a script essentially. Then the person might feel a bit like, it's too formal, and it's just a tick box exercise, and they are not really being heard so yea, I think yea, pretty much**			found it helpful opending up - having trust and safety in a stranger - **I think it just helped me just open up a bit more to someone I had not met, yea?**			**Yea I do briefly remember, kind of making sure that you have enough access to support networks, and making sure that you've got family and friends to speak, to whether it be virtually or possibly in-perso**n - her having a network not just relying on MH services	
				formailty in language = overwhelming - **Yes very important, make it feel a little bit formal, so not to be too overwhelming I suppose.**			but not the actual relational - quite reserved when comes to personal relationships - hence the worry around confidentiality etc - I don't think so, I don't think so no. I'm still actually quite reserved when it comes to personal relationships I don't think its really helped much in that				
							wanted it to be one sided because that was their job - **Umm I don't.. From what I can remember it didn't really make a difference because obviously like I knew that that person was there to kind of listen and to help me**				
							that person - didn't use she, dettachement from her?				
							could have used some personal experience to agument the technique explanation but did not want their life story - I guess she not seeking a seceure attachment here she is wanting tools for help - as it comes back to the techniques not the relationship - **Ummm I think it would depend what it was. If it was kind of something like to share their own experiences not like there experiences in full detail but if they kind of shared, kind of methods of coping that worked for them, I think that would be really useful and if they were to kind of say this really worked for me and this is how I did it.I think that would be kind of helpful. But if they were just going on like, giving me their life story I don't think that would be helpful.**				

Appendix X: Exemplar of write up of individual participant data

Example of write up of individual themes – Kate

Overview of themes

1. ***"I don't really see myself as having a struggle with power at this point in my life" - Previous experiences of power***
    - Limited experiences of being disempowered
    - Mostly positive experiences in the NHS
    - Lots of contact with physical health professions and fear of judgement
    - Power as authority and able to take action without anything standing in their way
2. ***"You're doing this"***
    - Help coming at the right time
    - Feeling like she was taken seriously
    - 'I just kind of went along with that' – containing
    - Relief she 'finally had someone who I could open up to that didn't know me'
3. ***"It's never kinda been equal, but yea it didn't feel like at the same time it didn't feel inequal"***
    - Having to expose the self and risk judgment
    - Ensuring confidentiality
    - Trust
    - Informality balancing power from the past
    - Feeling understood
    - Consistent
4. ***Security in relationships and attachments***
    - Focusing on the techniques over the relationship
    - Judgement and managing her image with the therapist?
    - Empowerment and support outside of the room
    - I've definitely felt it's not really stigmatised anymore

Example write up of individual participant theme

1. ***"I don't really see myself as having a struggle with power at this point in my life" - Previous experiences of power***

Limited experiences of being disempowered.

Overall, Kate has had positive experiences of the NHS and there was limited evidence to suggest that she has experienced significant disempowerment and oppression. Her demographics (with the exception of being female & having physical health probs) are those of someone who is not exposed to typical systemic disempowerment.

> *Ummm I think to some extent, ... I'm not quite sure, I don't really see myself as having a struggle with power at this point in my life, I can't really think of any examples to be honest-*
>
> *No not really, no hahaha, so ummm no I think ever been asked [have you considered power before] that to be honest, that's just kind of what comes to mind.*

She notably does not have a formal MH Dx. Power is not something she has really considered, and it feels like this is because she hasn't had to. She is aware of power and feels it.

Mostly positive NHS experiences.

Her experiences of the NHS are mostly positive and she has limited experiences of being disempowered. This arguably impacts how she experiences power in the relationship. The expectation that that she will not have a bad experience or be made to feel a certain way is an important consideration.

And how do you like feel about you feel about the NHS in general? I know that's a big question. - umm yea, I think, yeah pretty good, yea from what I've experienced anyway, yea definitely.

yeah but I would say 90% of my experience has been positive, and probably had a couple of people that I've really not gotten along with, yea, that's definitely doesn't really give a negative opinion.

Furthermore, with regards to MH services, this is her first experience of therapy, and she has not had chronic contact with services. Not having the opportunity to be disempowered in services because of the lack of contact is an important consideration.

that is kind of my first ever experience with therapy.

That being said she had an experience of feeling the pressure of those in power in her physical health care and well as significant contact and an operation that went wrong. She provides a clear example with being pressured by doctors to have an operation. However, we will see that she was able to respond to this in a more powerful way – see next section.

I've been in and out of hospital since an operation I had [O:ohh] <u>that had went wrong</u> and I had just been feeling a bit down and feeling a bit suicidal, so I took an overdose of sleeping tablets and so I went into hospital in [location

a couple years ago when I've been in and out of hospital and had all these doctors kind of making decisions for me, and I remember once they were telling me to have this operation and I really didn't want it, ummm and thinking, telling them no, and yea

Kind of being felt like I was pushed, to be saying yes, I didn't want to, but

Lots of contact with physical health professions and fear of judgement.

Her being in and out of physical hospital impacted on her. Throughout the interview she voiced her concerns and the importance of her mental health information being confidential. This gave the impression of shame/embarrassment and fear of judgement from medical professionals. This could have been a powerful and potentially unseen force on her in therapy – but as we will see this was addressed effectively.

*Um, so I think I was kind of a bit worried when you go the doctors and you see GP and you know they are writing everything down on their computer and they can see everything***.**

Yea, So think it was just worrying that if went to A&E with a broken foot they'd be able to see all my mental health records which would be embarrassing.

Um yea, I think, yea I think so, yea I think I would depend on it's just, I think it actual feeling that I want that kind of discretion when it comes to sharing sensitive information

no one was judging me (regarding the therapist)

I didn't need to kind to explain things in a certain way that, it was just kind of get it off ya chest it doesn't matter it doesn't matter how you kind of explain it

Understanding of power as authority and action .

Her previous experiences arguably have shaped her conceptions of power – her conception of someone in power is around authority and being able to able to make decisions without restriction. This arguably makes sense in term of her most salient description of power being used against her in the medical setting. Doctors have authority (to know what to do and what's best).

> *I think it's more like someone having kind of the authority ummm and kind of ability to actually action something, umm, mmm yes, it's a tricky one, I think when someone kinda says power you think about someone who is high authority, makes all the decisions*
>
> *Not really anything standing in your way, if you've got power there's not really much stopping you doing what you want.*

Her descriptions of someone being bound by those restrictions for someone who is disempowered gives the feeling of no choice and almost being physically restrained from choice.

> *I think kind of the opposite of having power is being restricted and umm having a lot of people make decisions for you and you feeling kind of bound by those restrictions and not having much say in kinda what goes on, ye*

The ubiquity of power is something she acknowledges. Further note how she says it something that can be used, like a tool or something that can be actively deployed and not just something that is passively there.

> *Yea it can be used in so many different contexts*

Appendix Y: Table of individual participant themes

KATE	AXEL
- ***I don't really see myself as having a struggle with power at this point in my life*** **- Previous experiences of power**	- **Their experience in the relationship/power is shaped by their experience prior**
○ ***Mostly positive experiences in the NHS***	○ **Fearing people in authority throughout life**
○ ***Limited experiences of being disempowered***	○ **Radical acceptance**
○ ***Lots of contact with physical health professions and fear of judgement***	○ **Rejection and dismissal from childhood to services on repeat**
○ ***Power as authority and able to take action without anything standing in their way***	○ **Society and the structure of the NHS being disempowering**
- ***You're doing this***	- **Going along with it because you are desperate – compliance**
○ ***Help coming at the right time***	○ **Desperate for any help (wait)**
○ ***Feeling like she was taken seriously***	○ **Coercion to accept what you were offered (without consent)**
○ ***'I just kind of went along with that' – containing – I didn't really know what I needed***	○ **Having to passively accept whatever you are offered even when it is not enough**
○ ***Relief she 'finally had someone who I could open up to that didn't know me'***	- **You bring this all into the therapy room & the relationship – power transfers to the relationship and experience of power**
- ***its never kinda been equal, but yea it didn't feel like at the same time it didn't feel inequal***	○ **The poor experiences with clinicians and people in power comes into the TR.**
○ ***Having to expose the self and risk judgment***	○ **The previous experiences are something to work through (building trust), internally and externally**
○ ***Ensuring confidentiality***	- **Power was never felt as equal but there were things that did or could help**
○ ***Trust***	○ **The imbalance is natural and deeply known and felt**
○ ***Informality balancing power from the past***	○ **The behaviours of the therapist – consistency, validation respectful- welcoming disagreement**
○ ***Feeling understood***	○ **Power is something that needs to acknowledged and relinquished**
○ ***Consistent***	- **The effort of learning to the language of MH services and the processes to show you need care.**
- **Security in relationships and attachments**	○ **Adopting the language of professionals to gain credibility**
○ **Focusing on the techniques over the realtionship**	○ **Needing to show them that you needed their care and to be believed**
○ **Judgement and managing her image with the therapist?**	- **Limited options for holding on to ones power**
○ **Empowerment and support outside of the room**	○ **What the therapist thought mattered**
○ ***I've definitely felt it's not really stigmatised anymore***	○ **Not disclosing, holding on to their shame**
Not us and them	***Us and them***
Identity as a SU - not having one	SU - lots of identies relating to trans, neurodivergent etc
Pivotal moment - Confidentiality reassurance	Pivotal moment - Not agreeing on A PTSD Dx

CECILIA

- **Historical factors impacting on the self and experience of power**
  - ***Being made to feel stupid (not good enough/worthy)***
  - ***Dehumanised***
  - ***Not belonging – ashamed of MH***
  - ***A bad person***
- **Power a dynamic spectrum**
  - ***Hold/control***
  - ***Influencing***
  - ***The role of the individual (self blame?)***
- **Feelings before therapy**
  - ***Anxious*** **- anxious that it will end, anxious wont be good enough for the process (intelligence?), judgement?**
  - **Anxious will be judged**
  - ***Gratitude – accepting what was offered ?***
- **Protecting the self**
  - ***Externalising,***
  - ***language, credibility, knowledge,***
  - ***reassurance seeking***
  - ***Being a good enough patient? Not risking rupture***
- **Therapist behaviours**
  - **Validating, reassurance, encouragement, respect, equity in relationship, humanising**
  - **Time in the relationship**

Us and them

Dual ID - BPD strong ID
Pivotal moment - Coming to terms with that they were good enough for therapy

VIOLET

- **The impact of previous experiences -** ***I was functional but I was always a bit fragile***
  - **Fragile but functional (seeing the self as weak dominance/submissive)**
  - **Not being able to trust services**
  - **expecting to be let down**
  - **Experience of navigating professional relationships (it's a skill)**
- **The desperation to make sense of things and repair what is broken –**
  - ***I was very much desperately willing to engage in whatever needed to be done to achieve my recovery***
  - **Broken and wanting to make sense**
- **The fight to get care & the injustice**
  - **Sick and tired of having to fight for it (Frustration) –** ***gone to war with them***
  - **Having to learn the languages of services and service users**
  - **The injustice and harm of it all for her and others (unequal parity of Physical health)**
  - **It shouldn't be a life sentence**
  - **Too big to fight**
  - **Becoming complex and not being understood**
- **The Excitement of finally feeling they'll get a recovery & the expectations this set up in the TR**
  - **The achievement of just getting therapy**
  - **Embarking on a journey of recovery**
  - **Wanting a secure attachment**
- **The reality & disappointment of therapy**
  - **Deception and broken trust**
  - **Feeling like she had been cheated out of her recovery**
- **Power in the relationship**
  - **Learning to wield my power usefully** `- powerful person`
  - **Fear of her own power (I break people)**
  - **Unconscious uses of her power – testing, showing her power**
  - **Able to close the screen (stop it)**
  - **His knowledge and qualifications**
  - **Power in his influence in the service (gatekeeper)**
  - **Not forming an attachment**
  - **Power in services – The disconnect between services – it's like they have DID**
  - **Service processes challenging**
- **Being grateful**
  - **Transactional thinking and NHS being free at PON**

Us and them

SU - CPTSD - activist
Pivotal moment - Rupture around timing for therapy

LOLA

- **The duality of being clinician and a patient**
    - **Expectations of a clinician to be ultra human**
    - **The constant fear of being professionally judged and disempowered**
    - **Relief at not being feeling judged and having her 'shit' acknowledged and seen**
- ***I've always been under someone's power perhaps***
    - **Her previous experiences of trauma and MH services shaping her thinking and feeling about power *So the past experiences if you like had shaped my thinking,***
    - **Disempowerment attunes you to power and how it feels & operates –**
    - **Humanising versus dehumanising**
    - **Power being bound in hierarchy as well as ubiquitous & truly felt**
    - **The relational aspects of power – its how ppl do things**
- **Levelling out the power dynamic**
    - **Being offered choice and flexibility**
    - **Subtle forms of power – being compliant and grateful for a service**
    - **Using her power to gain action – being a difficult client**
- **How the therapist held her**
    - **First impressions count – needing a sense of the person**
    - **Differences in class**
    - **Being consistent in her approach**
    - **Taking the leap (to trust)**
- **Things outside of the room - misc**
    - ***Support networks (feeling alone)***
    - ***The reputation of a service***
    - ***The therapeutic environment***

Us and them

Pivotal moment - Trust to get through distress

JASON

- **Previous experiences of disempowerment impacting on being able to trust institutions/services and people**
    - **Not having a secure base/attachment**
    - **People in power will abuse you**
    - **When you need help you can only get it from your abusers**
    - **Unable to separate the person from the institution**
- **Lies, lies, lies**
    - **Feeling lied to and the consequences of this**
    - **Needing to hold people to their word**
- **Surviving the danger that power and powerful people pose**
    - **Power is dangerous**
    - **Reading people to survive**
    - **Being a chameleon**
    - **Exerting his power** `(not being compliant)`
- **Do you know what I mean?**
    - **Desperately wanting to be understood**
    - **The impacts of not being understood**
    - **Going through the motions – powerless to the process**
    - **repeating and having to give up your story**
- **Wanting to be treated like a human**
    - **Dehumanisation**
    - **Desperately wanting human connection**
    - **Being treated like an invidual**
    - **Not being patronised and taken seriously**
- **Society is broken**
- **The impacts on the relationship**

Us and them

SU - one of the people

Pivotal moment - Not being able to his questions about disclosure - oulling in a another - communication

Appendix Z: Table of all individual participant themes and emergent analytic themes

“So the past experiences if you like had shaped my thinking” – bring concept of power into focus

- *I don’t really see myself as having a struggle with power at this point in my life* - Previous experiences of power
- *Limited experiences of being disempowered*
- *Mostly positive experiences in the NHS*
- Their experience in the relationship/power is shaped by their experience prior
  - Fearing people in authority throughout life
  - Rejection and dismissal from childhood to services on repeat
  - Society and the structure of the NHS being disempowering
- Historical factors impacting on the self and experience of power
  - *Being made to feel stupid (not good enough/worthy)*
  - *Dehumanised*
  - 0
- The impact of previous experiences - *I was functional but I was always a bit fragile*
- Fragile but functional (seeing the self as weak dominance/submissive)
- Not being able to trust services
- expecting to be let down
- Experience of navigating professional relationships (it’s a skill)
- The fight to get care & the injustice
- Sick and tired of having to fight for it (Frustration) – *gone to war with them*
- Having to learn the languages of services and service users
- The injustice and harm of it all for her and others (unequal parity of Physical health)
- It shouldn’t be a life sentence
- Too big to fight
- Becoming complex and not being understood
- *I’ve always been under someone’s power perhaps*
  - Her previous experiences of trauma and MH services shaping her thinking and feeling about power *So the past experiences if you like had shaped my thinking,*
  - Disempowerment attunes you to power and how it feels & operates –
  - Humanising versus dehumanising
  - Power being bound in hierarchy as well as ubiquitous & truly felt
  - The relational aspects of power – its how ppl do things
- Previous experiences of disempowerment impacting on being able to trust institutions/services and people
  - Not having a secure base/attachment
  - People in power will abuse you
  - When you need help you can only get it from your abusers
  - Unable to separate the person from the institution

Despaerate for help and understanding

- *You’re doing this*
- *Help coming at the right time*
- *Feeling like she was taken seriously*
- *‘I just kind of went along with that’ – containing – I didn’t really know what I needed*
- *Relief she ‘finally had someone who I could open up to that didn’t know me’*
- Going along with it because you are desperate – compliance
  - Desperate for any help (wait)
  - Coercion to accept what you were offered (without consent)
  - Having to passively accept whatever you are offered even when it is not enough
  - *Gratitude – accepting what was offered ?*
- The Excitement of finally feeling they’ll get a recovery & the expectations this set up in the TR
- The achievement of just getting therapy
- Embarking on a journey of recovery
- Wanting a secure attachment
- The duality of being clinician and a patient
  - Expectations of a clinician to be ultra human
  - The constant fear of being professionally judged and disempowered
  - Relief at not being feeling judged and having her ‘shit’ acknowledged and seen
- The desperation to make sense of things and repair what is broken –
- *I was very much desperately willing to engage in whatever needed to be done to achieve my recovery*
- Broken and wanting to make sense
- Do you know what I mean?
  - Desperately wanting to be understood
  - The impacts of not being understood
  - Going through the motions – powerless to the process
  - repeating and having to give up your story

Power conceptualised as part of the self and experience

- *Power as authority and able to take action without anything standing in their way*
  - Fearing people in authority throughout life
- Power a dynamic spectrum
  - *Hold/control*
  - *Influencing*
  - *The role of the individual (self blame?)*
- Fragile but functional (seeing the self as weak dominance/submissive)
- Learning to wield my power usefully
- Fear of her own power (I break people)
  - Disempowerment attunes you to power and how it feels & operates –
  - Power being bound in hierarchy as well as ubiquitous & truly fel
  - The relational aspects of power – its how ppl do things
- Surviving the danger that power and powerful people pose
  - Power is dangerous
  - Reading people to survive
  - Power is something that needs to acknowledged and relinquished

The stuble/unconscious experiences

- Differences in class
- *Support networks (feeling alone)*
- *The reputation of a service*
- *The therapeutic environment*
- Subtle forms of power – being compliant and grateful for a service
- Using her power to gain action – being a difficult client
- Disempowerment attunes you to power and how it feels & operates –
- expecting to be let down
- Experience of navigating professional relationships (it’s a skill)
- *I was very much desperately willing to engage in whatever needed to be done to achieve my recovery*
- Unconscious uses of her power – testing, showing her power
- Power in services – The disconnect between services – it’s like they have DID
- Service processes challenging
- Being grateful
- Transactional thinking and NHS being free at PON
  - Time in the relationship
  - *reassurance seeking*
  - *language, credibility, knowledge,*
- Having to learn the languages of services and service users
  - *Gratitude – accepting what was offered ?*
  - *A bad person*
  - *Not belonging – ashamed of MH*
  - Radical acceptance
  - Society and the structure of the NHS being disempowering
  - Desperate for any help (wait)
  - Having to passively accept whatever you are offered even when it is not enough
  - The imbalance is natural and deeply known and felt
- The effort of learning to the language of MH services and the processes to show you need care.
  - Adopting the language of professionals to gain credibility
  - Needing to show them that you needed their care and to be believed
  - What the therapist thought mattered
- *You’re doing this*
- *‘I just kind of went along with that’ – containing – I didn’t really know what I needed*
- *Having to expose the self and risk judgment*
- Judgement and managing her image with the therapist?

