Helping or Harming in Clinical Psychology?

Jodie Wells

Under the supervision of:

Dr Laura Golding and Dr Nic Horley

Date: 06.06.2022

A thesis submitted in partial fulfilment of the Doctorate in Clinical Psychology

University of Liverpool

Acknowledgements

First and foremost, to the courage of the six people who volunteered to speak with me. Without you, there would be no project so my biggest thank you goes to each of them.

To all of the people I have worked with over the years- your stories and challenges have inspired me to be better, and to do better, always.

To Liverpool Experts by Experience- for your encouragement, collaboration and continued support.

This thesis would not have been in any way possible without the support of my supervisors:

Laura- For believing in the project and in me. Thank you for three years-worth of unwavering patience, integrity and encouragement- from the vague and tentative beginning, to finally seeing something on paper. I'm so grateful you took a chance on me.

Nic (my long distance, ex-work colleague acquaintance/friend)- Thank you for saying yes to supervising this and providing the analysis knowhow. It wouldn't be what it is without your fabulous mind! Thanks for reminding me that silence never makes for change, to have faith in my voice and the courage to use it.

To my family- my fiercest and most consistent supporters in this, and in life- for your belief, love, laughs, telephone calls and care packages.

To old friends and new friends (Heather, Ais, Jen, Alex, Yasmine, Mishca)- for providing kindness, laughter, solidarity and distraction and seeing me through to the end. I'm grateful for you all.

To Estelle- I couldn't wish for a better mentor. For seeing things in me that I didn't. For nurturing those things and giving me space and opportunities to grow. I'll never be able to say thank you enough.

And finally to Claire- for being the spark that lit the flame and the beginning of it all. But mostly for being my person.

Table of Contents

5. List of Tables

6. List of Figures

Thesis Word Count: 21, 300

1. Introductory Chapter

1.1 Thesis Overview

Qualitative researchers are encouraged to be open and provide their readers, clarity with regards to their chosen topic of research and their position within that (Squire, 2008). Ahern (1999) highlights that the researcher's background and perspectives provide important insights about how the narratives of those researched will be made sense of and understood.

"What can we do with our stories', he said, 'but tell them?" (Sena Jeter Naslund; Four Spirits).[1]

This is mine.

The last thing a service user ever said to me before being returned to prison was, "you're going to get me killed" with a big grin. I had been encouraging him to continue to use the anger management skills we had been working on over the preceding years. That moment stayed with me, despite the many more we had shared. Plato (427 BC-347 BC) said, "the measure of a man is what he does with power"[2]. Powerful is not necessarily a word synonymous with young assistant psychologists, however as a white, educated woman, holding a set of keys in a setting that detained people, that is what I was. My instinct was to deny the possibility that the skills we had worked on together would not be helpful, but I was left with nagging doubt and it was perhaps, the first time I had considered that psychological intervention could be harmful.

---

[1] Naslund, S. J. (n.d). *Four Spirits.* Retrieved from: Four Spirits Quotes by Sena Jeter Naslund (goodreads.com)

[2] Plato Quotes. (n.d.). *BrainyQuote.com*. Retrieved from: Plato - The measure of a man is what he does with power. (brainyquote.com)

“If you do not tell the truth about yourself, you cannot tell it about other people.” (Virginia Woolf, 1882-1941)[3].

I believe that we do not often hear issues of harm in clinical psychology commonly debated amongst professionals. It is important that professionals engage with the literature to encourage accountability, address power imbalances and reflect on the limitations of theory and science embedded in western, capitalist and politicised contexts. Finding ways for silenced, marginalised or undervalued voices to be heard in society is important to me and provides the rationale for the narrative literature review. However, hearing the voices of clinical psychologists is vital to further extend the literature and this is the basis for the following empirical paper. It is important that clinical psychologists take responsibility for highlighting actual and potential harm and for generating ways to prevent this, rather than this resting with people who use services. In this thesis, I offer a novel means of exploring harm and extend the literature, to support learning and development which facilitates effective, safe and helpful interventions. This thesis includes the following papers:

1. A **Narrative Review** of the literature that aims to explore the adverse effects of engaging with psychological therapy from the perspectives of people who have accessed it. In this chapter, I qualitatively synthesise the literature to set out the ways in which psychological therapy has been experienced negatively or as harmful.