Fear of the powerful

- Fearing people in authority throughout life
- Rejection and dismissal from childhood to services on repeat
- *Lots of contact with physical health professions and fear of judgement*
- *Limited experiences of being disempowered*
- *I don’t really see myself as having a struggle with power at this point in my life* - Previous experiences of power
  - Coercion to accept what you were offered (without consent)
  - The imbalance is natural and deeply known and felt
  - *Anxious -* anxious that it will end, anxious wont be good enough for the process (intelligence?), judgement?
  - Anxious will be judged
- Learning to wield my power usefully
- Fear of her own power (I break people)
  - The constant fear of being professionally judged and disempowered
  - Relief at not being feeling judged and having her ‘shit’ acknowledged and seen
  - Humanising versus dehumanising
  - Subtle forms of power – being compliant and grateful for a service
- Society is broken
  - Power is dangerous
  - Reading people to survive
- Surviving the danger that power and powerful people pose
  - People in power will abuse you
  - When you need help you can only get it from your abusers

Attachements

- Security in relationships and attachments
- Focusing on the techniques over the realtionship
- Judgement and managing her image with the therapist?
- Empowerment and support outside of the room
- *I’ve definitely felt it’s not really stigmatised anymore*
  - Rejection and dismissal from childhood to services on repeat
  - *Not belonging – ashamed of MH*
  - *Anxious -* anxious that it will end, anxious wont be good enough for the process (intelligence?), judgement?
  - Anxious will be judged
  - *reassurance seeking*
  - *Being a good enough patient? Not risking rupture*
- Wanting a secure attachment
- Unconscious uses of her power – testing, showing her power
- Not forming an attachment
  - Disempowerment attunes you to power and how it feels & operates –
  - The relational aspects of power – its how ppl do things
  - Not having a secure base/attachment
  - People in power will abuse you
  - When you need help you can only get it from your abusers
  - Unable to separate the person from the institution
- Wanting to be treated like a human
  - Dehumanisation
  - Desperately wanting human connection
  - Being treated like an invidual
  - Not being patronised and taken seriously
- The impacts on the relationship

Problems in the process

- *You’re doing this*
- *Help coming at the right time*
- *Feeling like she was taken seriously*
- *‘I just kind of went along with that’ – containing – I didn’t really know what I needed*
  - Rejection and dismissal from childhood to services on repeat
  - Society and the structure of the NHS being disempowering
- Going along with it because you are desperate – compliance
  - Desperate for any help (wait)
  - Coercion to accept what you were offered (without consent)
  - Having to passively accept whatever you are offered even when it is not enough
  - *Gratitude – accepting what was offered ?*
  - Time in the relationship
  - *Not belonging – ashamed of MH*
  - *Dehumanised*
- Not being able to trust services
- expecting to be let down
- Experience of navigating professional relationships (it’s a skill)
- *I was very much desperately willing to engage in whatever needed to be done to achieve my recovery*
- The fight to get care & the injustice
- Sick and tired of having to fight for it (Frustration) – *gone to war with them*
- Having to learn the languages of services and service users
- The injustice and harm of it all for her and others (unequal parity of Physical health)
- It shouldn’t be a life sentence
- Too big to fight
- Becoming complex and not being understood
- Feeling like she had been cheated out of her recovery
- Power in services – The disconnect between services – it’s like they have DID
- Service processes challenging
- Being grateful
- Transactional thinking and NHS being free at PON
  - The constant fear of being professionally judged and disempowered
  - Power being bound in hierarchy as well as ubiquitous & truly fel
  - Using her power to gain action – being a difficult client
  - *The reputation of a service*
  - *The therapeutic environment*
  - Not being patronised and taken seriously
  - Being treated like an invidual
  - repeating and having to give up your story
  - Going through the motions – powerless to the process
  - The impacts of not being understood
- Do you know what I mean?
  - Unable to separate the person from the institution
- Lies, lies, lies
  - Feeling lied to and the consequences of this
  - Needing to hold people to their word

Soecity and ideology

- Empowerment and support outside of the room
- *I’ve definitely felt it’s not really stigmatised anymore*
- Security in relationships and attachments
  - Society and the structure of the NHS being disempowering
  - *Not belonging – ashamed of MH*
  - *A bad person*
  - *Being made to feel stupid (not good enough/worthy)*
  - *Gratitude – accepting what was offered ?*
  - *Being a good enough patient? Not risking rupture*
- The fight to get care & the injustice
- Too big to fight
- Being grateful
- Transactional thinking and NHS being free at PON
- The duality of being clinician and a patient
  - Expectations of a clinician to be ultra human
  - The constant fear of being professionally judged and disempowered
  - Disempowerment attunes you to power and how it feels & operates –
  - Power being bound in hierarchy as well as ubiquitous & truly felt
  - Subtle forms of power – being compliant and grateful for a service
  - Differences in class
  - *The reputation of a service*
- Society is broken

gratitude and compliance

- Being grateful
- Transactional thinking and NHS being free at PON
  - *Gratitude – accepting what was offered ?*
  - Having to passively accept whatever you are offered even when it is not enough
- Going along with it because you are desperate – compliance
- *You’re doing this*
  - Subtle forms of power – being compliant and grateful for a service
  - Exerting his power `(not being compliant)`

Human connection and dehumanisation - understood	power innate / natural - lang? - us and them	the self - us and them	Stepping into power - using power	Therapist power	CRITICAL events that shift power - tippijng the scales - bring to consciouness	bringing it all into the therapy room - giving up power?	The emotional experience	coersion
- Wanting to be treated like a human ○ Dehumanisation ○ Desperately wanting human connection ○ Being treated like an invidual ○ Not being patronised and taken seriously ○ People in power will abuse you ○ Humanising versus dehumanising ○ Relief at not being feeling judged and having her ‘shit’ acknowledged and seen ○ It shouldn’t be a life sentence - The fight to get care & the injustice ○ *Dehumanised* ○ *Not belonging – ashamed of MH* ○ *Being made to feel stupid (not good enough/worthy)* ○ Coercion to accept what you were offered (without consent) - The effort of learning to the language of MH services and the processes to show you need care. ○ Adopting the language of professionals to gain credibility ○ Needing to show them that you needed their care and to be believed ○ Having to learn the languages of services and service users ○ *Feeling like she was taken seriously* ○ *Feeling understood* - Do you know what I mean? ○ Desperately wanting to be understood ○ The impacts of not being understood ○ Going through the motions – powerless to the process ○ repeating and having to give up your story ○ Relief at not being feeling judged and having her ‘shit’ acknowledged and seen ○ Becoming complex and not being understood ○ The injustice and harm of it all for her and others (unequal parity of Physical health)	○ *Power as authority and able to take action without anything standing in their way* - *its never kinda been equal, but yea it didn’t feel like at the same time it didn’t feel inequal* ○ Fearing people in authority throughout life ○ Having to passively accept whatever you are offered even when it is not enough ○ The previous experiences are something to work through (building trust), internally and externally - Power was never felt as equal but there were things that did or could help ○ The imbalance is natural and deeply known and felt ○ Power is something that needs to acknowledged and relinquished - The effort of learning to the language of MH services and the processes to show you need care. ○ Adopting the language of professionals to gain credibility ○ Needing to show them that you needed their care and to be believed - Power a dynamic spectrum ○ *Hold/control* ○ *Influencing* ○ *The role of the individual (self blame?)* ○ *language, credibility, knowledge,* - Power in the relationship ○ Unconscious uses of her power – testing, showing her power ○ His knowledge and qualifications ○ Power in his influence in the service (gatekeeper) ○ Power in services – The disconnect between services – it’s like they have DID ○ Service processes challenging - Being grateful ○ Transactional thinking and NHS being free at PON ○ Expectations of a clinician to be ultra human ○ Disempowerment attunes you to power and how it feels & operates – ○ Power being bound in hierarchy as well as ubiquitous & truly felt ○ The relational aspects of power – its how ppl do things ○ Subtle forms of power – being compliant and grateful for a service ○ Differences in class ○ People in power will abuse you - Surviving the danger that power and powerful people pose ○ Power is dangerous ○ Reading people to survive	○ *Not belonging – ashamed of MH* ○ *A bad person* Identity as a SU - not having one *Us and them* SU - lots of identies relating to trans, neurodivergent etc *Us and them* Dual ID - BPD strong ID *Us and them* SU - CPTSD - activist *Us and them* Dual ID - TRAUMA and clinician *Us and them* SU - one of the people ○ Fragile but functional (seeing the self as weak dominance/submissive) ○ Learning to wield my power usefully – `powerful person` - The duality of being clinician and a patient ○ Subtle forms of power – being compliant and grateful for a service - Society is broken - Protecting the self ○ *Externalising,* ○ *language, credibility, knowledge,* ○ *reassurance seeking* ○ *Being a good enough patient? Not risking rupture* ○ Broken and wanting to make sense	○ Judgement and managing her image with the therapist? - The effort of learning to the language of MH services and the processes to show you need care. ○ Adopting the language of professionals to gain credibility ○ Needing to show them that you needed their care and to be believed - Limited options for holding on to ones power ○ What the therapist thought mattered ○ Not disclosing, holding on to their shame ○ *Externalising,* - Protecting the self ○ *Externalising,* ○ *language, credibility, knowledge,* ○ *reassurance seeking* ○ *Being a good enough patient? Not risking rupture* ○ Experience of navigating professional relationships (it’s a skill) - The fight to get care & the injustice ○ Sick and tired of having to fight for it (Frustration) – *gone to war with them* ○ Having to learn the languages of services and service users ○ The injustice and harm of it all for her and others (unequal parity of Physical health) ○ It shouldn’t be a life sentence ○ Too big to fight ○ Becoming complex and not being understood - Power in the relationship ○ Learning to wield my power usefully – `powerful person` ○ Fear of her own power (I break people) ○ Unconscious uses of her power – testing, showing her power ○ Able to close the screen (stop it) - Levelling out the power dynamic ○ Subtle forms of power – being compliant and grateful for a service ○ Using her power to gain action – being a difficult client - Surviving the danger that power and powerful people pose ○ Power is dangerous ○ Reading people to survive ○ Being a chameleon ○ Exerting his power `(not being compliant)` - Lies, lies, lies ○ Feeling lied to and the consequences of this ○ Needing to hold people to their word ○ Unable to separate the person from the institution	- *its never kinda been equal, but yea it didn’t feel like at the same time it didn’t feel inequal* ○ *Having to expose the self and risk judgment* ○ *Ensuring confidentiality* ○ *Trust* ○ *Informality balancing power from the past* ○ *Feeling understood* ○ *Consistent* - Power was never felt as equal but there were things that did or could help ○ The imbalance is natural and deeply known and felt ○ The behaviours of the therapist – consistency, validation respectful-welcoming disagreement ○ Power is something that needs to acknowledged and relinquished - Therapist behaviours ○ Validating, reassurance, encouragement, respect, equity in relationship, humanising ○ Time in the relationship ○ His knowledge and qualifications ○ Power in his influence in the service (gatekeeper) ○ Not forming an attachment - How the therapist held her ○ First impressions count – needing a sense of the person ○ Differences in class ○ Being consistent in her approach ○ Taking the leap (to trust) - Lies, lies, lies ○ Feeling lied to and the consequences of this ○ Needing to hold people to their word - The impacts on the relationship	Confidentiality reassurance - judgement by others reassured Not agreeing on A PTSD Dx - invalidated Coming to terms with that they were good enough for therapy Rupture around timing for therapy Trust to get through distress - demonstrating non judgement Not being able to his questions about disclosure - oulling in a another - communication - Levelling out the power dynamic	- You bring this all into the therapy room & the relationship – power transfers to the relationship and experience of power ○ The poor experiences with clinicians and people in power comes into the TR. ○ The previous experiences are something to work through (building trust), internally and externally ○ *Informality balancing power from the past* ○ Judgement and managing her image with the therapist? ○ *Ensuring confidentiality* - Feelings before therapy ○ *Anxious -* anxious that it will end, anxious wont be good enough for the process (intelligence?), judgement? ○ Anxious will be judged ○ *Gratitude – accepting what was offered ?* - The Excitement of finally feeling they’ll get a recovery & the expectations this set up in the TR ○ The achievement of just getting therapy ○ Embarking on a journey of recovery ○ Wanting a secure attachment - The reality & disappointment of therapy - *I’ve always been under someone’s power perhaps* ○ Her previous experiences of trauma and MH services shaping her thinking and feeling about power *So the past experiences if you like had shaped my thinking,* ○ Disempowerment attunes you to power and how it feels & operates – ○ Humanising versus dehumanising ○ Power being bound in hierarchy as well as ubiquitous & truly felt ○ The relational aspects of power – its how ppl do things - The duality of being clinician and a patient ○ Expectations of a clinician to be ultra human ○ The constant fear of being professionally judged and disempowered ○ Relief at not being feeling judged and having her ‘shit’ acknowledged and seen - Previous experiences of disempowerment impacting on being able to trust institutions/services and people ○ Not having a secure base/attachment ○ People in power will abuse you ○ When you need help you can only get it from your abusers ○ Unable to separate the person from the institution - Lies, lies, lies ○ Feeling lied to and the consequences of this ○ Needing to hold people to their word - Surviving the danger that power and powerful people pose ○ Power is dangerous ○ Reading people to survive ○ Being a chameleon ○ Exerting his power `(not being compliant)` - Do you know what I mean?	○ The constant fear of being professionally judged and disempowered ○ Relief at not being feeling judged and having her ‘shit’ acknowledged and seen ○ Disempowerment attunes you to power and how it feels & operates – ○ Subtle forms of power – being compliant and grateful for a service ○ Dehumanisation Anger Fear - The reality & disappointment of therapy ○ Deception and broken trust ○ Feeling like she had been cheated out of her recovery like she was good enough Very helpful ambivalacne - not enough like she was good enough fear of not being good enough / stupid	○ *Power as authority and able to take action without anything standing in their way* - *You’re doing this* ○ *‘I just kind of went along with that’ – containing – I didn’t really know what I needed* - Going along with it because you are desperate – compliance ○ Desperate for any help (wait) ○ Coercion to accept what you were offered (without consent) ○ Having to passively accept whatever you are offered even when it is not enough ○ The imbalance is natural and deeply known and felt ○ *Gratitude – accepting what was offered ?* - Being grateful ○ Transactional thinking and NHS being free at PON ○ When you need help you can only get it from your abusers ○ Subtle forms of power – being compliant and grateful for a service

Appendix A1: Exemplar of iteration of theme development

1. ***“I’ve always been under someone’s power perhaps” – how power is experienced, conceptualised and impacts before therapy***
    - a. *“past experiences if you like had shaped my thinking” – how sustained disempowerment attunes you to power*
        - i. Lots of experiences of disempowerment & trauma in cohort. Both from services and outside.
        - ii. Feelings of invalidation, dehumanisation, stupid, powerless, fear.
        - iii. Experiences shape how they conceptualise self, power & expect powerful ppl to operate
        - iv. Disempowerment attunes them to power
    - b. *“they have that natural power” – power differences are natural, obvious and felt*
        - i. Participants explained that power differences were not just shaped by experience but were more deeply held and felt.
        - ii. Us & Them
    - c. *“Do you know what I mean?” – desperation for help and understanding*
        - i. Desperate for help
        - ii. Desperate for understanding
        - iii. Gratefully accepting what is offered because desperate (also society)
    - d. *“you bring that all into the therapy room” – how previous experiences and thinking impact therapy before it has even started*
        - i. Fear of judgement or things repeating themselves, mistrust
        - ii. Something to be worked through

2. ***“Levelling the playing field” – the dynamic and relational experiences of trying to balance power***
    - a. *“that’s the only power I had in that situation“ – personal power of the participant in the relationship*
        - i. *‘that I didn’t want my therapist to think less or differently of me’* – Fear of judgement and image management
        - ii. *‘they don’t speak service user’* - Adopting the language to add credibility
        - iii. *‘Asserting my power’* - using their power to get action
    - b. *The psychologist’s power*
        - i. *“she nurtured me, she gave me what I needed in that session”* - Responding to what they needed - Validation, consistency &, non-judgement
        - ii. Feeling more empowered through having choices and flexibility
        - iii. Emotional distance
3. *Therapeutic moments and ruptures that bring power into focus*