---

[3] Virginia Woolf Quotes. (n.d.). *BrainyQuote.com*. Retrieved from: Virginia Woolf - If you do not tell the truth about... (brainyquote.com)

2. An **Empirical Project** exploring clinical psychologists' experiences of helping, harming and consent in their practice. In this chapter, I present a narrative inquiry and analysis to understand their experiences, incorporating identity construction.

2. Chapter One: Narrative Literature Review

What are the adverse effects associated with psychological therapy from the perspectives of people who access it?

*This review has been provisionally prepared for submission to the Journal of Clinical Psychology and Psychotherapy. Author guidelines can be found in appendix I.

2.1 Abstract

Background

This narrative review aimed to explore the literature on the adverse impacts, negative effects and harm experienced by people in relation to their engagement in psychological therapy. Through a qualitative narrative synthesis, the review provides an overview of the topic of harm in psychological therapy, and identifies knowledge gaps and disparity between concepts.

Methods

A literature search of four electronic databases was undertaken. Studies were included if they assessed harm, negative effects or adverse outcomes in individual psychological therapy, including, but not limited to, relational and therapy model specific harm. The reviewed papers reported studies focusing on people who have engaged in psychological therapy, using either qualitative or quantitative methods.

Results

A total of eight papers met the eligibility criteria for review. These were assessed for quality and outcomes synthesised for the review.

Conclusions

Harm and negative effects occur in the context of engaging in psychological therapy. Gaps in conceptual understanding of what constitutes harm and negative effects, and disparities in approaches to investigation by the studies, limit the conclusions drawn. Clinical and service implications and future research are discussed.

2.3 Introduction

Psychological therapies are interventions (sometimes referred to as psychotherapy or talking therapies) which apply psychological theories and models to understand distress and help people to make changes that may alleviate suffering and improve functioning (Public Health Scotland, 2022). Psychological therapy is carried out by a range of professionals, including clinical psychologists, psychotherapists, psychiatrists etc. and involves both relatively brief interventions or longer term psychological input. The National Health Service (NHS) Long Term Plan (2019) sets out the vision for the future transformation of health provision over the next ten years with a specific focus on the contributions of psychological professionals in early intervention, such as perinatal and children and young people's mental health. The plan proposes a requirement for an additional 2520 more psychologists and 5610 psychotherapists; an expansion of more than 50% (Psychological Professions Network, 2019). This potential increase in offer for psychological intervention adds to the rationale for this review; to understand the potential harms[4] that can occur in psychological therapy to develop the means of prevention. In the UK, the National Institute for Clinical Excellence (NICE) has the authority to determine what forms of psychological therapy should be provided within the NHS (Mollon, 2009). NICE reports on, and recommends, 'evidence based' psychological therapies, for example, Cognitive Behavioural Therapy (CBT) for a range of what are labelled as 'mental health disorders' or problems which are thought to have an adverse impact on psychological wellbeing. It is important to note that NICE largely takes a medicalised view of distress and

---

[4] In this review, 'harm', 'negative effects' and 'adverse events' are used interchangeably.

therefore language[5] and 'treatments' are recommended based on this understanding of disorder and recovery (Mollon, 2009).

2.3.1 The Evidence Base for Harm

As the mental health industry has expanded, so too has interest in the efficacy of psychological interventions to understand and improve the factors associated with psychological distress and wellbeing. Consequently, concerns about potential iatrogenic effects of psychotherapies have also grown (Mercer, 2017; Berk & Parker, 2009; Lilienfeld, 2007). Despite this, in a review exploring the reporting of harms in randomised controlled trials (RCTs) of psychological interventions, Jonsson, Alaie, Parling and Arnberg (2014) found only 28 trials (out of 132: 21%) included information about the monitoring of harms on the patient. Of these trials, methods of monitoring, and descriptions and range of adverse events were variable, suggesting harms are not systematically reported. This highlights potential bias when looking at the risk-benefit ratio of psychological intervention.