Appendix B1: Exemplar of iteration of analysis being linked back to data

“So the past experiences if you like had shaped my thinking” - Disempowered Hx	***I don't trust people in authority. Um, because they have that natural power***	***“Do you know what I mean?”***	***“bringing it into the therapy room”***	***The critical event(s) that bring power into focus – The clear***		***Finding the balance – levelling the playing field – the subtle***	
- ***Disempowerment attunes you to power*** - ***Inherent power in structure, status etc*** - ***Soc and ideology/the self*** - ***Humanisation***		- ***Desperate to have the self understood*** ***Desperate for help*** Just going with it	- ***It has to be unpacked regardless of what it looks like, where it comes from*** - ***Fearing the powerful - judgement*** ***The process and journey*** (Not just the individual - byut the system)	- ***Coming into therapy*** - ***Therapeutic moments and ruptures*** - ***Bringing power into the sharpest of focus*** Having the right Dx?	- ***Where the inequity lies*** ○ ***Us and them*** ○ ***Speaking different languages*** ○ ***A secure base (or not)*** ○ ***Being a good, grateful and compliant patient*** structural?	- ***Their power*** ○ ***Fear to use own power?*** ○ ***Managing their image*** ○ ***Adopting the language of the professional*** ○ ***Adding credibility*** ○ ***Fighting injustice*** ○ ***Testing, showing their power*** ○ ***Power to get action*** ○ ***Not being a good patient*** ○ ***Being a chameleon*** ○ ***Holding them to account***	- ***The therapist's power*** ○ ***Validation, consistency, empowerment*** ○ ***Qualification and knowledge*** ○ ***Language*** ○ ***Power in the role/influence*** ○ ***“obviously the therapist will always have power” – Power is innate and obviously held by clinicians*** authenticity?
Ummm I think to some extent, … I'm not quite sure, I don't really see myself as having a struggle with power at this point in my life, I can't really think of any examples to be honest-	*Yeah power means different things to other people, it's just power, it gives you… Yeah it's very easy to abuse, to harm people, it's often used to harm people, so as a result I specifically don't have a lot… well, I don't trust people in authority. Um, because they have that natural power, you know, and because of my past I'm never sure are they going to abuse it?*	*Ummm but yea ummm on the initial triage which was telephone, I opted for the CBT by telephone, umm and yea that was kind of the course of therapy that I chose. I think it was just kind of recommended to me by the triage call I think they kind of worked out from there what would be the best course of therapy for me, so I just kind of went along with that, it seemed to be the best option at that time*	*yea, there wasn't much waiting around it was just kind of like I literally came out of hospital on the Thursday and within the next week or 2 that I got the email and got triaged very quickly.*	*I think it was very kind of early on. And if not kind of first triage then definitely from the first session I felt comfortable, and to kind of share how I was feeling*	- **Having a secure base**	Emotion regulation – intrusive memories – hypervigilance – window of tolerance – radical acceptance	It was just the consistency in her behaviour so after a few sessions the fact that she remained the same, she still validated my problems, she still encouraged me and praised me when I made achievements, she was still respectful. It was the fact that she was showing me that some people in authority and indeed in the NHS itself can be trusted.
No not really, no hahaha, so ummm no I think ever been asked [have you considered power before] that to be honest, that's just kind of what comes to mind. -	*Umm not sure I think it's always been a bit one sided because it's, I'm the one in therapy and I'm telling you all this information and I don't know anything about you and so think its ever its never kinda been equal, but yea it didn't feel like at the same time it didn't feel inequal. It didn't feel like I was kind of made to be put down or anything.*	*which was kinda best I think because it don't really give you the time to kind of umm and arghh about it, you're just kinda doing this and it is starting now hahaha. Okay so yea cos that I guess that that space to just sort of mull things over and sort of Kind of may be put you off it, but I didn't really have that chance Because when they kind of called me, I wasn't really sure. I'd never really been in therapy before I didn't really know what I needed, so I just kind of went along with what they recommended, umm yea that sounded good at that time.*	*Yea, yea I do remember it being quite quick, umm. But I don't whether that was anything to do with the fact that I was referred by the MH crisis team or if anyone at the hospital had pushed it through.*	*Yea um I think it was quite a… definitely quite a trusting relationship, and I felt I was like listened to and ummm, almost a bit like a friendship but not like a very personal friendship.*	*yea I feel like they really helped me with what was a very difficult time in my life, and I'm definitely grateful for the sessions we had and I think they helped me a lot and I use kind of the techniques that she taught, me still to this day, so there's like quite a lot of techniques she told me about, ways to manage worries and anxieties that I still use and still helps with day to day worries now*	However I.. the ability to trust her was impacted, she didn't think I had PTSD, now having gone over the DSM 5, I have every single symptom bar two or three, um, and it was not in her remit to, she didn't have the authority to diagnose, she didn't have the authority to say I didn't have it, because she didn't go through all the criteria with me so, I confronted her, I do think I have this, I don't think you do, and it was just one of those things which was like, oh well, I had to shelve it aside.	not just saying it to appease me, I could see her saying it and meaning it.
And how do you like feel about you feel about the NHS in general? I know that's a big question. - umm yea, I think, yeah pretty good, yea from what I've experienced anyway, yea definitely.	*So I don't know it's kind of strange, but there would be times that where we would have a little bit of a laugh and yea it was just like chatting to someone, so felt quite comfortable and not not kind under pressure. Didn't feel like I was talking to a, I don't know someone who was a medical professional, it felt like I was talking to someone who was giving me advice or yea*	*I don't remember there being much time to think worry about it, it just started it haha*	*No I don't think so, cos at that time it was really helpful for me. So I don't think I would have done anything different.*	*So in the first in the first meeting um confidentiality was mentioned and it made me feel very comfortable to know that it wouldn't be shared outside with people when it wasn't necessary.*	*And if there is something you can do about it then write down the options, then if there's nothing you can do about it, you just throw it away and that's kind of like really helps you in your mind to just throw it away. Stuff like that I still do and I think it has really helped me like having someone to talk about the examples and kind of help me with that technique.*	Shame and fear, shame and fear of what the response would be [to disclosing something to the therapist]……… And also the fact that I didn't want my therapist to think less or differently of me, if that makes sense, and that's something I have no power over. but the thing I have the power over was whether I say this or do I not tell her this. So I chose not to tell her this because that's the only power I had in that situation, if that makes sense.	*Oh yea that's the word! yea definitely less formal than I expected it to be.*
I think it's more like someone having kind of the authority ummm and kind of ability to actually action something, umm, mmm yes, it's a tricky one, I think when someone kinda says power you think about someone who is high authority, makes all the decisions	*O: What sort of things when they [someone who is disempowered] be doing differently to people who say have more power? A: Um they might avoid authority figures, so they, they might avoid people who have power to avoid being abused by that.*	*I think the big differences were, kind of I my negative experience there was a lack of understanding and like a lack of compassion as well. Whereas I definitely felt that with the therapist, I felt like she was very understanding, and quite sympathetic as well, and which I think makes all the difference when you are going through like a difficult time. I think that's the main thing that like made it a positive experience really*	*kind of if I had an argument with someone and I was thinking, oh I hate them. I wouldn't mention that to my therapist because she wouldn't need to know. But nothing that was kind of really bothering me, and yea*	*The psychiatrist was amazing, I literally have no faults with him, he was a really good guy. He listened to me, he validated me, urmm, yea he was just really good, I can't find any faults with him. He didn't abuse his power, he took my feelings and what I wanted into consideration. So I started ADHD meds, it made me sleep even worse. Ermm he took that into account and offered me a different medication choice for example. So he gave me the choices, I was able to be open with him because he didn't judge me, I could do all of that without having choices*	*Um it was fine and they have known I struggled with kind of anxiety anyway. So It seemed that they were relieved [her family – that she had sought help] as I was ha, um yea, it kind of an achievement really, and they saw as that as well.*	*People don't have power over you unless you allow them to have power over you*	*Um did your feelings sort of towards your psychologist or just the relationship, did that change over time that you spent in therapy? Ummm no no, I don't think there was much change, in kind of the way that so ..*
Not really anything standing in your way, if you've got power there's not really much stopping you doing what you want.	*Hmmm, differences obviously, yeah yeah, the psychiatrist [psychologist] is in a position of power has a good job, therefore has good money, I'm poor I live on benefits, I'm disabled and I can't work.*	*So kind of your needs, feelings and kind of how to kind of manage them, is suppose, I come to therapist with an issue. And her kind of understanding and providing the solution is kind of her saying I understand because I've listened to you and I can offer you a solution, and these are my thoughts, and here's how we can help you*	*: I cant remember if there was anything in particular that I purposively didn't share, if it was it wouldn't have been anything that was major, that was something like make that makes me sound a bit petty, so not gonna mention it because it's not important, but nothing like really deep thoughts that kind of were important, nothing like that*	A Dx being the key to unlock care and be taken seriously??? – ceclia?	*O: So an achievement, did you see as that as well? K:Yea definitely yea yea so I saw it as me as actually taking steps to kind of help myself and yea-*	*Um and the amount of influence that somebody can have over you, purely depends on your ability to accept it or not, whether you're wanting to accept it or not.*	*I think it was very early on [felt trust]and from what I can remember. Um I think it would just the initial kind of um reassurance and that kind of the information wouldn't be shared with anyone unnecessarily and that kind of talking about the goals of the sessions*
I think kind of the opposite of having power is being restricted and umm having a lot of people make decisions for you and you feeling kind of bound by those restrictions and not having much say in kinda what goes on, ye	*That means the people who don't have power will only have if those with power give it up.*	*Yes, when I started experiencing symptoms of said trauma, ermm it declined rapidly into crisis point, I had ended up like, I couldn't stop crying, everything was just awful. So I ended up being in contact with the crisis team. Um it may have been them made the initial referral through to therapy? Um obviously there was massive waiting list, I can't remember how long I waited, it may have been a year or more, um yep on the nhs I may have had two or three crises, where I'd either got the crisis team involved, or had to go to A&E, then they'd been involved.*	*I think it was more it wasn't relevant to the sessions really so she'd say like how are you feeling, if I just, say I had an argument with my mum or yea, I wouldn't mention it, because I wouldn't see it as relevant, yea*	However I.. the ability to trust her was impacted, she didn't think I had PTSD, now having gone over the DSM 5, I have every single symptom bar two or three, um, and it was not in her remit to, she didn't have the authority to diagnose, she didn't have the authority to say I didn't have it, because she didn't go through all the criteria with me so, I confronted her, I do think I have this, I don't think you do, and it was just one of those things which was like, oh well, I had to shelve it aside.	*No no, nothing like that, I mean did briefly mention it to my line manager at work, she was very supportive and yea, no no negative responses at all .*	*you're guiding them down that road and you're influencing them, but ultimately they have to got to engage and invest in it*	*And kinda take it at your own pace really, which was really nice.*
O: what would be the worst thing someone could do? K: I think kind of being unprepared, and not really, kind of going in don't really know what to ask and reading from a script essentially. Then the person might feel a bit like, it's too formal, and it's just a tick box exercise, and they are not really being heard so yea, I think yea, pretty much	*That's how it is in the real world, that's how it is in therapeutic settings, it's just how it is.*	The NHS, okay, the sheer amount of time that it takes to ever be put on the waiting list and get treatment at this point means that you get there and you're desperate	*With my care coordinator it was like you have to go to these emotion regulation groups, with all these other young people or you'll be seen as uncooperative and you won't get further care. That needs to stop. People have the right to say no. For instance, consent in sex you say no and sex doesn't happen, why don't you say no I don't want this treatment, don't think is right for me I'm not comfortable in a therapeutic setting?*	*So no, she always like at the end of each session said that I had done well and that she appreciated my engagement and the fact that I stayed even when things got difficult and that kind of thing, she did always give me feedback, and reassure me, so yeah that was nice to hear that, but there were times in it when I didn't really believe it, like she was saying that so that I would come back the next week*	*Yea I do briefly remember, kind of making sure that you have enough access to support networks, and making sure that you've got family and friends to speak, to whether it be virtually or possibly in-person*	*And to kind of learn more about myself really because I think, um how do I put it, you kind of, what with having an unstable sense of self,*	If people are aware of the power they hold, they then have the power to not to abuse it. If they are not even aware that they have power… how are they going to know if they've abused it or their use of power has harmed someone?
Umm no, not so much stigma, but I just know there's quite a few nosy people in my office, so I just did not want to talk to them about it. Definitely not stigma.	*O: So that's how the NHS impacts on you, how do you think the NHS impacts on the therapist?* *A: It makes their job more difficult because you know if the patient doesn't trust them and ends again the patient might say defensive things then they may say hurtful things to the therapist themselves, that's not nice for the therapist, um, it means they can't do their job as well, which might make them feel crappy, because I mean it's their job, they want to help people, but they can't help people, because people don't trust them because the NHS has made them not trust them.*	The crisis team, is a whole other piece of shit. Um, is has had a long-term impact, because obviously everyone else I met before was shit.	O: Yeah it was about the choices that you were given. What kind of choices did you have with it [the type of therapy you received]? A: Yeah was either do it or don't. Pretty much	Yeah, I was very very upset when I found it wasn't long term I was under the impression that I been allocated finally long term therapy	That means the people who don't have power will only have if those with power give it up.	*Whereas when I qualified, um, like my GP started taking me really seriously*	Yes I said that I don't think this is true, I have all of these symptoms, I think I have it, I can't remember how the conversation went it yea was just that… Yeah, I can't remember properly but we did speak over it, and she did praise the fact that I was able to disagree with her bring it up, which means she is trying, I would presume, that is trying to empower me. Um you know, in like ‘it's good you reached out', because you know that we can address the problems kinda thing.
No I think it's kind of don't really think it's much of an issue anymore [stigma], very much kind of improved over the past 10 years I've definitely felt it's not really stigmatised anymore, which definitely helped because. I don't think stigma was anything I was really worried about, if I'm honest.	*disempowered, for me that would be the control, the hold bit of the control, if you see what I mean, if you look at it as a spectrum with one end being influence, and the other end being hold.*	Um. I may have expressed the fact that I was displeased because it [the therapy] wasn't addressing trauma, I could have spoken about it, but I didn't because I was like well it's what she's offering. I can't I can't really, I have no power to do anything about that if that makes sense?	Part of trauma is you go through a bad experience and when it keeps happening and at some point you lose hope you give up feel powerless and helpless,	he'd let slip, by accident, that we only had something like three months left or something	*In a therapeutic setting that would mean providing the patient with a range of therapies, providing the patient with the ability to say no, without, and this is common, often things up offered and if you don't accept them, they say that you are uncooperative.*	*Um and so we had that kind of relationship, so when I said to her, I went to her and I explained my symptoms, and I said you know I think this is what's wrong and she said look Cecilia you are much better qualified in this kind of thing then I am, she said if that's what you think and those symptoms match then you should run with it*	*people need to be able to make choices without being made to feel bad about those choices*
Um, I then moved into the property I'm at now, and the symptoms had escalated, I was getting nightmares, like hypervigilance, to the degree whereas like in the shower and I would have to close my eyes and wash my head because it felt like someone was going to jump our me, so the doors were locked so I couldn't let anyone in the house, that kind of thing.	*But I think power is on a line, it's on spectrum*	So like, I'm still like, I don't how to explain it, but one thing it [ACT] didn't cover abusive relationship with my ex, it only covered my childhood trauma, and that means that I have unresolved trauma, and I still get nightmares I still get hypervigilance, I'm a lot more in my window tolerance, because of the Acceptance and Commitment Therapy, um but you know the ability to be triggered is still there, so was good therapy but it wasn't everything I needed. Hence why every rereferred myself back so I can address what hasn't been addressed. So basically, she gave me the ability to cope, but didn't address the source if that makes sense?	You have to give so much of your personal information and dignity away [when applying for benefits], all for somebody who might turn around say you can't have this, so the built in overall lack of trust in the government and authority and carries over into the therapy environment because they got authority, I don't know if I can trust them, they're supposed to help me, will they even help me?	I think psychologically it tapped in to all my attachment stuff and I disconnected very much by knowing there was.. I'd gone into it thinking this was gonna be a long-term piece of work	As a therapist she has the power to say, yes, I will treat you, no I will not treat you, this is the treatment I am offering. I don't get a say in this, I can't say, well I don't want this, offer me something else, because she can turn around and say there is nothing else.	*because being a psychotherapist myself I had already actually diagnosed myself with what was wrong*	*Whereas influence, is more like somebody giving people options, and that other person perceiving that is either a good or bad thing. But not feeling like they have to conform um to that to that person, whereas when they are being controlled, people feel like they have to conform.*
Radical acceptance, it is what it is, I've come now I can only move forward and try and improve what I can	*I suppose control is where somebody is actually has some kind of hold on somebody, whatever that might be, there might be a number of reasons why they have control over them, but um yea it is about, kind of, having some kind of hold over somebody, so whether that is you know an emotional or institutional, financial or whatever it is, so you can have lots of different holds in order to gain control of somebody.*	*[pip assessor] doesn't sound intelligent enough to understand*	The NHS, okay, the sheer amount of time that it takes to ever be put on the waiting list and get treatment at this point means that you get there and you're desperate, you're kind of hopeless, you're no longer, because obviously if you had to wait for a massive period of time for care, well it's like the NHS doesn't really care about us, we're like mentally ill now, we need help now, we don't need help in a years time, we want help now, but it takes that long to wait for the help, so in the interim you're hopeless that anything will ever be done, will they even help at the end of this, what's the point, then you bring that all into the therapy room at the beginning and you have to work through that, you then have to learn that okay my therapist can actually be helpful despite the massively long wait. Like the therapist, even if the NHS and government don't care about us, the therapist does, um that kind of thing.	*And things like that and he had me find images for that, and he gave me a printout on PTSD and substance misuse, and next week I brought it back to him and I bought the book, and i was like 'so you've read the book' no he hadn't read the book he just sent me the printout (laughing), so um it was a bit like so trust building was a little bit -*	Yes. I would, if the sessions weren't timed if there weren't a limited number, I would have loved to have gone through every single one of the experiences I've gone through my life just so I could have got that validation and understanding.	engagement, client, as we know, input, my professional point of view, intervention	*I think that if you go back to that power balance and you think the psychologist, my relationship was very much on the empowerment, kind of influence side, and Dr [name] was on the hold, kind of I know best and you know nothing and if you don't do this, this will happen and all of that kind of thing, yeah, so if you put that on the power scale, they are two ends of the scale.*
You know if I hadn't learnt to trust my therapist, so that adults could be trusted, I would have never been able to trust my dad	*you can very quickly you know if somebody pushes something to far you can become disempowered.*	*it's difficult you know I've just got certain things, if people sound like the stupid or they look like they've just come out of a tanning salon, I would have zero interest in engaging with them.*	Um, wary,, because I didn't know if they were going to be like my last coordinator, I didn't know if they would dismiss me, if they would validate my problems, if they would listen, um I didn't even know if they would like treat me. So when I saw psychologist they might not of given me the correct therapy for my traumas, um yeah, just a lot of distrust. A little bit of hope that things could get better, but there was obviously a lot of natural distrust wariness and fear.	*because if he'd read my case notes that is*	*You can't do that [not value/humanise] with people with mental health problems because, we, the majority of us feel lonely and empty and disregarded as it is and if you then come in from that kind of angle as a therapist you're going to be in real trouble -*	*And previously when I've been with the well-being service I've had CBT, but, as **we** kind of well-know CBT doesn't work well with people with personality disorders*	*[when asked how she is different from her psychologist] I think it's just a case of on that particular occasion I was sat on one side, and they were sat on the other. And in my experience, it could easily change, you know.*
*Um he would have seen some evidence of my parents abuse, and as a mandatory reporter he should have reported it, he didn't. Um I was constantly asking him [care co] for help, therapy you know, meds, anything, ‘I'll look into it', and he never would, **and it would be that on repeat**.*	*I've always looked at it from a kind of dominance/submissive type perspective, - All right in the past whenever I've researched power I'd always looked at it from a kind of very 50 shades of grey perspective*	*.-Yes, yes I thought so, I mean I didn't have a therapy wheel in the beginning, but she very quickly worked out, I really struggled to identify different types of emotions.*	Maybe not necessarily, discuss it with the therapist but internally it takes time to unpack the fact that, sorry my washing machine is making a really loud noise, you then have to learn internally that the therapist cares, it takes time, you need to build that trust, that you don't have the NHS services	*so I don't massively know because I was never really entirely sure that he was entirely real*	*Yeah, I think I probably would have dropped out of therapy to be honest. I mean for me being validated is very important because, because of my unstable sense of self and the thought that I'm not a nice person and sometimes I think I'm evil,*	*we're dealing with ppl with mh probs*	*Yeah we got on really well, um, and she respected as well that I used to be a psychotherapist, when we were having kind of conversations, it was like, like her coaching me, but in return sometimes there were bits where I could associate them with my own learning, and so I was able to feed that back, and say like oh so really like that this's theory or this theory, and she be like yes that's right, ah all right I get that. So so it was helpful to have the knowledge to be able to kind of bounce that backwards and forwards between us.*