It is estimated that up to 10% of people become 'worse' after psychotherapy (Berk & Parker, 2009). Some literature details risks of adverse outcomes, both as a result of the therapeutic model (Lilienfeld, 2007) and as a consequence of the therapeutic relationship (Knox, 2019). Berk and Parker (2009) suggest that few studies go beyond documenting deterioration in the primary outcomes for which the psychological intervention was applied. Dimidjian and Hollon (2010) suggest that harmful treatments can have a causal effect, for

---

[5] Throughout this review, the author would like to acknowledge that some of the language used (in relation to medicalisation of distress) corresponds to the language that is used in the literature. For this reason, the language used in the review papers has been retained in this review to ensure identification of the findings.

example producing outcomes that are worse than they would have been without treatment. They further propose that treatments can worsen outcomes in domains other than the primary problem a person has sought psychological therapy for. For example, a person who seeks support for difficulties relating to anxiety, completing treatment and then experiencing a breakdown in their relationship. Dimidjian and Hollon (2010) note the difficulties inherent in assessing harm caused by psychological therapy, describing the importance of perspective and time, arguing that treatments can be harmful initially, whilst later beneficial and vice versa. Berk and Parker (2009) propose that the evaluation of adverse events across all psychotherapies are fundamental to allow the opportunity to identify all risks and take into account therapeutic models, therapist related factors, and process issues, for example length of time of interventions.

Whilst research suggests that harm, negative effects and adverse events can occur in the process of engaging in psychological therapy, to date, the findings are limited. Key to this are the gaps in conceptual clarity as to what constitutes harm or negative effects (Parry, Crawford & Duggan, 2016; Klatte, Strauss, Flückiger & Rosendahl, 2018). Indeed, some schools of thought indicate that harm (or deterioration at least) is typified and to be expected in engagement in psychological therapy; an 'it will get worse before it gets better' or a 'no pain no gain' understanding of the dogma of psychological therapy (Moritz et al, 2015). Up to now, exploration of harms in the context of psychological therapy, has focused on model specific harms, prevalence, and risk factors for negative experiences (Lilienfeld, 2007; SchermulyHaupt, Linden & Rush, 2018; Linden, 2013; Hardy et al., 2019). Barlow (2010) suggests that negative effects (including multifactorial causes) have not been given the same attention as the efficacy rates for psychological therapy. This means that the harms experienced by people are likely to be obscured. It also suggests that greater emphasis needs to be made in exploring idiographic experiences if psychological therapists are to avoid harming their patients.

2.3.2 Rationale

Research suggests that harm can occur in psychological therapy. However, the evidence base for this is limited, specifically in relation to how harm or negative effects are understood, experienced and can be prevented. Additionally, there is little agreement about what constitutes harm in psychological therapy, and, therefore, the literature differs in terms of condition studied, for instance, model of therapy, versus therapeutic relationship, versus patient/therapist factors and effects (deleterious, non-improvement or new harms). This review aims to examine the main findings from research which has explored the perspectives of those who have received psychological therapy. It aims to understand their experiences of adverse or other impacts; allowing those effected to define the modes through which they have been harmed by psychological therapy. This review synthesises literature from studies with heterogeneousness samples. For example, the data extracted from some of the studies apply to participants who have both accessed psychological therapy and are, themselves, a psychological professional. The decision was made to include these data so as not to exclude experiences of harm. In addition, in studies reporting on national survey methods, there is little information about the professional occupation of those taking part in the study, and it could be suggested, that participants could also be psychological professionals. However, it is acknowledged that, how therapy is experienced may differ for those who have knowledge regarding therapy and therapeutic relationships, experience in carrying it out themselves and if they are accessing therapy as a mandatory part of their training.

Given the disparity in the literature, as discussed above, and the broad review aim, a narrative methodology has been adopted. Systematic searches of the published literature were used to support the synthesis of information.

2.3.3 Review Aims

1. To undertake a narrative review of the literature on adverse impact, negative effects and harm experienced by people in relation to their engagement with psychological therapy. This will involve: identifying harms and describing the impact for those who have engaged in psychological therapy.

2.4 Methodology

2.4.1 Search Strategy

Searches were completed on HDAS between December 2021 and March 2022, using the following databases: PsycINFO, MEDLINE, EMBASE and CINAHL. The search strategies included the following terms: “advers* OR negativ* (oucome* OR effect*)” OR harm* AND Psychological Therap* OR Psychotherap* OR Psychological Intervention*. The papers selected represent a range of methodological approaches including mixed method data.

2.4.2 Inclusion/Exclusion Criteria

The inclusion criteria for this review were:

- Papers reporting studies that explored any adverse, negative or harmful impacts associated with engagement in one to one individual psychological therapy (irrespective of the model of therapy).
- Reported studies were empirical, using either quantitative or qualitative methodology.

- Studies using samples inclusive of the experiences and voices of people who have accessed psychological therapy, including both adult and child populations.
- Journal articles published in English, between 1982 and 2022.

Papers were excluded from this review if:

- The reported studies were not about harm, negative effects or adverse impacts in relation to engagement in psychological therapy.
- Data reported clinicians’ experiences of causing harm in the process of facilitating psychological therapy.
- The studies primarily explored group therapy outcomes.
- Data were reported as secondary data or consequential data as a result of examining the effectiveness of a psychological therapy or intervention.
- They were articles, discussion papers, editorials or dissertations.
- They were published before 1982.
- They were written in a language other than English.

Initial searches yielded 226 papers. Following screening abstracts, 34 full text articles were read for potential eligibility by the lead researcher. Seventeen of these papers were further selected to be reviewed by an independent rater (AC) to assess agreement. Any discrepancies regarding eligibility for inclusion were resolved through discussion. A final total of eight papers were included in this review.

2.4.3 Quality Assessment

Quality assessment was conducted to better understand the context of the evidence. The Mixed Methods Appraisal Tool (MMAT; Hong et al., 2018) was utilised (see appendix II for quality appraisal tool). The MMAT was designed to critically appraise qualitative, quantitative and mixed method studies. The papers were further screened for quality by an independent rater (NH) to test agreement and establish validity.