"So the past experiences if you like had shaped my thinking" - Disempowered Hx	I don't trust people in authority. Um, because they have that natural power	"Do you know what I mean?"	"bringing it into the therapy room"	The critical event(s) that bring power into focus – The clear		Finding the balance – levelling the playing field – the subtle	
- **Disempowerment attunes you to power** - **Inherent power in structure, status etc** - **Soc and ideology/the self** - **Humanisation**		- **Desperate to have the self understood** **Desperate for help** Just going with it	- **It has to be unpacked regardless of what it looks like, where it comes from** - **Fearing the powerful - judgement** **The process and journey** (Not just the individual - byut the system)	- **Coming into therapy** - **Therapeutic moments and ruptures** - **Bringing power into the sharpest of focus** Having the right Dx?	- **Where the inequity lies** ○ **Us and them** ○ **Speaking different languages** ○ **A secure base (or not)** ○ **Being a good, grateful and compliant patient** structural?	- **Their power** ○ **Fear to use own power?** ○ **Managing their image** ○ **Adopting the language of the professional** ○ **Adding credibility** ○ **Fighting injustice** ○ **Testing, showing their power** ○ **Power to get action** ○ **Not being a good patient** ○ **Being a chameleon** ○ **Holding them to account**	- **The therapist's power** ○ **Validation, consistency, empowerment** ○ **Qualification and knowledge** ○ **Language** ○ **Power in the role/influence** ○ **"obviously the therapist will always have power" – Power is innate and obviously held by clinicians** authenticity?
Um well yeah because of the constant dismissal of my problems… Medical invalidation is not fun. Um and she would always be like 'there's no magic pill to fix you', I never asked for a magic pill, I'm not stupid I have a brain and I know these things don't exist. Um and I've had physical health problems, dismissal from doctors so yeah I have a lot of medical trauma it has impacted my ability to to be able to reach out My mental health hadn't improved and because he [care co] was leaving his job post he didn't tell me with any warning, that I was being discharged because of that. I was like 'the fuck'. And that trauma messed with my ability to reach out for help in a timely manner. But also in terms of the government in the way that they treat people that are disabled or unwell, the pip forms the pip assessment and the people that do the face-to-face meetings are not medically trained, yet they are somehow supposed be able to determine you're your disability affects you, without knowing anything about your disability, so that means people stop trusting in authority in general, the benefit system is just awful. You have to give so much of your personal information and dignity away, all for somebody who might turn around say you can't have this, so the built in overall lack of trust in the government and authority and carries over into the therapy environment because they got authority, I don't know if I can trust them, they're supposed to help me, will they even help me? therefore people with BPD might struggle in reaching out for help or accessing help because they get turned away, erm that kind of thing. Or like if they go into hospital because one of the symptoms may be increased self harm are more suicidal thoughts, the hospital might then say, oh they're doing this for attention, instead of getting them the help for the suicidal feelings that they have. Because those suicidal feelings, even though they experience them more frequently are a risk are still a risk, they might still kill themselves, they should still be treated, but they might not be because of an abuse of power trope - therapy is for the weak - stigma - you don't need to be ashamed of it - implied shameful perceptions I don't trust people in authority. Um, because they have that natural power Dr [name of psychiatrist] was on the hold, kind of I know best and you know nothing and if you don't do this, this will happen and all of that kind of thing, yeah, so if you put that on the power scale, they are two ends of the scale I can remember having input there before I was qualified or anything, and and kind of feeling like, like I was, was this little person who was kind of like less than a human, and I felt like I was being talked down to because whatever I, and the psychiatrist I had the time, she's probably dead by now, but her name was Dr [name], she was a lovely lady but she was very 'there there, there there' very much patting you on the head. Very patronising and I very much felt like I was to do as I was told, in that time yeah? little person, less than human. I didn't I didn't want to be treated like I was stupid. So um it was, I kind of really worried that I would just be treated like I was a mental health problem and that wasn't actually me, just the sum of my parts, I was just a mental patient with a personality disorder i used to like go to coffee mornings with other people with mental health problems and I did then feel really really stupid like I didn't belong. And I desperately did not want to be like all these other people I could see around me, with the cuts all over their arms and the drug and alcohol problems and the fact that they tried to kill themselves again today, and I didn't want to be like that, say people in their 40s upwards because their experiences of mental health services will be different to younger generations that've not experienced the same stigma and the same shame and disgust at themselves and that kind of thing.	Like if I had to do one thing for someone, they had to do in return, or if they did something for me then I had to do something in return, pay money, how to keep the power balanced I think because we have this NHS, the power balance is always very confused, people don't really understand how it is paid for, a lot of people, most people I know have transactional thinking, so we assume, a lot the times that if we are provided a service somehow we either need to accept it and be grateful and submissive to it ,because we should just be grateful and say thank you because it's a gift I was very aware that I had trauma from being a teenager, but I hadn't fully processed, and had learnt or managed to avoid, mostly really relationships, so that I couldn't be triggered. Hierarchy. I think that's the kind of the main word that comes to it, power has been a difficult thing I think in my life at times, not necessarily within therapeutic relationships, but perhaps working within therapeutic services, but perhaps working within therapeutic services, and different managers et cetera and the power that they've had, power that they had when my mental health is been poor, that has been a real difficult thing. You know including discussions, although this one is actually nearly 10 years ago, but you know about sick time, but when I should take it and entering treatment you know and things like that, the the power dynamic of managers is one that I've always struggled with . I've always experienced power as quite a hierarchical thing, the people in power are the people at the top, the people in power are the people above me… effectively, so you know I've always been under someone's power perhaps, you know Yes yes yeah, so yeah the other clinicians [not current CP] how did they use power? That's interesting because they definitely had it… is not like to things away from you, but they sort of enforced certain things from within your care plan I suppose, power has a huge impact is just hard to put into words what is, it's how people do things I think? Didn't fit with either side of the power dynamic, and it was very much a them and us, with the power being with the clinicians she sort of had the power by default by being the clinician with the power being with the clinicians, that often seems to be the case, in eating disorder treatment services, partially because what is psychologically happening for clients with eating disorders, it creates a parental dynamic when you're being refed, it creates a lot of projections towards clinicians and their power and their status. you know it brings up memories of school, teachers, it creates a bit of a, not necessarily a power dynamic, well it might be a power dynamic? It does set up some sort of them and us Power's danger, power is… how I see it is anyone who wants power shouldn't be given it. It should be given to those that don't want it .	i dont know, being quite desperate for my recovery I suppose I was very much desperately willing to engage in whatever needed to be done to achieve my recovery I describe my brain sort boxes and bubbles and how I have these boxes in my head that I can't see, I can't look into, and that when they explode they're my triggers type thing and they tend to ricochet and anyway, I tried it was me explaining the way my way my brain works and the way I visualise my brain. as well as piecing together my story one of the reasons I wanted inpatient treatment at [inpatient rehab] was that I wanted to address, they would have looked at my entire self, not just the drugs, I would have actually been able to access learning how to actually build relationships and look at my trauma and be in a safe environment to actually fall apart and achieve a level of recovery that I don't think I will ever achieve just staying in the community and having to maintain my life if that makes sense. So I kept fighting and fighting on waiting lists and eventually they gave me a psychological therapist gone to war with them [the trust] And I wanted to make actual progress in.. in resolving my trauma disorder. I felt very strongly that my mental illness, my complex severe mental illness, is not, it shouldn't be a life sentence. What crime to I have to commit to get treatment They didn't know what to do with… they have no idea completely out of their depth. My previous care coordinator would always being bipolar, schizophrenia based no concept of C-PTSD, PTSD, trauma disorders none of that nso I decided that I would go to the crisis team to try to write my crisis plan so I was working quite well with um one of the managers we've been building, it was fine, then we had this incident with this member of staff in the crisis team, then I… her email bounced back, so I escalated it to her boss, because it was named as if it was an emergency contact him, so I did, and that led to a complaint my condition isn't easy I didn't do any work with him on it at all [telling her story], um we didn't, it was very much an assessment was six months of assessing me pretty much, we didn't really make much progress in any of my areas yeah.. it was done that way I didn't do it with him [learning to tell story] at all and that's not what I wanted I've always stumbled at being able to know where to begin in trying to explain what led to me having a severe mental illness, you know what led to my complex trauma, with aspects of DID or whatever you want to call it and it, and I didn't get that through with him, I didn't achieve any of that work…	Yeah, pretty much, so because the therapist is a part of the NHS, you don't trust the NHS, start from with no trust, the therapist then has to build themselves up to show that you can trust them not like the NHS as a whole. It was just the consistency in her behaviour so after a few sessions the fact that she remained the same, she still validated my problems, she still encouraged me and praised me when I made achievements, she was still respectful. It was the fact that she was showing me that some people in authority and indeed in the NHS itself can be trusted. That means the people who don't have power will only have if those with power give it up. Shame and fear, shame and fear of what the response would be [to disclosing something to the therapist]……… And also the fact that I didn't want my therapist to think less or differently of me, if that makes sense, and that's something I have no power over. but the thing I have the power over was whether I say this or do I not tell her this. So I chose not to tell her this because that's the only power I had in that situation, if that makes sense. I didn't I didn't want to be treated like I was stupid. So um it was, I kind of really worried that I would just be treated like I was a mental health problem and that wasn't actually me, just the sum of my parts, I was just a mental patient with a personality disorder when I was referred back to [service] all those memories of how I felt {stupid/didn't belong} about that 20 years previously came flooding back, but of course things are very different now 20 years later luckily, No, and it's exactly the thing, if you had a bad experience with mental health services, you'd be really reluctant to go back and do that again. Even if the person was different So um it was, I kind of really worried that I would just be treated like I was a mental health problem and that wasn't actually me, just the sum of my parts, I was just a mental patient with a personality disorder for example if you're talking to someone who has been a victim of domestic violence or coercive control or anything like that, their willingness and trust in you will be severely affected, again it might take much longer because of their experience of negative things happening to them if they talk to people. I was also really anxious about it because I know that something starts it has to come to an end, and I'm not very good with endings I suppose the other thing that worried me as well, is that I wouldn't be good enough for the therapy process, and that's.. Yea I think when she was kind of reassuring me, that I was a good person and that I was engaging, and that I was doing a good thing, as helpful yeah I don't give enough	Um and even in the last session, after six months, I still didn't believe a word he said. It's yeah. It isn't so yeah it was it was it was brilliant, but at the same time it wasn't, I feel cheated And just achieving therapy with him to start, was sort of my, that was like my big goal and it didn't happen at all [sigh] I didn't really make any more progress I was so angry at him I was angry that my entire therapy had been….[implied for nothing] that perhaps I had some poor experience's of psychologists and social workers, but actually I now I have had positive experience of people with those backgrounds that I've worked with, because actually for me the work was quite uncomfortable, at times, on a physical level it was the physical sensations and I think because I mentioned to you previously that the PTSD is related to sex or a sexual trauma, that, so so keeping in line with the physical feelings, I didn't wanna to talk about what they were, or what those physical sensations were all the things that I was struggling with because it felt just too embarrassing to me… – it dissipated and it was probably because I took the leap one day I think, because as having horrible sensations, I need to stop this session, because I can't deal with what my body is doing right now and I don't like how it feels, and we didn't stop the session, we just stopped that particular thing we were doing all that particular thought process we were doing, we moved to grounding I think it was, we can handle this together probably… or that actually she's not judging me, it was some you know, being able to feel that, okay she's not judging me, you know I've already said this bit that I didn't want to be saying, I can't say more to it, but she didn't have a shocked response or actually, it wasn't as bad as I thought it was gonna be by saying those things. But because we got to that point I think I've got to go, I can't deal with this and she guided me back down and levelled out some of that adrenaline I was feeling, I think that was probably turning point where I felt more able, regardless of how I projected onto her to share, I was able to put my projections aside I think at that point and go, she nurtured me, she gave me what I needed in that session, and I didn't have to leave the session, let's go with this, I just felt more trust from that point. So it was through having a difficult interaction in the session perhaps? It was about three weeks in. Three or four weeks in, I had to get him involved because she couldn't give me no answers… so to ask him in as a witness, who could perhaps explain it in her intelligent terms rather than my fucking laymen terms, do you know I mean	And to kind of learn more about myself really because I think, um how do I put it, you kind of, what with having an unstable sense of self, because even now to this day I have times when I think I'm a horrible person, um it doesn't happen as often as it used to but it does still happen. So, um, I suppose it is a combination of other people's behaviour and also your reaction to their behaviour No. They said I needed emotional regulation therapy and but also trauma work, but they weren't willing to do the trauma work yet, because they didn't think I was in a good enough place to do it Grateful to be given the opportunity Yeah I felt quite anxious about it, but I wasn't anxious about the therapy because I was grateful to have it because I really struggle to identify emotions. Okay, I hope I answered the question. Um yeah so I always feel like like I don't give enough, I don't, I can't think what to say, I don't, I always feel like my engagement or my answers or my response will not be what's required.23 O: Okay yeah, oke doke, just to say as well now if any of that is coming up now you are doing brilliant, and thank you so much, because I know it can be really anxiety provoking speaking to a complete stranger, like me, as well, and there's no right or wrong answer, it's just your experience, and don't worry if you're struggling to find the words for it, that's fine, that's fine, I'm asking you to think back, quite a way, and talk about it, so really I just wanted to say that. C: Okay thank you {looked visibly relieved and less anxious after this also more free with answers} I think, because I, because I have a lot of experience of working with professionals ever since I was a child, because I was a looked after child, I am/was a looked after child, because of that I've always, I understand the boundaries of the professional relationship quite comfortably and instinctively [in response to me saying I'm taking notes] you're fine. I know. Take notes, I'm used to it, that's fine None of us are speaking all the same language all of the time I realised that he could keep up with me, intellectually, that I could just speak and I didn't have to reword everything and anything to get him to understand, so I appreciated that. And I hadn't felt that, hadn't felt that with the previous psychological therapist or any of my previous CPN's actually, care coordinators, I always felt like a was having to explain myself, um, and I also liked the fact that he seemed, he could keep up with me intellectually but he could also keep up with the different language I was using because I would often jump between, obviously I've googled too much, so I often jump between psychiatric language, psychological language, DID language, CPTSD language, PTSD language, all the different. So we're expected as the service user to try and pull the dots together and most people don't have the level of, I don't know communication skills and stubbornness, to fight the system that I do, you know, they… or the capabilities.. even when I was very very ill, I launched a letter writing campaign to [local trust] in a dissociative state, writing continuous ongoing letters to the complaints department on children's paper, in pencil (laughing) I drowned them in letters	So I was really grateful for that, but also because of the borderline. Yeah, I think I probably would have dropped out of therapy to be honest. I mean for me being validated is very important because, because of my unstable sense of self and the thought that I'm not a nice person and sometimes I think I'm evil, I didn't connect at all, to so I went through the complaints process and said I needed to see I needed to see a male, that was that was less triggering so that I could actually start look at it so I often jump between different languages I am powerful and my words are powerful and if I learn, instead of trying to hide from my power, if actually learn to wield it, carefully, and like use my power in a way that is useful for me and useful for the world, that actually instead of, yeah, actually I can be really, I can do something with my life. you know, I can be powerful. And that that doesn't mean I have to dominate people, or control them or tell them what to do or dictate, that I can be powerful just by being me and kind of allowing others to be themselves So I was aware of that, I imagine he was probably a little bit apprehensive and scared of me I basically I'm quite a powerful person Like I didn't used to think I was I used to think I was weak but I have realise that I come across, quite authoritative and quite powerful, and I think I scared a previous counsellor and fired her, basically, [laughs sheepishly] so I imagine whatever notes he had read and he read a lot of journal entries, because I'd been submitting them so, he would have, because if he'd read my case notes that is… That is something I feel very strongly, is that I break people, it's one of my core beliefs and I almost test to make sure before I would disclose or share too much I want to check that they are tough enough to take it. we're expected as the service user to try and pull the dots together and most people don't have the level of, I don't know communication skills and stubbornness, to fight the system that I do, you know, they… or the capabilities. I think I did show my anger and try to verbally shred him a little bit.92 Which the little bit of my MO sometimes as I can be testing, it's like almost like I want to check I'm not going to break somebody. That is something I feel very strongly, is that I break people, it's one of my core beliefs and I almost test to make sure before I would disclose or share too much I want to check that they are tough enough to take it. So I think.. I think in the beginning I probably tried to assert my power. It's not even necessarily always conscious, it is often in reflection I realise, oh crap I was testing him. maybe because she was a woman, or maybe because of my read on her, I felt like if I, I felt that I could quite easily, within just one session, put her off sick, without meaning to, like if I'd shared or expressed myself without being gentle enough with her, I felt like she would have needed sick leave. I was a lot more confident because I was in my own home and I knew I could just close the screen if it got too much. I had projections still towards the therapist which probably impacted on how much I shared,	Being validated is very important to me if somebody doesn't give me that validation I can quickly become you know disengaged from the process and be like no I don't want to do this anymore she always like at the end of each session said that I had done well and that she appreciated my engagement and the fact that I stayed even when things got difficult and that kind of thing, she did always give me feedback, and reassure me, so yeah that was nice to hear that, but there were times in it when I didn't really believe it, like she was saying that so that I would come back the next week I think when she was kind of reassuring me, that I was a good person and that I was engaging, and that I was doing a good thing, as helpful yeah the psychiatrist I had the time, she's probably dead by now, but her name was Dr [name], she was a lovely lady but she was very 'there there, there there' very much patting you on the head. Very patronising and I very much felt like I was to do as I was told, in that time yeah? Whereas the emotional regulation therapy felt completely the opposite to that, because I felt very included and validated as well So no, she always like at the end of each session said that I had done well and that she appreciated my engagement and the fact that I stayed even when things got difficult and that kind of thing, she did always give me feedback, and reassure me, so yeah that was nice to hear that, but there were times in it when I didn't really believe it, like she was saying that so that I would come back the next week I can remember with the psychologist we didn't always do things in order, we had things we had to go through, but sometimes I wasn't in the right place to do certain things so sometimes we would go back and recap. I mean for example when I was really poorly, I couldn't, I couldn't even make choices about why was going to wear that day. You know, um, where if, if like somebody said to me, well you know it's not very warm out there today so how about trousers instead of shorts? you might say to them you could have a quick look, what are you happy to do today, what do you think you could manage today, so you're kind of giving that back to them, so they can say in actual fact if you want to talk about childhood trauma, I really can't do that today, but I can talk about how I've been feeling in the last week [here speaking in the abstract about what ppl could do] It's quite interesting to think about the power of that, the fact that I respected and trusted his qualifications and his training and experience. Whereas a lot of people who I know who had therapy it wouldn't even cross their mind Other than his training and experience, and his knowledge and understanding, How am I different from him? Yeah, I don't think I am, which I liked, I don't think I am as intelligent as him, intelligence is an iffy one, I have a lot of different opinions about types of intelligence but I couldn't study in the way that he studies, Yeah I felt like he could keep up with my entire self, he kept up with me when I was in a trigger, and I was in the child state and flipping between Um in the NHS my understanding is that you're not to form an emotional attachment to the professional in your life, um, it almost seems to be the opposite of trauma informed,