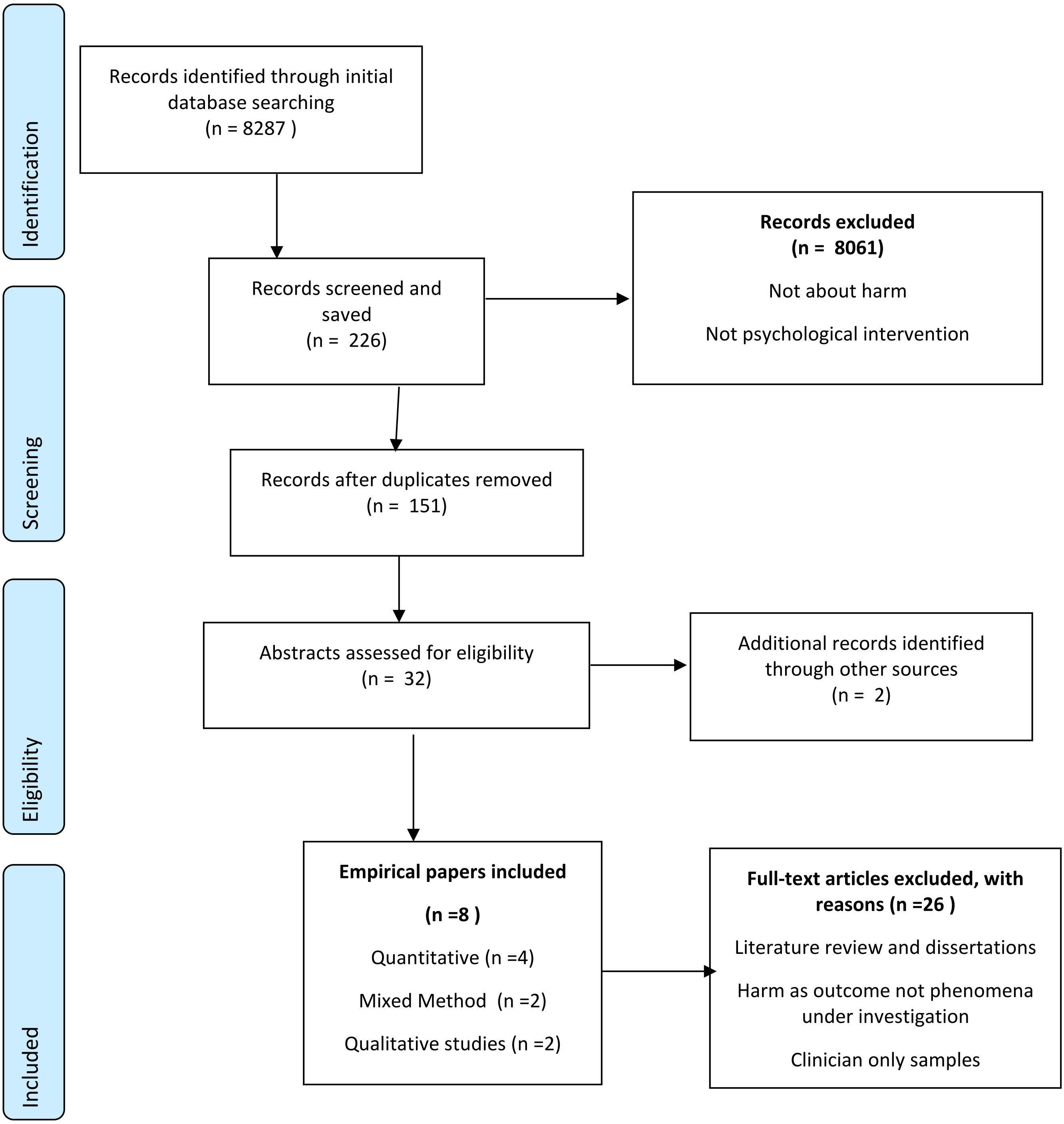
2.4.4 Data Extraction

Table I details characteristics of the eight included studies and key findings. A narrative synthesis highlights the data extracted regarding how harm is experienced in psychological therapies in the following ways: adverse experiences are discussed and potential causes or contributory factors contributing to harm are highlighted (these include therapist factors and system and process issues). Finally, the data are synthesised to highlight prevalence, and associated consequences of the harm experienced by people who have engaged in psychological therapies. For studies which included experiences of clinicians rating the potentials harms for a recipient of psychological intervention for whom they worked with, only data pertaining to those who had undergone psychological therapy were extracted.

2.5 Results

Search results are presented in Figure I. Characteristics of the eight included studies are provided in Table I.

Figure I: PRISMA



2.5.1 Quality Appraisal

A table outlining outcomes from the quality appraisal with regards to the papers reviewed can be found in appendix III. All papers were included in this review, irrespective of quality, with the implications of those that were of lower quality taken into account in the synthesis and conclusions. Of the eight papers reviewed, one was considered low quality due to the lack of information regarding the process of analysis and therefore, interpretation of data. The remaining seven papers were deemed to be of high (n=6) and medium (n=1) quality.

2.5.2 Key Findings

Table I: *Key Characteristics of the Reviewed Studies*[6]

Author(s)	Year	Country	Method	Sample (n)	Key Findings in Relation to Harm
Bowie, C., McLeod, J., & McLeod, J.	2016	UK	In depth interviews took place face to face in professional settings with participants. A semi-structured interview schedule was employed. Interviews lasted between 50 and 90 minutes and were audio-recorded. The study used a qualitative analysis approach and, more specifically, Interpretive Phenomenological Analysis to analyse the data.	(n=10) Qualified therapists (counsellors=8, psychotherapists=2) who self-defined as having an experience of unhelpful psychological therapy. Sample consisted of one male and nine females with ages ranging from 30 to 62 years. Sample consisted of previous trainees, staff and supervisors associated with a counsellor training university programme with therapy experiences happening, pre, during and post training between one and 12 years prior to interviews. Therapy took place in settings including university student counselling, private practice and workplace schemes.	A central aspect of the experience of unhelpful therapy, for all participants, was the sense that their therapist was following his or her own agenda and not responsive to what the client needed or wanted. All participants reported that their experience of unhelpful therapy had a medium-term, negative impact on their well-being. Participants attributed the cause of their negative therapy to a failure on the part of their therapist to engage with them in an authentic and caring manner, work collaboratively, elicit feedback or facilitate progress reviews.

---

[6] Information in the table pertains to and describes the data extracted from those who had accessed psychological therapy only and therefore sample sizes and methodology characteristics relate only to the data extracted, and not the overall study characteristics, for example, studies which looked at both clinician and service user data or individual and group therapy.

Crawford M. J., Thana, L., Farquharson, L., Palmer, L., Hancock, E., Bassett, P., Clarke, J., & Parry, G. D.	2016	UK	Cross-sectional Survey Participants were invited to complete an anonymous questionnaire that examined people's experience of the process and outcomes of psychological treatment. Data were analysed quantitatively using Multivariate Analysis.	(n=14 587) Community sample consisting of people on the case-load of NHS services across England and Wales (220) providing psychological treatment. Known sample demographics indicate 9656 identified as female, with 4298 people identifying as male. A total of 13,134 participants identified themselves as White, with the remaining 870 people self-defining as Black, Asian, Chinese or of Mixed Heritage. Participants were between the ages of 18 and 75+ and receiving (or had recently completed) outpatient treatment for anxiety and/or depression.	Of the 14 270 people who provided information about the impact of therapy, 763 (5.23%, 95% CI 4.88–5.60) strongly or slightly agreed that it had resulted in lasting bad effects. Factors associated with the likelihood of negative effects included some patient characteristics, types of therapy and aspects of the process of care. Likelihood of reporting lasting bad effects of therapy was associated with receiving 'other' forms of treatment or being unsure what type of therapy the person had received.
Grunebaum, H.	1986	US	Face-to-face interviews lasting between 60 and 90 minutes with 45 participants took place. The remaining two participants were interviewed via the telephone and through letter writing with the researcher. Participants were asked to describe in detail a harmful	(n=47) Patients who were also psychotherapists and identified themselves as having experienced harmful psychotherapy. Sample consisted of 18 social workers, 14 psychologists, 10 psychiatrists, and five other professionals working in mental health settings. There were 32 female participants, with the 15	Harms were organised around the type of therapeutic relationship experienced. These included: rigidity and distance of therapist, emotionally seductive therapists, explicitly sexual therapists, poor matches and 12 unclassified harms (no information). Different types of therapeutic relationships associated with different experiences of harm.

			therapy experience and give examples as to the specific aspects seen as central to the harm occurring. The researcher defines the analysis as a clinical interview, whereby it was conducted solely by the researcher with no validation or reliability measures in place. Analysis involved two stages: specifying the severity of harm that occurred and grouping cases in terms of harmful mechanics in therapeutic relationship.	remaining participants identifying as male. Age ranges at the time of undergoing therapy included: under 25 (11), 25-30 (19), 30-40 (11) and 40-50 (6). Therapy had taken place for the most part in the previous five to 10 years, with 15 participants reflecting on an experience post 10 years, and two participants describing more than 20 years pre interview.	
Hardy, G. E., Bishop-Edwards, L., Chambers, E., Connell, J., Dent-Brown, K., Kothair, G., O'Hara, R., & Parry, G.D.	2019	UK	The study comprised of two means of data collection. With regards to the survey, it was designed specifically for the study and piloted before use. Questions included closed and open ended questions relating to harmful therapy experiences and demographic data collection questions.	(n= 185) patient questionnaires (n=20) patient interviews. The sample consisted of participants, over the age of 18 who had experienced individual psychotherapy. The sample included 27 male participants, with the remaining 158 identifying as female. Age ranges for patients were between 20 to over 70 years old, with a mean age of 45.	A model of risk factors was developed: "Lack of fit" (service structures, therapist skills and patient needs) leading to a "Tension" (safety and containment/ power and control) that results in "Strain" (poor engagement) and "Consequences" (failure, regret, hopelessness, low confidence). Rare for a single contributory factor to be implicated. Lack of communication about these things so resolution becomes impossible. Risk increases as more factors come into play- e.g. harm occurring.