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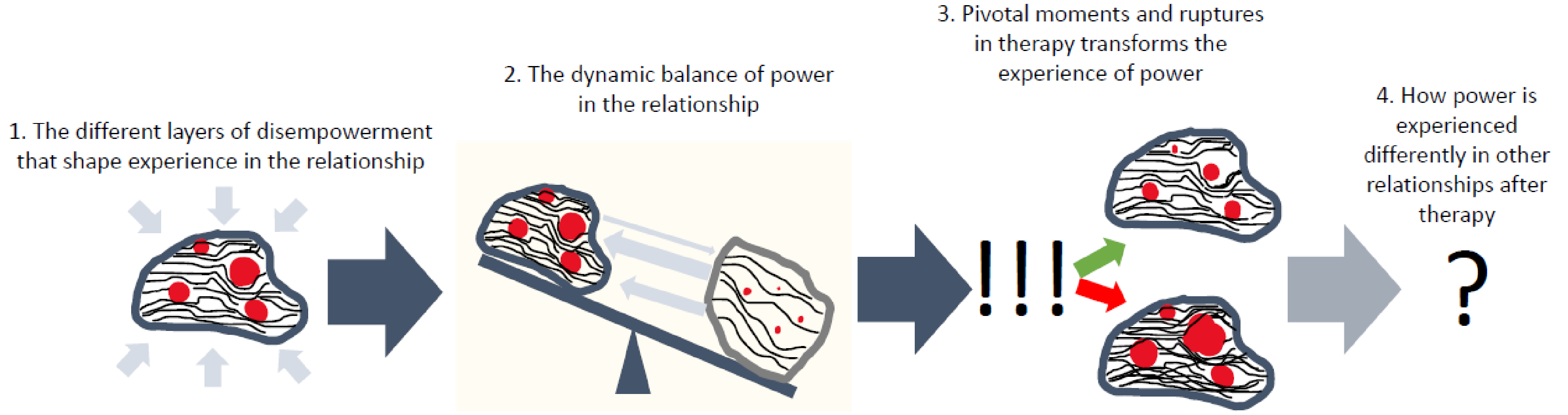
- ***Disempowerment attunes you to power*** - ***Inherent power in structure, status etc*** - ***Soc and ideology/the self*** - ***Humanisation***		- ***Desperate to have the self understood*** ***Desperate for help*** Just going with it	- ***It has to be unpacked regardless of what it looks like, where it comes from*** - ***Fearing the powerful - judgement*** ***The process and journey*** (Not just the individual - byut the system)	- ***Coming into therapy*** - ***Therapeutic moments and ruptures*** - ***Bringing power into the sharpest of focus*** Having the right Dx?	- ***Where the inequity lies*** ○ ***Us and them*** ○ ***Speaking different languages*** ○ ***A secure base (or not)*** ○ ***Being a good, grateful and compliant patient*** structural?	- ***Their power*** ○ ***Fear to use own power?*** ○ ***Managing their image*** ○ ***Adopting the language of the professional*** ○ ***Adding credibility*** ○ ***Fighting injustice*** ○ ***Testing, showing their power*** ○ ***Power to get action*** ○ ***Not being a good patient*** ○ ***Being a chameleon*** ○ ***Holding them to account***	- ***The therapist’s power*** ○ ***Validation, consistency, empowerment*** ○ ***Qualification and knowledge*** ○ ***Language*** ○ ***Power in the role/influence*** ○ ***“obviously the therapist will always have power” – Power is innate and obviously held by clinicians*** authenticity?
You can’t do that [not value/humanise] with people with mental health problems because, we, the majority of us feel lonely and empty and disregarded as it is and if you then come in from that kind of angle as a therapist you’re going to be in real trouble - any time I gone anywhere they [clinicians] would be like I was just anxious, oh you are just depressed, you’re just this that and the other I used to think if I was just thin and fitted in and looked like everyone else in the street that I could be invisible and that I could just hide and I wouldn’t get the attention that I would get people wouldn’t insult me in the street and call me insults in the street *One of the things that worries me a lot about, especially NHS mental health services, I always get the word wrong, iatrogenic?* *it seems to be quite common for people with DID to experience this ongoing harm from staff in their lives and I think it’s a very, I feel like trauma informed therapy doesn’t mesh very well with the NHS programs and systems, they're coming from different angles.* *It led me to the what ifs? Yeah kind of so that’s my personality type of thing, that my personality type. I’m always questioning. I’m always sort of yeah.* *[end career] & break me* *I’ve been trying to get crisis plan written with [trust] for a long time, and I’ve been trying to get one so I decided, right I am sick and tired of trying to get care coordinators to write a crisis plan because they’re not trained in my condition and know what a crisis plan* *I’m very frustrated because should be able to achieve actual discharge from services, there is no reason at all why mental illness should completely just end my career and yeah.* *I was that angry* *I wanted to make a negligence complaint against [the trust] and I wanted to and I wanted a judicial review into the provision for trauma.* *It comes back to when I was thinking around the judicial review and not just, yeah, it was treatment myself but it was also treatment for others and it was the harm that was being caused by the lack of provision.* Didn’t fit with either side of the power dynamic, and it was very much a them and us, with the power being with the clinicians, *Where as being a clinician has always been a bit of a worry, because although we're human beings, we're expected I think… or projected on to us, that we are perhaps ultra human? You know…* *That we can do things that you know, other people can’t do, that we can fix other people. Which is aren’t necessarily true, we help them with their journeys.* I was very aware that I had trauma from being a teenager, but I hadn’t fully processed, and had learnt or managed to avoid, mostly really relationships, so that I couldn’t be triggered. One example of that was camp America for instance, just by seeing anorexia and PTSD, previous, on my form, I was therefore not allowed to be part of the programme,		*what really actually meant something was when both the psychologist and the nurse said to me,’ I’m actually blown away by your journey, by how much you’ve been through, and how you’re still standing’. I’ve never had someone look at it and go wow, am I allowed to swear?-- It was, if you want it in true language, someone really recognising the shit of the past, and saying that your shit was really big shit, really nasty shit. Where it was actually like, yeah you’ve got shit, but the someone to actually acknowledge how bad the shit was,* *It was just a very calm, wow respect, you’ve been through some stuff, you know, and it did feel like respect. I was sat with two women that were a lot older than me,* *Um I think the initial feeling was actually relief [of them acknowledging what she had been thru]* *Where it was actually like, yeah you’ve got shit, but the someone to actually acknowledge how bad the shit was, you know how awful it was, was actually a really um quite a connective experience I suppose because rather than, I think it will feed into power questions later, it basically levelled out some of that power dynamic and it was like okay we are all on a level playing field* “do you know what I mean?” He used this after almost every point and this was noted around 60-70 times in the interview. I also see the damage it does when you’re not listened to, and there’s a lot of people who fall through the cracks, because of people’s lapsed, dazed attitudes, misjudgements and things, do you know what I mean? *I need proper therapy, proper one-to-one therapy and they give me this lady, [name] who I’ve just sacked* *Who makes these decisions about how long therapy sessions should be, what the content should be, whether it’s based on an American fucking professor*	*I'm not immediately identifiable as who I am* *there’s no judgements about my dress or shoes I’m wearing or the way I walk or my weight* *O: Was there anything that the psychologist who was working with you did to help with that, to help with you feeling less judged? C: Um I didn't share that with her* *for me it was actually much better because I really really am always thinking that people are judging me and saying stuff about me and you know. Making judgements about who I am and what you know* *Sometimes you have to go round the houses to prove that you are that they are the kind of person that they can get on with, before you can actually start the real work* *but hopefully as well as once you’ve built rapport and trust and you’ve offered choice, when you come and say okay these are the things we need to do today and they are a little bit more challenging, but I’ll be here and I’m supporting you, you know, they will have enough trust in you by that point* And could tolerate that whereas in the past all my previous mental health workers from [trust] would have just bailed on that situation, that was the standard protocol, was leave her to it, that was the standard protocol, was leave her to it *I can’t be an isolated incident there are many children that have come to my age through being a looked after child and experienced complex trauma, so many different reasons and that there is no provision that it’s not, that there is no, you know, there is no service the same and there is no autism services in all [County] there is no service for it.* *like the implications of not being in treatment when you have the label of a severe mental illness is.. yeah.. is I don’t know.. it’s a strange one. It’s like having the diagnosis of, I don’t know, diabetes, but saying well I don’t currently receive any insulin, I can’t get it. So it’s yeah, it’s, yea, I don’t know failure to provide* *And just achieving therapy with him to start, was sort of my, that was like my big goal* *It was a big…. I was just excited* *I think in the beginning I was just so excited and relieved and we been waiting for the sessions to start because of COVID and I’d been chasing… and there had been it was all very… I don’t know… it was all very when is this going to begin, when can we start, when it did, it was just it was just relief to start with and excitement and I came with a plan and some quite specific goals.* *let’s do some work, really embark…* *I had really strong routine of meetings in place and had been clearing the decks and making sure that I was you know* *And I was prepared for really a sort of deep dive* *A whole mission that I wanted to achieve with him* *so I came to him was some very strong kind of goals I wanted to achieve, I knew that my time with him I wouldn’t address all of them but I wanted to a lot more functional*		*They’ve now combined the complaint’s department with PALS and that’s how they’ve overcome that issue because my issue was they don’t speak ‘service user’ and I don’t speak ‘complaints department’. And it's just…We weren’t communicating.* It never came up because I don’t think it needed to, I remember telling him I was angry or acknowledging that, like when he let it slip that, about the timeframe I guess my biggest gratitude to him of the whole lot because at the end he wanted me assessed for autism. - I’m very, I didn’t realise how grateful I should be to him for that. Still in a lot of reflection, wow *I think I think that then I would have had to then needed support to mourn the loss of that relationship. If that makes sense? So on reflection I’m quite grateful that he didn’t do me any harm, because I wasn’t sad, well I was angry and pissed off and sad that I wasn’t getting my own recovery* *I didn’t feel like I was losing a relationship in my life, a professional relationship in my life. I mean in the past I have mourned the loss of social workers, one of my previous care coordinators, he was my care co for too long, and it was, it took me a long time to get over that. My previous social worker it took me a long long time to get over the loss of him as a professional in my life, there was never inappropriate, there was never inappropriate relationships it was just an attachment I had formed* *why I didn’t go for my [private physical hospital] surgery was because [Psychologist’s] time was ending and they tried to delay my [private physical hospital] surgery and it was passed the day I was finished with [Psyctrhologist]. So I wouldn’t have gone, and so the impacts not being under therapy has been quite.. his accidental power over me without meaning to,* *It was also another one of the reasons why didn’t have my surgery at [private physical hospital] as one of their requirements was that I be under, I’d be under therapy for my severe mental illness,* *I was under [Drug and alcohol service], I still am under [Drug and alcohol service]. Not that they do anything. They refuse me inpatient treatment because my mental health wasn’t being treated* *And that was that was one of the big things that impacted on one on that. Was that there was not gonna be ongoing support afterwards* I remember I was.. I was going through my social care assessment at the same time and because I got so frustrated with none of the agencies communicating, I would email everyone. *they didn’t classify the previous counsellor [name of counsellor] she’s a specialist nurse they didn’t classify a psychological therapist as treatment* *I hadn’t realised the hierarchy, like is not translated to the service user very much of what the actual qualifications are. People generally don’t generally know the difference between a counsellor, a psychological therapist, a therapist, a psychologist, a clinical psychologist they don’t know the terms* *I couldn’t email [psychologist] I wasn’t allowed his email address* *I mean at the time I remember being quite angry at [psychologist] because they were using him as my care coordinator at one point and having him try to chase up things and I actually got quite angry at this* Like if I had to do one thing for someone, they had to do in return, or if they did something for me then I had to do something in return, pay money, how to keep the power balanced I think because we have this NHS, the power balance is always very confused, people don’t really understand how it is paid for, a lot of people, most people I know have transactional thinking, so we assume, a lot the times that if we are provided a service somehow we either need to accept it and be grateful and submissive to it ,because we should just be grateful and say thank you because it’s a gift Didn’t fit with either side of the power dynamic, and it was very much a them and us, with the power being with the clinicians,	*Equally I would often attend sessions, with a lower energy, and I would say I don’t know if I have the energy to do as much, today. So in that, in the framework of what we were doing with CBT, not CBT sorry, EMDR, I having had a few sessions could gauge how much it took out of me, and then use my power if you like as a client to guide how much we did in each session, rather than feel it was, today we going to do X, Y, and Z, and this is what we are going to complete you know it was like, but that’s okay, if we can’t do it all today will set up another one, for the end of the week, so that you actually get…* *My power probably was around the arranging of sessions and so if I woke up one morning and I thought, I don’t want to do this appointment today, or I can’t do this appointment today, my power was being able to say, you know so not DNA, even if it was marked as one, but to be able to actually contact the clinician to say I don’t have the energy to do this today.* *But to that note, 10 years prior, I did use it in the same stubborn way, I would not turn up. Um sometimes I wouldn’t phone, but that was often because I was asleep, so I would be a difficult client at times but I would also then be very apologetic afterwards, so I know the power struggle the power dynamic between me and the clinical psychologist at the eating disorder service,* *So yeah I did use power as a client and it would have been things like not coming, and thinking back to that power dynamic, it was like the power that I know that that had now* *And I don’t think you’ll find many clients that can talk about that. Because I have no shame, I did, I don’t anymore.* *The EMDR I feel help me get rid of that shame and now I don’t have shame looking back, I can say yeah I cut myself for people responses, whereas actually if you say that to a teenager ‘whaaaat!! I don’t do on purpose’* *so I can talk about a lot of my past experiences and the ways in which I would have used them unconsciously more at the time, but I don’t have the shame about it anymore so I know I used my own illness as power against services, against clinicians, as an excuse to get out of other things in other contexts of life sometimes.* *It’s hard to say because it’s used unconsciously, I only have a concept of what was because at the time, like I say, I couldn’t have been challenged on it, I couldn’t have thought about it, now I can..* *reflecting back I did have traits of borderline personality, refused to ever be diagnosed with it because I knew I had PTSD, and I don’t have borderline traits any more I don’t think,* it was more level playing field, so I didn’t really need to use power such with, I didn’t need to question power or use power against my therapist. *I’ll hold them to account for that, it caused me a lot of problems in life* *and I’m pretty much on people’s word and put ya on the spot..* and she made me a promise that she would be working with me from now on, I said are you sure you not gonna go off ill, fucking whatever… no no no, then strike bang on the first fucking lockdown she made a phone call, oh I won’t be working with you soon because I’m pregnant and I’ll be going off on maternity. Yeah I’m more upfront. - And transparent. And will give explanations why I’m behaving the way I am towards them. I’ll apologise for myself as well… for ourselves *that’s why I said to you feel free to access any of my medical history, to help you fill in any gaps, where I might jump from point to point or there’s many me’s… I've had many surnames, I’ve had many scenarios, I’ve had, I’m a chameleon do you understand?* *You have to adapt any environment, any situation* *And have had to blend in, I’ve had to be a chameleon, I’ve had to for survival*	*I found out very little personal information about him, I feel like he wouldn’t, it almost felt like he made a conscious decision to keep himself separate. I don’t think he wanted me to attach and form a secure attachment to him. That was my impression, I don’t know if that’s a fact.* *It was like okay this is our final session. There was no emotional attachment whatsoever and I think that was partly me, that I put up my boundaries once I found we were on a deadline, um and I do think that part of it was didn’t expose any of himself to me at all, and I think that was his choice* is he has chosen a career where he is forced to disengage from people. The same way as a doctor does, a surgeon does, you know, even a paramedic, you have to disengage from people. So we are very different in that sense *although they said yes, we think we can put you on a waiting list,* *Yes yes yeah, so yeah the other clinicians [not current CP] how did they use power? That’s interesting because they definitely had it… is not like to things away from you, but they sort of enforced certain things from within your care plan I suppose,* power has a huge impact is just hard to put into words what is, it's how people do things I think? *I was I suppose I was given some choice, because it was always going to be either you fit the formulation for EMDR or trauma CBT, so I was given a choice which again I think was nice, I don’t know if other clients have been given those sort of choices before or whether it’s just made for them by the clinician’s formulation so i don't know again whether that was perhaps kindly thinking well she’s got her own clinical perspective, shall we ask?* *rather than feel it was, today we going to do X, Y, and Z, and this is what we are going to complete you know it was like, but that’s okay, if we can’t do it all today will set up another one, for the end of the week* *so the flexibility of the therapist in response to my requests, because they weren’t demands, they were requests, made the power dynamic feel less like a power dynamic, it was more level playing field, so I didn’t really need to use power such with, I didn’t need to question power or use power against my therapist.* *It was very calmly, and let’s discuss this together* *the reservedness of the psychologist actually unnerved me… But it didn’t stop me engaging with them* *because I hadn’t seen enough of the psychologist to get a taste of who they were –* *Yeah no I think you are right and that’s how it is, I used the phrase blank screen, didn’t I which is open to projection quite literally in theory so, the blank screen is more off putting, I’ve learned that as a therapist myself, and I've learnt that as a client, I find if you’re too blank screen, you know it brings up memories of school, teachers, it creates a bit of a, not necessarily a power dynamic, well it might be a power dynamic? It does set up some sort of them and us,* *I think it was only when I was able to let my own guard down a little bit I’m not even sure what or how just because she was consistent, very consistent with calm, with the quiet, with the softly spoken and actually then some more forgiving messages came in to the work* *And they don’t, they’re fucking rude they don’t talk to you like a human. They don’t, they dehumanise you like your fucking, I don’t know, and then they categorise you, and tell you this and then they tell you that, I’ve gone from manic-depression, to post-traumatic stress disorder, to fucking bipolar, in fucking two years, how can you put a trust in people who can’t even figure out what you have got? If you have got owt, do you get what I mean* *As for [care coordinator] yea I didn’t really want [care coordinator] but I gave him a bash, were still not, I wouldn’t say I trust the bloke, do you know what I mean, but I talk to him and that, we have great conversations he's quite an intellect and that so. We talk about all sorts, we don’t just, he is not patronising, he talks to me like a human, he’s… I dunno he’s a bit different than what I’ve usually experienced* *It’s just being fucking human mate, and have a human conversation on how you do with everybody you greet in life*

“So the past experiences if you like had shaped my thinking” - Disempowered Hx	***I don’t trust people in authority. Um, because they have that natural power***	***“Do you know what I mean?”***	***“bringing it into the therapy room”***	***The critical event(s) that bring power into focus – The clear***		***Finding the balance – levelling the playing field – the subtle***	
- ***Disempowerment attunes you to power*** - ***Inherent power in structure, status etc*** - ***Soc and ideology/the self*** - ***Humanisation***		- ***Desperate to have the self understood*** ***Desperate for help*** Just going with it	- ***It has to be unpacked regardless of what it looks like, where it comes from*** - ***Fearing the powerful - judgement*** ***The process and journey*** (Not just the individual - byut the system)	- ***Coming into therapy*** - ***Therapeutic moments and ruptures*** - ***Bringing power into the sharpest of focus*** Having the right Dx?	- ***Where the inequity lies*** ○ ***Us and them*** ○ ***Speaking different languages*** ○ ***A secure base (or not)*** ○ ***Being a good, grateful and compliant patient*** structural?	- ***Their power*** ○ ***Fear to use own power?*** ○ ***Managing their image*** ○ ***Adopting the language of the professional*** ○ ***Adding credibility*** ○ ***Fighting injustice*** ○ ***Testing, showing their power*** ○ ***Power to get action*** ○ ***Not being a good patient*** ○ ***Being a chameleon*** ○ ***Holding them to account***	- ***The therapist’s power*** ○ ***Validation, consistency, empowerment*** ○ ***Qualification and knowledge*** ○ ***Language*** ○ ***Power in the role/influence*** ○ ***“obviously the therapist will always have power” – Power is innate and obviously held by clinicians*** authenticity?
I’d also had lots of therapeutic relations previous so that also impacted my thinking *So the past experiences if you like had shaped my thinking,* *I think power itself is certainly a trigger point for me at times, so it is something that is quite pertinent if you like, to how I relate in the world* *Some people for instance could just bob along with no worry about hierarchy, with no need to challenge hierarchy, whereas I’ve always experience power is quite a hierarchical thing, the people in power are the people at the top, the people in power are the people above me… effectively, so you know I’ve always been under someone’s power perhaps, you know,* *So weigh in for instance is something that comes up in my mind, because it wouldn’t always be the same person each week allocated to weigh everyone before breakfast. So I had different experiences of being weighed, being weighed whereby someone asked me how to I want to do it, and do I want to know, and what will happen if I do know the numbers, because numbers is quite thing. That was useful, that was dispelling some of the power,* *I’ll go on backwards please, and she did, so that’s it, she held my hand so I could walk backwards without falling over onto these scales, you know, okay lovely, off you get, one of your planned for today? So wasn’t even see ya later, you know like, there was a whole engagement in that weighing process that made it another engagement* *And whether they show empathy, and whether they relate to you, or whether actually they just treat you like a number, that's literally probably how I felt, I was treated like a number, come in get on the scales, I’ll write that down, and see ya later. Who was I? I could have been anyone. She could have just weighed an orange, like an object you know, so I suppose if one treated me more like an object, one more like a person, personable approach is always gonna be the one I choose.* *Hierarchy. I think that’s the kind of the main word that comes to it, power has been a difficult thing I think in my life at times, not necessarily within therapeutic relationships, but perhaps working within therapeutic services,* *but perhaps working within therapeutic services, and different managers et cetera and the power that they’ve had, power that they had when my mental health is been poor, that has been a real difficult thing. You know including discussions, although this one is actually nearly 10 years ago, but you know about sick time, but when I should take it and entering treatment you know and things like that, the the power dynamic of managers is one that I’ve always struggled with .* *‘cause obviously I’ve moved about a lot, since I was a child, and I’ve been registered at a lot of different doctors, throughout that time, so you could obviously see there was a problem in my past* *because I’ve been brought up in kids homes, foster parents and all sorts of walks of life, I’m pretty good at reading people, pretty accurately* *When there’s an angry me, a sad me, there’s many me’s, do get why mean? Because I’ve been lived with so many different people, I've had no structure really.* *Because that was hard work, being the way I was in like a work capacity, it was tricky man… never stood on education anyway, I went to 6 different secondary schools from the age of 12 to 15, because I kept moving about and getting expelled. I had home tutors, they didn’t work out, but I’m not, I wouldn’t say that I’m not academic, or intelligent but mine is mainly through life experiences, a quest for the truth, do you get what I mean?* *I’ve got institution problems, I know that, do you know what I mean? Through my past and my experiences… but I don’t try and treat them all the same, I always go in with open eyes and an open mind, I try to.* *I didn’t want the bloke, I asked for a woman because I relate to em better, I’ve had a lot of bad experiences with males in the care profession, not saying like mental health, but like children’s homes, social services, do you know what I mean?* *the police and they come in at the weekend to work with us vulnerable children, but they’re not working with us they are playing a game called cops and robbers and we are obviously the robbers because we are the children in the kids home, we are naughty little bastards, do you know what I mean? And they’re the officers, and they are physically abusing us mate. They’re beating us and they’re telling us as they are bending arms and legs back, we’ll see you in about three or four years time, this is what you gonna be getting, do know I mean? That’s my experience* *They didn’t send the crisis team to me they called the police, four police officers came to escort me off the premises, that's ya systems for ya O: that sounds so difficult… S: Why does it sound difficult? It sounds fucking illegal and immoral to me* *So that’s your systems for ya, they’re fucking broke mate, they have been for years. Nothing has changed in this world since I was in the care system, did you know I went to [service] back in the fucking 80s when I was in the care system because of my behaviours, I had to see a child psychologist*			*I came with a plan and some quite specific goals. Which I thought were realistic actually, I didn’t think I was coming with the expectation of him fixing me I thought I was quite prepared for therapy, yea, you know some people think they’ll go and it’ll be like surgery and the surgeons are going to fix their brain. I wasn’t in that mindset.* *I wanted to focus on the therapeutic relationship this and I was aware that once I started the weight brain might explode because been looking at some really deep stuff so I had really strong routine of meetings in place and a been clearing the decks and making sure that I was you know. I as much as I possibly could, that my life was clear and ready to just focus on my recovery and yeah I was excited.* *But came to it wanting to build trust within with him wanting to feel safe and build this therapeutic, boundairied, safe relationship and… I don’t know, being quite desperate for my recovery I suppose* *So I was very aware from Google that the suggested main treatment for complex trauma is to really look at the attachment issue and to form one secure attachment and to sort of to work from there* maybe because she was a woman, or maybe because of my read on her, I felt like if I, I felt that I could quite easily, within just one session, put her off sick, without meaning to, like if I’d shared or expressed myself without being gentle enough with her, I felt like she would have needed sick leave. because I am a clinician, bringing back that clinician stuff, so that was very much there at the beginning *even I … perhaps could also make those projections towards clinicians [they have to be ultra human], you know the fear of being judged, is why ended up with an out of area service in the first place.* *you know because when you are a clinician and you are having a mental health breakdown you always remember the back of your mind from your training fitness to practice, HCPC all of that stuff.* *And that has always been a worry of mine, you know, someone might judge me and say actually, you know, not sure she should be practising.* *And you never know what that level is that someone might trigger that and say actually I don’t think you should be practising. So I’m gonna inform the HCPC of your health and well-being… I’ve never wanted to routinely inform them because, I’ve had previous bad experiences where I’ve offered truth and then been disbarred from doing things because they worry about my past.* “So I’m gonna inform the HCPC of your health and well-being..”. *Um I think the initial feeling was actually relief, because coming back to having worked in services and overheard, we’ve all been part of formulation’s, just that say that process happens and I’m aware of it… hearing how clients have been presented, um not necessarily saying that’s whether that is positive or negative, I suppose when they acknowledged the shit it was, it allowed, was allowing me to take off my professional cap and just be human I suppose.* Bless me, I’m not even looking at you, what do you make of that? I was very aware that I had trauma from being a teenager, but I hadn’t fully processed, and had learnt or managed to avoid, mostly really relationships, so that I couldn’t be triggered. the power dynamic in my present, not present because it’s not present, most recent therapy which was under [the trust], I would say was really quite balanced, I was not worried about the power dynamic, I had projections still towards the therapist which probably impacted on how much I shared, but that the power dynamic, I never felt that my psychologist had more power over me, I never felt that my psychologist would do things without me wanting her or share information without me wanting her to I didn’t worry that my psychologist report me to the HCPC *Four times over the last 10 years I have been at [service name] being assessed by psychologists to see if I need any help, four times I got turned away, there’s nowt wrong with you, and as soon as my doctor sent me, that last time, oh fucking hell he’s got PTSD, he’s got manic-depression, now we are giving him medication for bipolar, that’s without all the other meds I’m on for my other health issues, do you know what I mean?* *Even though I’m getting help obviously it’s not [care coordinator] who I’ve got the problem with, is the association and people in it, the lies I’ve been told, and the promises I’ve been made, that never materialised*		*in relation to my own thoughts about peoples qualifications and abilities backgrounds and knowledge, and when I was given a band six psychologist to treat me 10 years ago, and I won’t say too much about it, because it is not relevant to this particular treatment, I actually fell a real struggle with power because although she sort of had the power by default by being the clinician, and I was there for treatment, I felt that, given her level where she was at…* *I’m not saying her training wasn’t relevant, of course it was relevant and potentially good enough as well, but for me I was recent out of training and having had this relapse and becoming incredibly ill, that was still intact* *The banding does definitely impact, I think there’s something there I can’t quite put my finger on it* *so for instance you could be a social worker on a BA, you can be a nurse on a BA, be various allied health professions on a BA, you need a masters level to do various other professions, particularly the therapeutic ones, need a PhD to be a psychologist* *Didn’t fit with either side of the power dynamic, and it was very much a them and us, with the power being with the clinicians* *she sort of had the power by default by being the clinician* *with the power being with the clinicians, that often seems to be the case, in eating disorder treatment services, partially because what is psychologically happening for clients with eating disorders, it creates a parental dynamic when you’re being refed, it creates a lot of projections towards clinicians and their power and their status.* *you know it brings up memories of school, teachers, it creates a bit of a, not necessarily a power dynamic, well it might be a power dynamic? It does set up some sort of them and us* the power dynamic in my present, not present because it’s not present, most recent therapy which was under [the trust], I would say was really quite balanced, I was not worried about the power dynamic, I had projections still towards the therapist which probably impacted on how much I shared, but that the power dynamic, I never felt that my psychologist had more power over me, I never felt that my psychologist would do things without me wanting her or share information without me wanting her to I didn’t worry that my psychologist report me to the HCPC *DNAs we talk about DNAs all the time in the service, I wouldn’t want to be a DNA client, you know, so again it sets up ideas of people of how they are thought about and how they’re judged* And they were genuine because I didn’t feel like I could do the work on the day, so… but compliance aspect certainly does relate to me. As a clinician, even as a patient once you’ve already said you’re a clinician, and people know that, what are the team gonna think if I don’t turn up for what they offer me, how rude! Like they’re working really hard, I’m working really hard, but their time doesn’t mean anything to me? *And again that comes round to probably the end of our conversation around systems, coming back to me saying I’m grateful and I’m compliant and I understand the NHS* *because I’m compliant like that, and I’m grateful like that, to be offered a service, yep so-and-so is going to start with you tomorrow, come on in for an appointment I would have come* *So compliance with me is also a personal trait. I don’t ever like to get things wrong or be wrong, you know* So it feeds into my thinking of being a client… to be compliant, and to gratefully accept what is offered to me *As opposed to having anything set up regularly, their main goals were really checking whilst waiting, so they had put me on a waiting list for therapy after assessment, their main goal was to erm, sort of check my weight at the time, because anorexia* *So maybe it was because I didn’t put much pressure on the service, but my needs were met, someone with more needs by not feel their service needs were me* *So in a nutshell, very quiet, that’s the main thing I would hold onto, quiet, softly spoken, my projections were… bit of a geek, quite middle-class, perhaps a bit posh, well spoken, possibly not very… I don’t really know what the word is I want to use, I suppose what I projected was that this person might not be very common or very familiar with perhaps some more common ways of behaving*	*And I pick up on the things that make you uncomfortable as well, I’m very astute, I don’t know why I’m so good it.* *I need to read your body language I need to see the sweat on your brow, do you know what I mean?* *[with regards to online therapy] I can’t see your pupils if they’re dilated or not you know I mean, that’s how intense I am, that’s how much how I look at people, and I’m like that everyday for everyone I meet, my brain don’t ever shut off, do you know what I mean?* it does pose difficulties to therapy [his intensity/scrutiny], it’s not all the therapists fault, I do carry half the can sometimes, do you know what I mean? I have an air of awkwardness about me at times, but I think that’s me putting them through their paces, to see how committed they are, do you know what I mean *Or why she did it, do you understand? Because it’s give-and-take in my eyes, I want to know as much about you as you want to know about me, and that’s how situations should be, you know, keeping yourself safe, you know the ins and outs of the cats arse about me. Not that’s just how I’m talking, you understand? You know, you’ve got to give a bit, if you want to take a bit, do you understand?* *Yeah yeah, if you were in [psychologist] shoes, and I said how’s your family mate, alright? How they getting on? What have you been up to at the weekend, have you been anywhere? Well we’re not here to talk about me we’re here to talk about you, I don’t feel comfortable talking about my family again?* *I’ll tried, I’ll really tried, because I didn’t want to quit out of principal. Because she wanted to,* *So she didn’t fight to, oh hang on a minute are you having a moment mate do you want to talk about it?* *That’s all right. I’m not saying like I hate her, you know what I mean? She’s probably a nice lady out of work, do get what I’m saying, but she’s very indecisive, does tell porkies, she doesn’t commit to… how can you fucking accept therapy from people like that?*	*There being clinical, they’re not being, they’re dehumanising you mate, that’s what they’re doing, you don’t feel like a human. You’re not part of this conversation, do you get..?* *Because she told me basically, wouldn’t you be better off with something like art therapy,*

“So the past experiences if you like had shaped my thinking” - Disempowered Hx	***I don’t trust people in authority. Um, because they have that natural power***	***“Do you know what I mean?”***	***“bringing it into the therapy room”***	***The critical event(s) that bring power into focus – The clear***		***Finding the balance – levelling the playing field – the subtle***	
- ***Disempowerment attunes you to power*** - ***Inherent power in structure, status etc*** - ***Soc and ideology/the self*** - ***Humanisation***		- ***Desperate to have the self understood*** ***Desperate for help*** Just going with it	- ***It has to be unpacked regardless of what it looks like, where it comes from*** - ***Fearing the powerful - judgement*** ***The process and journey*** (Not just the individual - byut the system)	- ***Coming into therapy*** - ***Therapeutic moments and ruptures*** - ***Bringing power into the sharpest of focus*** Having the right Dx?	- ***Where the inequity lies*** ○ ***Us and them*** ○ ***Speaking different languages*** ○ ***A secure base (or not)*** ○ ***Being a good, grateful and compliant patient*** structural?	- ***Their power*** ○ ***Fear to use own power?*** ○ ***Managing their image*** ○ ***Adopting the language of the professional*** ○ ***Adding credibility*** ○ ***Fighting injustice*** ○ ***Testing, showing their power*** ○ ***Power to get action*** ○ ***Not being a good patient*** ○ ***Being a chameleon*** ○ ***Holding them to account***	- ***The therapist’s power*** ○ ***Validation, consistency, empowerment*** ○ ***Qualification and knowledge*** ○ ***Language*** ○ ***Power in the role/influence*** ○ ***“obviously the therapist will always have power” – Power is innate and obviously held by clinicians*** authenticity?
I’ve been in systems too long I think, you know I mean? *Just supposed to wait in the waiting room. And then she’s come out, and I understand appointments run over, I’m not total fucking idiot, but when you blatantly come out of a meeting and go out, cos I’m very observant, you have to be, it’s a survival technique, I’ve seen her come out, seen her go out with her friends, sit at the top of the road for 15 minutes having a fag, I know everyone’s entitled to a break. She comes back again, straight in the room, I’m ever so sorry but the meeting ran over, I’m thinking how can you trust these people? -* *You just sat in a fucking room of people, professionals, blatantly lied to me knewing you was pregnant, and that you was going to be off anyway, because I said to her don’t bother if you are just going to be leaving in six months* *And they don’t, they’re fucking rude they don’t talk to you like a human. They don’t, they dehumanise you like your fucking, I don’t know, and then they categorise you, and tell you this and then they tell you that, I’ve gone from manic-depression, to post-traumatic stress disorder, to fucking bipolar, in fucking two years, how can you put a trust in people who can’t even figure out what you have got? If you have got owt, do you get what I mean* *As for [care coordinator] yea I didn’t really want [care coordinator] but I gave him a bash, were still not, I wouldn’t say I trust the bloke, do you know what I mean, but I talk to him and that, we have great conversations he's quite an intellect and that so. We talk about all sorts, we don’t just, he is not patronising, he talks to me like a human, he’s... I dunno he’s a bit different than what I’ve usually experienced* *It’s just being fucking human mate, and have a human conversation There being clinical, they’re not being, they’re dehumanising you mate, that’s what they’re doing, you don’t feel like a human. You’re not part of this conversation, do you get..?* *The world aint getting any easier or better is it?* *Because I see so much corruption, it’s like a green stench, I can feel it like psychologically, I can feel it in my soul, when you’re around certain people, I don’t know whether it’s I’m that good at reading body language it’s like second nature, but I just, you know… you can’t do owt about it38, and if you’re honest you get persecuted for it, so you have to be so careful how you tell people things and how and what you tell people.* *And I haven’t met anyone that has succeeded in therapy, they might have succeeded slightly in some areas of their life, but have never fully recovered, do you understand?* *Sure. And I’m sure therapy does work for some people, do you know what I mean, I’m sure it probably does, I’m just one little voice out of millions do you know what I’m saying,*			but to me she got no common sense, I can’t get anywhere with them You know cos when I was a child I was leathered with plimsolls, belts and things for lying. Then soon as you hit adulthood, you are trained to lie, I just don’t get the world. Do you understand? or thinking it’s okay to lie about something small, not realising the catastrophic major effects it might have later on down the line Yeah I’m more upfront. - And transparent. And will give explanations why I’m behaving the way I am towards them. I’ll apologise for myself as well… for ourselves *because I’ve been brought up in kids homes, foster parents and all sorts of walks of life, I’m pretty good at reading people, pretty accurately* *cos I’m very observant, you have to be, it’s a survival technique,* *It’s not tailored to the individual at all, it’s still on one footprint…. And that sickens me to my stomach* *because that’s what they need, they don’t need this clinical footprint fucking by the book, ask this question we ask them all this question, do you know what I mean? Everyone needs a tailored experience. No different to going on holiday mate, do you know what I mean?*		*I really don’t know how to classify it, but I felt like they were a little bit of a cut above, like a teacher, and there were certain behaviours that I might not talk about, they might be thought of as worse than they really are. Or they might be shocking to the therapist, maybe that’s what I thought, they may be shocking.* *Support network, if you haven’t got one, there was a period of time when I felt I didn’t have one so you don’t really want to engage sometimes you’re scared of getting things out in case you can’t put them away or in case the therapist can’t contain you enough at the end the session. Which you know, I know it happens, I know I probably let people as well as go, the end of the session where we’ve just haven’t had the time to pack everything away nicely* *I know that as a service user, thinking about power, I think a bit more in the context of the NHS organisationally, than the people that work in the service. So for me whilst yes it’s very important that we think about the power dynamic between a client and therapist, I do think the service always needs to be addressed at a wider level because I know that I’ve been very good clinician working in a bad service, so if we don’t address the bad service, I’m always the bad clinician anyway, even if I’m doing a good job. I still receive a complaint, even though I’ve done a good job, because it’s the service perhaps, you see what I’m saying?* Clinical rooms are horrible. Clinical rooms often look bare, empty, soulless, and they reflect the emptiness of your depression. That’s my personal feeling, they reflect the emptiness of your depression. That’s my personal feeling they reflect the emptiness of your depression. It was about three weeks in. Three or four weeks in, I had to get him involved because she couldn’t give me no answers… so to ask him in as a witness, who could perhaps explain it in her intelligent terms rather than my fucking laymen terms, do you know I mean *it feels like you’re repeating yourself, felt like you had indigestion* *Now I end up explaining this whole shit to someone else again* *See what I found this mate what therapy is is that you repeat yourself a lot and review what you repeated a lot, do you know what I mean, that’s how therapy seems to me* *When I was going through the motions with [service]* *it's all about forms and paraphernalia they ram in-your fucking face as soon as you are there, this explains this, about what your undergoing at the minute, this is what we offer, this is go… home and read that, but what about if I can’t fucking read?* *and then when you ask to see notes, you can’t do that you have to write to this, go around that* *and then the staff got restructured, do you know what I mean, so she got hoiked off, I lost [name], she was like a support worker,* *So I’m eating into my 26 hours, when you’re only putting in a measly effort, it’s a good screw really, I imagine she gets half decent pay, do you know what I mean.* *Who sits in an office, do they have like a tombola machine and pulling fucking numbers out it or something, how has that been scientifically proven that that is the right amount of time one individual needs to deal with their history of abuse and neglect of elders, and systems as well?*		

Appendix C1: Visual iteration of the analysis


1. The different layers of disempowerment that shape experience in the relationship

2. The dynamic balance of power in the relationship

3. Pivotal moments and ruptures in therapy transforms the experience of power

4. How power is experienced differently in other relationships after therapy

- *o (Historical) - Disempowerment shapes thinking & attunes one to power = thinking shapes experience - "past experiences if you like had shaped my thinking" – Lola*
- *o (Acute) – The desperation felt from consistent disempowerment and search for understanding - "Do you know what I mean?" - Jason*
- *o (Action) - Gratefully accepting (disempowering) – "gratefully accept what is offered to me" - Lola*
- *o (Consequence) – You bring that disempowerment in to therapy as expectations and fears – "then you bring that all into the therapy room at the beginning and you have to work through that" - Axel*

- *o (Historical) – Power is naturally unbalanced - 'it was very much a them and us, with the power being with the clinicians' – Lola*
- *o (Acute) – The see-saw of trying to balance power - dynamic, conscious / unconscious – "it's never kinda been equal, but yea it didn't feel like at the same time it didn't feel inequal" - Kate*
- *o (Action) – Levelling the playing field: The giving and receiving of power as a relational dynamic - it is a combination of other people's behaviour and also your reaction to their behaviour – Cecilia*
- *o (Consequence) – new experiences of power or change in the TR*

- *o (Historical) - People have the areas where power most impacts them (fear)*
- *o (Acute) – These get tapped into by something happening in the room*
- *o (Action) – Responses matter – 'she nurtured me, she gave me what I needed in that session' - Lola*
- *o (Consequence) – the relationship changes & so do others.......... - I think that was probably a turning point - Lola 'I put up my boundaries once I found we were on a deadline' - Violet*

?

Key:
- *Layers of disempowering experience* 〰
- *Key meanings/fears related to disempowerment (Eg dismissal, abandonment, dehumanisation etc)* ●
- *Power actions, relational or structural* ↖

Appendix D1: Exemplar extracts from final analysis

1. *"Past experiences, if you like, had shaped my thinking" - The different threads of disempowerment that shape experience in the relationship*

"Ummm I think to some extent… I'm not quite sure, I don't really see myself as having a struggle with power at this point in my life, I can't really think of any examples to be honest" - Kate

"it [power] can be abused very easily" – Axel

"Power's danger" – Jason

"I was treated like a number, come in, get on the scales, I'll write that down, and see ya later. Who was I? I could have been anyone. She could have just weighed an orange." - Lola

"She was a lovely lady, but she was very 'there there, there there'. Very much patting you on the head. Very patronising and I very much felt like I was to do as I was told, in that time yeah? A little person, less than human." - Cecilia

"I don't know, being quite desperate for my recovery I suppose" – Violet

at this point means that you get there and you're desperate – Axel

"A little bit of hope that things could get better, but there was obviously a lot of natural distrust wariness and fear" – Axel

"I was very much desperately willing to engage in whatever needed to be done to achieve my recovery" - Violet

"Um. I may have expressed the fact that I was displeased because it [the therapy] wasn't addressing trauma, I could have spoken about it, but I didn't because I was like well it's what she's offering. I can't, I can't really, I have no power to do anything about that if that makes sense?" – Axel

"With my care coordinator it was like 'you have to go to these emotion regulation groups, with all these other young people or you'll be seen as uncooperative and you won't get further care'. That… Needs… To… Stop…" - Axel

"if we are provided a service, somehow we either need to accept it and be grateful and submissive to it, because we should just be grateful and say thank you because it's a gift"- Violet

"then you bring that all into the therapy room at the beginning and you have to work through that, you then have to learn that okay my therapist can actually be helpful despite the massively long wait. Like the therapist, even if the NHS and government don't care about us, the therapist does, um that kind of thing" - Axel

"They're being clinical, they're not being… they're dehumanising you mate, that's what they're doing, you don't feel like a human." - Jason

"Um well yeah because of the constant dismissal of my problems" – Axel

"I've always experienced power as quite a hierarchical thing, the people in power are the people at the top, the people in power are the people above me... effectively, so you know I've always been under someone's power perhaps, you know" - Lola

"umm, mmm yes, it's a tricky one, I think when someone kinda says power you think about someone who is high authority, makes all the decisions" – Kate

"Dunno, power is just, you have more influence and authority than other people, um it comes along with certain responsibilities, you can't use power, it can be abused very easily" – Axel

"There's in the past when I've researched power, umm… I don't know how to word this, I've always looked at it from a kind of dominance/submissive type perspective" - Violet

"You can't do that with people with mental health problems because, we, the majority of us feel lonely and empty and disregarded" - Cecilia

"we're like mentally ill now, we need help now, we don't need help in a years time, we want help now" - Axel

"So um it was, I kind of really worried that I would just be treated like I was a mental health problem and that wasn't actually me, just the sum of my parts, I was just a mental patient with a personality disorder" - Ceclia

"I respected and trusted his qualifications and his training and experience." - Violet

"Yes, when I started experiencing symptoms of said trauma, ermm it declined rapidly into crisis point, I had ended up like, I couldn't stop crying, everything was just awful" – Axel

"Um I was constantly asking him [Axel's care coordinator] for help, therapy you know, meds, anything" - Axel

2. "it's never kinda been equal, but yea it didn't feel like at the same time, it didn't feel inequal" - The balancing of power in the relationship

"Ummm I think to some extent… I'm not quite sure, I don't really see myself as having a struggle with power at this point in my life, I can't really think of any examples to be honest" - Kate

"it [power] can be abused very easily" – Axel

"Power's danger" – Jason

"I was treated like a number, come in, get on the scales, I'll write that down, and see ya later. Who was I? I could have been anyone. She could have just weighed an orange." - Lola

"She was a lovely lady, but she was very 'there there, there there'. Very much patting you on the head. Very patronising and I very much felt like I was to do as I was told, in that time yeah? A little person, less than human." - Cecilia

"I don't know, being quite desperate for my recovery I suppose" – Violet

at this point means that you get there and you're desperate – Axel

"A little bit of hope that things could get better, but there was obviously a lot of natural distrust wariness and fear" – Axel

"I was very much desperately willing to engage in whatever needed to be done to achieve my recovery" - Violet

"Um. I may have expressed the fact that I was displeased because it [the therapy] wasn't addressing trauma, I could have spoken about it, but I didn't because I was like well it's what she's offering. I can't, I can't really, I have no power to do anything about that if that makes sense?" – Axel

"With my care coordinator it was like 'you have to go to these emotion regulation groups, with all these other young people or you'll be seen as uncooperative and you won't get further care'. That… Needs… To… Stop…" - Axel

"if we are provided a service, somehow we either need to accept it and be grateful and submissive to it, because we should just be grateful and say thank you because it's a gift"- Violet

"then you bring that all into the therapy room at the beginning and you have to work through that, you then have to learn that okay my therapist can actually be helpful despite the massively long wait. Like the therapist, even if the NHS and government don't care about us, the therapist does, um that kind of thing" - Axel

"As a therapist she has the power to say, yes, I will treat you, no I will not treat you, this is the treatment I am offering. I don't get a say in this." – Axel

"You can't do that with people with mental health problems because, we, the majority of us feel lonely and empty and disregarded" - Cecilia

"why do we only get a mental health day or mental health week" – Jason

"we're like mentally ill now, we need help now, we don't need help in a year's time, we want help now" - Axel

"I think in the beginning I probably tried to assert my power. It's not even necessarily always conscious. It is often on reflection I realise, oh crap I was testing him." – Violet

"I didn't want my therapist to think less or differently of me, if that makes sense, and that's something I have no power over, but the thing I have the power over was whether I say this or do I not tell her this." - Axel

"And I have had to blend in, I've had to be a chameleon, I've had to for survival" - Jason

"You have to adapt any environment, any situation. I pick up on the things that you want to hear, do you understand?" - Jason

'Emotion regulation' – 'intrusive memories' – 'hypervigilance' – 'window of tolerance' – 'radical acceptance' – 'engagement' – 'intervention'

"because I knew she wanted to quit" – Jason

"I need to read your body language I need to see the sweat on your brow, do you know what I mean?"

"[with regards to online therapy] I can't see your pupils if they're dilated or not you know I mean, that's how intense I am"

"It was a more level playing field, so I didn't really need to use power as such. I didn't need to question power or use power against my therapist." – Lola

"It was just the consistency in her behaviour so after a few sessions the fact that she remained the same, she still validated my problems, she still encouraged me and praised me when I made achievements, she was still respectful. It was the fact that she was showing me that some people in authority and indeed in the NHS itself can be trusted." - Axel

"That means the people who don't have power will only have if those with power give it up." - Axel

"rather than feel it was, today we going to do X, Y, and Z, and this is what we are going to complete you know it was like, but that's okay, if we can't do it all today will set up another one, for the end of the week" - Lola

"I can remember with the psychologist we didn't always do things in order, we had things we had to go through, but sometimes I wasn't in the right place to do certain things." – Cecilia

"it's never kinda been equal, but yea it didn't feel like at the same time, it didn't feel inequal" – Kate

"so the flexibility of the therapist in response to my requests, because they weren't demands, they were requests, made the power dynamic feel less like a power dynamic, it was more level playing field, so I didn't really need to use power such with, I didn't need to question power or use power against my therapist." – Lola

"And also the fact that I didn't want my therapist to think less or differently of me, if that makes sense, and that's something I have no power over, but the thing I have the power over was whether I say this or do I not tell her this. So I chose not to tell her this because that's the only power I had in that situation, if that makes sense." - Axel

"so for me it actually was about getting a response, so I would use that power that I had because the riskiness of me… to get action" - Lola

"I can say yeah I cut myself for people responses, whereas actually if you say that to a teenager 'whaaaat!! I don't do it on purpose'" - Lola

"I used my own illness as power against services, against clinicians, as an excuse to get out of other things in other contexts of life sometimes." - Lola

"I think the big differences were, kind of I my negative experience there was a lack of understanding and like a lack of compassion as well. Whereas I definitely felt that with the therapist, I felt like she was very understanding, and quite sympathetic as well, and which I think makes all the difference when you are going through like a difficult time." - Kate

"It's not tailored to the individual at all, it's still on one footprint…. And that sickens me to my stomach." - Jason

3. *"I think that was probably a turning point" - Pivotal therapeutic moments & ruptures that transform the experience of power*

"Yea, So think it was just worrying that if went to A&E with a broken foot they'd be able to see all my mental health records which would be embarrassing." - Kate

"So in the first in the first meeting um confidentiality was mentioned and it made me feel very comfortable to know that it wouldn't be shared outside with people when it wasn't necessary." – Kate

"But because we got to that point I think I've got to go, I can't deal with this and she guided me back down and levelled out some of that adrenaline I was feeling, I think that was probably a turning point where I felt more able, regardless of how I projected onto her to share, I was able to put my projections aside I think at that point and go, she nurtured me, she gave me what I needed in that session, and I didn't have to leave the session, let's go with this, I just felt more trust from that point." - Lola

"he'd let slip, by accident, that we only had something like three months left or something" - Violet

"I was angry that my entire therapy had been….[implied for nothing]" - Violet

"put up my boundaries once I found we were on a deadline." - Violet

'even in the last session, after six months, I still didn't believe a word he said' - Violet

"I suppose the other thing that worried me as well, is that I wouldn't be good enough for the therapy process, and that's.. yea" - Cecilia

"Um we did some work on kind of me being a good person, because even now to this day I have times when I think I'm a horrible person, um it doesn't happen as often as it used to but it does still happen. I think when she was kind of reassuring me, that I was a good person and that I was engaging, and that I was doing a good thing, as helpful yeah." – Cecilia

"That did make me feel invalidated, I feel like that was an abuse of power, because shouldn't follow, she can't diagnose, she didn't follow protocol to diagnose or to say someone doesn't have something but overall I trusted her, but I was wary that invalidation could still occur.41 Um so year other than that it didn't. so Yeah I'm just like, you shouldn't overstep and say someone doesn't have something without the criteria with them but overall, I believe she's a good therapist, I would happily see again, well-not happily, but I would see her again and would still trust, to a degree, you know she's one of the better therapists, that are out there. Yeah." - Axel

Appendix E1: Example of analytic process for systematic review

Raw data	**Descriptive codes**	**Descriptive theme**	**Analytic theme**	**Subsidiary theme**	**Superordinate theme**
'I was in control. I was in control of it. . . Er, not as in control as in nasty control. More say, like, if there was something I was thinking about at the same time, I knew there was no obligation for me to even bring it out or mention it at that time. A lot of the time I did, a lot of the time. That's what was helpful about a lot of the time.' (Participant 36, Paper 9)	- Feeling in control - Choice in what they can say and do - Frequent choices - Agency - Not feeling obliged	- Having choice and control	- Allowed to have choice and stay in control. - Therapist being flexible to what they asked or expected from them.	- Direction vs flexibility	- Therapist actions

Appendix F1: Considered qualitative approaches and rationale for disqualification for empirical paper

Considered qualitative approaches and rationale for disqualification

Approach	Description	Rationale for disqualification
Grounded Theory (GT; Glaser & Strauss, 1967; Charmaz, 2006; Braun & Clarke, 2013)	GT is a bottom up theory building approach with an emphasis on understanding social processes, which has a number of iterations from different covering a range of epistemological positions, from positivist (Glaser, 1978) to constructivist (Charmaz, 2006; Madill et al., 2000).	The primary reason for exclusion of GT was that it is theory building and often exclusionary to existing literature. There are significant theoretical insights around power, albeit from multiple and often conflicting perspectives, and not engaging in this literature would miss opportunities for deeper understanding. IPA is 'interrogative', as results 'do not stand on their own, but rather are subsequently discussed in relation to the extant psychological literature' (Smith, 2004). For this reason, IPA was chosen over GT.
Narrative Analysis (NA; Riessman, 1993; Gergen & Gergen, 1988)	NA looks to understand how participants construct stories and narratives from their personal experience. Like IPA there operates a double hermeneutic forming the basis of the analysis. There are a number of iterations of NA with differing approaches and there have been concerns that there is no 'singular or best way to define and study narrative' (Mishler, 1995, p117).	NA was excluded as it was felt that the core phenomenon, the experience of power, was potentially too abstract to be captured in a narrative manner and that keeping the accounts intact would be challenging. For this reason, IPA was chosen over NA.
Thematic Analysis (TA; Braun & Clarke, 2006)	Method to identify themes and patterns of meaning across a dataset in relation to the research question. Flexible approach with a number differing approaches from bottom up (inductive TA) to top down (theoretical TA) as well as experiential and constructionist.	The flexibility of TA is arguably both a strength and weakness of the approach and there are apparent similarities to IPA, however, the lack of rigorous philosophical grounding (that grants flexibility), particularly in phenomenology and idiography, for a research question is explicitly focused on a specific context and experience is why IPA was chosen over TA.
Discourse Analysis (DA; Coyle, 2006; Potter & Wetherell, 1987)	DA is generally concerned with patterns in language use connected to the social production of reality, and how objects are constructed in certain ways (Braun & Clarke, 2013). A social constructionist and relativist approach.	DA was deemed unsuitable as an approach, despite Critical Discourse Analysis' (CDA) attendance to power in discourse (see van Dijk, 1995). This is because DA and CDA typically look at power through a Foucauldian and more alethic relativist lens, which would deny the subjective reality of participants, thus making it challenging to answer the research question. For this reason, DA was excluded.

Appendix G1: Steps to develop interview schedule for the empirical paper

Steps to develop interview schedule for the empirical paper

1. An initial set of interview questions driven by the research question were drafted.
2. Topic areas and suitable areas of focus were then identified as well as refining important contextual questions that could support exploration of topic areas. Three areas were identified:
   i. Overview of therapy and understanding of power
   ii. Relational (or postmodern) Power in the therapeutic relationship
   iii. Structural power factors outside of therapy that affect the relationship
3. These topics and related questions were then sequenced in a logical order so that sensitive topics approached at a point in the interview where less challenging topics have been discussed previously and so rapport had time to develop.
4. Open questions were generated in line with identified topics. Any questions that were loaded or leading were eliminated. Openly phrased prompts and probes were also developed at this point for the more complex or abstract questions.
5. The developed questions were then discussed with all members of the team and examined in relation to utility and the research question, as well to check that assumptions of the researcher were not unduly impacting on the guide.
6. Following this the host trust's People Participation group was approached to recruit participants (who were paid for their participation with a £10 Amazon voucher, as per Trust policy) to support further development, refinement, and additional insight. This was done in an hour consultation with an expert by experience.
7. The schedule was then piloted with a colleague of the author to check for flow and relevance.

Appendix H1: Ethical considerations summary for the empirical paper

Ethical considerations summary for the empirical paper

Consent

Participant information and consent sheets were developed using templates from the Health Research Authority (2017) and guidance from the General Data Protection Regulation (European Union, 2017) was used. These can be found in appendix O, P and Q. Participant information sheets and consent forms were sent by email 72 hours prior to the contact to discuss consent. The researcher took care to make sure all information provided was understood and that ample opportunities to ask questions were provided, as well as frequent reminders of the right to withdraw.

During the telephone call to discuss the research and to gain consent, verbal consent was gained. Following this, the participant was offered the opportunity to provide written consent electronically (via online Qualtrics Survey). The interview did not proceed until written or electronic consent was obtained. Capacity to consent was initially assumed as participants are over 18 years old, however, the initial telephone discussion allowed for capacity to be assessed according to the Mental Capacity Act (2005). All participants had capacity to consent to taking part in the research.

Confidentiality

The minimum amount of identifiable information was collected and access to this was restricted to the research team. This included, names, dates of birth, contact addresses, telephone numbers, and email addresses. Other non-identifiable demographic information was collected but participants had the right not to provide this information. All information was provided electronically but systems were in place if participants wanted to provide paper information. All paper notes were stored securely in a locked filing cabinet according to Trust and university policy and electronic data was data stored on an encrypted memory stick or NHS encrypted laptop. Participant's contact details and identifiable information were stored on a secure Trust issued laptop, which was password protected. Interview data was kept on a password protected computer and immediately anonymised after transcription.

The author was responsible for the transcription of the interviews. Interviews were conducted over a secure video link and recorded on to an encrypted recording device. Published data, including interview quotes, was anonymised as to be unidentifiable.

Confidentiality was assumed, however, this would have been overridden if researchers were significantly concerned about risk (British Psychological Society, BPS, 2014). This was not necessary in this study, but protocols for managing this can be found in appendix I and R.

Due to contacts being conducted remotely by phone or video link the researcher was in a private office either on a trust site or at home. Participants were encouraged to choose a private and quiet location for the interview.

To contextualise some of the structural power operations within the therapeutic relationship, participants were asked to estimate the age, assumed gender, assumed sexuality, assumed ethnicity and whether they assumed the Clinical Psychologist they saw had a disability. Participants were not asked the name of the Clinical Psychologist to help them to speak freely about their experiences. A protocol was in place had the participant raised concerns around malpractice or risk and can be found in appendix R. No concerns were raised during interviews.

Coercion

Coercion was reduced in this study through participants being provided with study details (through the study literature and website) before deciding whether they provide consent to be contacted to discuss formal consent. This process was done with consultation with People Participation Leads (PPLs) in the host trust.

Deception

There was no deception in this project and aims were stated and freely discussed. Participants were able to ask questions about the research and these were answered openly.

Risk

Risk and participant safety was carefully considered in this study. It was possible that participants may have found aspects of reflecting on previous incidents of therapy distressing or upsetting and as such this was considered and discussed with participants prior to consent being obtained. All participants were offered time and space to discuss any concerns they had with the researcher during the study. The researcher conducting the interviews was trained and experienced in listening to distressing information and is aware of processes for obtaining additional mental health services for service users when required as well as attending to his own wellbeing through supervisory channels.

Consent was also gained from participants to inform their Lead Care Professional (if they were still in contact with mental health services) within their care team or their GP of their involvement in the study as well as providing consent for them to be contacted in the event that concerns were raised. No concerns were raised throughout the study.

Protocols for managing distress in the interview were developed in collaboration with the participant prior to the interview as well as additional sources of support. No interviews were stopped due to distress. Additional protocols for managing disclosure of risk of harm were developed in line with trust, national and university guidance, which included utilising the trust crisis services and emergency services if needed. These are detailed in appendix I. There were no disclosures of immediate risk from participants.

This project was completed in the context of COVID-19 pandemic in the United Kingdom. Risks pertaining to the COVID-19 pandemic were considered and reduced in this study as far as reasonably possible. All contacts with participants and professionals were undertaken remotely by either email, telephone, or video link. Where possible all consent and participant information sheets were delivered electronically so as to decrease the risk of viral transmission through post and exposure to other people (such as going to the post office). Current local and national guidance was followed at all times.

Burdens

The primary burden for the participant was the amount of time needed to take part in the informed consent process and the interview, approximately 30 and 90 minutes respectively. This time was during typical working hours (Monday – Friday, 9am – 5pm) and may have placed a burden on participants because of potentially needing to organise time off work or to arrange childcare. Approximately 20 minutes to read the literature about the study and provide consent to contact was required but was completed at times that suit the participant.

Participants that took part in the study were gifted an electronic £10 Amazon voucher for taking part following the interview regardless of whether they withdrew or not.

Debriefing

Due to the open nature of the research study the participant could ask questions at any point and following the interview were offered a full debrief of the research. Participants have also been offered a summary of the research on publication and the opportunity to discuss this with the author.

Conflicts of interest

The author conducting the research was a Trainee Clinical Psychologist who during the research was on clinical placement within the host trust. There was a chance that he may have previously known a participant who applied for the study. A protocol was established for this and can be viewed as part of the ethics application. Had he had direct clinical contact with them then they would have been excluded from the study. This did not occur in the study.

No other potential conflicts of interest were identified.

Appendix I1: Yardley's (2000) four principles for qualitative research and their application to the empirical paper

Yardley's (2000) four principles for qualitative research and their application to the empirical paper

Quality was maintained in the empirical paper through adhering to Yardley's (2000) principles for qualitative research.

The first is 'sensitivity to context', which places importance on contextualising the research withing the theoretical and empirical literature. Whilst the empirical literature is scant surrounding experiences of power in therapeutic relationships, there is substantial theory on power. This thesis has attempted to summarise pertinent aspects of this to 'set the scene' for which experiences of power can be understood within the analysis. The use of a systematic review as well as additional information in the bridging chapter provide further context than the empirical paper can offer alone. Furthermore, sensitivity to context has attempted to be addressed through sensitivity to participants' perspectives and contexts. The use of open questions and exploration of socio-cultural contexts of participants in the analysis supported this. The development of the interview schedule included people with lived experience of receiving therapy within the NHS (including a member of the supervisory panel). IPA as an approach with its grounding in idiography and phenomenology naturally is attentive to context when applied correctly, as such the author sought advice from colleagues and experts in the approach to support their application of this philosophy.

Secondly 'commitment and rigour' was addressed through the researcher, who was initially a novice in the application of IPA, attending specialised research training as part of their Doctorate in Clinical Psychology, as well as significant self-study and collaboration with peers and more qualified researchers and supervisors. IPA whilst being a flexible and iterative approach has a level of structure that other qualitative methods lack (Braun &

Clarke, 2013), mostly in thanks to guidance from Smith et al (2012). Supervision was also used to check plausibility of the analysis. Finally, the author and the supervisory team have an interest in the topic that goes beyond simply producing a research project and their experiences and engagement with it reach outside of their academic work. Audit trails were kept, and each iteration of the analysis was ordered so that development of themes can be traced and thought process surrounding this.

The third aspect of Yardley's criteria is 'transparency and coherence'. Coherence has been addressed through thorough consideration of the methodological approach and the underpinning philosophy, as evidenced above, as well as having a transparent account of how the data was collected as well as the assumptions and experiences of the analyst being clearly articulated, so that the reader can form their own perspective on accuracy, with reflexive statements to back this up.

The fourth and final aspect is 'impact and importance' and Yardley (2000) explains that this *'can only be assessed in relation to the objectives of the analysis, the application it was intended for, and the community for whom the results were deemed relevant'* (p. 223). The author has stated the potential applications for service users, Clinical Psychologists, researchers and policy makers, as well as where the research adds depth to the existing literature.

Appendix J1: Analytic process for the empirical paper

Analytic process for empirical paper

1. *Transcription* - anonymisation and verbatim transcription of interviews into Microsoft Excel software with comments added to text of notable non-verbal utterances, pauses and hesitations. During this phase some brief initial notes were made but primarily this was a procedural step. The data was transcribed before analysis began.
2. *Reading and re-reading* - was the initial step where the author became familiar with the transcript through several read throughs of a single transcript.
3. *Initial noting of first transcript* – the author then analysed the transcripts line by line noting the experiential claims of each participant making initial comments and reflections on the text. Attention was paid to the descriptive, linguistic and conceptual differences in the text. An exemplar of this can be seen in appendix V.
4. *Developing emergent themes* – the next step involved the researcher offering thematic commentary on the initial notes and finding concise ways to explain the content of initial noting. At this point noting and looking for themes became a combined and iterative process. The philosophical grounding in hermeneutics suggests movement between different parts of the text at different analytic stages, particularly moving between the ‘particular’ (more commonly notes) and the whole (themes). This is described by Smith et al. (2012) as the hermeneutic circle. An exemplar of a this can be seen in appendix V.
5. *Searching for connections across themes* – themes were then reviewed and brought together to find convergence and divergence, as well as commonality and nuance. Analytic devices suggested by Smith et al. (2012), including abstraction, polarisation, contextualisation, numeration and looking for function of themes,

supported the ‘dialogue’ between the data, the analysist, and their psychological knowledge about what this might mean for participants in this context. This supported the development of a frame that illustrates the relationships between themes. These collated and developed into individual themes for participants Appendix W.

6. After this was completed, the researcher moved on to the next case, repeating the aforementioned steps until all cases were examined. The experience of immersion in the preceding data influenced subsequent analyses, therefore careful use of the reflexive diary and supervision was used to make sure that novel meaning or interpretation was not lost.
7. Once all cases were analysed each was individually written up with evidence for each theme. An example of this can be found in appendix X.
8. Once all cases were analysed the final step involved drawing themes across all participants together and creating master themes for the cohort, looking for potency and connections or disparities between themes, and moving towards a theoretical conceptualisation of related themes. This was done over a number of stages and iterations and involved initially extracting all themes and sub themes from participants into an excel spreadsheet. Firstly all individual themes were brought together in a spreadsheet (appendix Y), then compared across participants to look for convergence and divergence, which started the higher order analytic process (appendix Z).
9. The analysis included six iterations of the data, which were discussed frequently in supervision sessions with the research team. These were written up at each iteration as well as being linked back to the original data in a table (exemplars of these can be seen in appendix A1 & B1). At this point a visual representation of

the experience was drawn up to support capturing the phenomenological aspects of the data. This can be seen in appendix C1 and was only used as guide and scaffold for the analyst to better understand the experience of participants. This helped to develop the overall superordinate theme in the final analysis as an analogy of different marbled layers of rock were used. However, this did not reflect the dynamic nature of the phenomenon and that is how the *dynamic tapestry of* power theme was developed as a more fluid, dynamic, and changeable analogy. Once completed and discussed a further two iterations of the analysis were completed with the scaffolds of the visual representation removed to expose the experience of the participants.

10. Once the final theme and subsidiary themes were developed the author had a final check on the data (both participant themes and actual interview data) to check the validity of the interpretations (see appendix D1 for exemplars). Throughout these steps the development of the themes was discussed in supervision to discuss the interpretive validity of them and to examine the analyst's assumptions and the bridling of these (as far was possible).
11. Final refinement of the themes occurred during the write up of empirical paper.