			Interviews took a similar approach to the questionnaire and were conducted face to face or via the telephone, lasting between 30 and 60 minutes. A qualitative approach to data analysis was employed: Thematic Analysis.	Ethnicity data included: 155 White, 13 Black British or Asian, 13 Mixed Heritage/Other. The sample participants reported on therapy experiences from the NHS (40%), private practice (25%), NHS primary care services (14%), voluntary organisations (8%), work or college/university setting (3%) and other or more than one setting (10%). For those interviewed, the sample was drawn from survey participants to be representative. Ages ranged between 20 to over 60. 15 of the 20 participants interviewed were female. 10 were receiving therapy in the NHS, three in private practice, six in primary care and one at a voluntary organisation.	
McGlanaghy E., Jackson, J-L., Morris, P., Prentice, W., Dougall, N., & Hutton, P.	2021	UK	This study used the Delphi Method (Yousef, 2007) with a panel of professional therapists and experts by experience over three rounds. Responses were qualitatively analysed using	(n=134) Participant inclusion criteria included being over the age of 18 with no significant neurological disorder and learning disability. Participants were also required to have English language skills. Of the sample of experts by experience recruited, 47 identified as White, with	Therapy amplifies problem with increased emotional lability (frequency or intensity), somatic/physical effects, increased use of negative coping strategies, sense of self, therapy process (power/ boundaries), practical burden, impact on relationships, and consequences/risks (harmful practice such as risk of abuse by the therapist) and others related to the process.

			Thematic Analysis to identify salient themes. In addition, an exploratory analysis comparing the median rating of all items generated within the panel was undertaken using Wilcoxon rank-sum test.	two defining themselves as Mixed Heritage and one as Asian ethnicity. Participants identified themselves as heterosexual (n=36), lesbian or gay (n=1), bisexual (n=7), and unsure or asexual (n=4). The sample was primarily female (n=30) with nobody identifying as male, however two participants self-identified as 'other'. Ages ranged between 18 and 74 with 26 of the participants from the UK and six from other countries (including USA, Ireland, Norway and New Zealand). Round One= 102 Pts (n=51 experts by experience) Round Two= 62 Pts (n=31 experts by experience) Round Three= 63 Pts (n=27 experts by experience)	
Moritz, S., Fieker, M., Hottenrott, B., Seeralan, T., Cludius, B., Kolbeck,	2015	Germany	An anonymous online survey consisting of questions assessing wanted and unwanted effects of psychological treatments. The questionnaire had	(n=85) Community sample of people with an established diagnosis of Obsessive Compulsive Disorder (by a registered mental health practitioner). People were	Males did not differ from females (p 4.2) and younger patients did not differ from older ones (Z 40 versus below 40, p 4.1). Participants with higher education (13 years or more) reported more adverse treatment responses (M¼4.95,

K., Gallinat, J., & Nestoriuc, Y.			previously been validated (Ladwig et al., 2014). Results were analysed quantitatively using non-parametric tests (Spearman's Rho).	excluded from the sample if they had any co-morbidities, for example psychosis or Bipolar disorder. The sample recruited had a mean age of 38.72, with 62% of the sample identifying as female.	SD¼3.80) than less educated ones (M¼3.00, SD¼3.47, t(83)¼2.28, p¼.025). Side-effects were strongly correlated with all adverse events scales (rho 4.47). Most patients complained that the therapeutic content was already known to them (53%) and that they developed new symptoms (29%). Adaptation problems after therapy, fear of stigma and relationship problems because of treatment were noted by approximately every fourth patient.
Moritz, S., Nestoriuc, Y., Rief, W., Klein, J., Jelinek, P., & Peth, J.	2019	Germany	An anonymous online survey using a revised and shortened version of the Side-Effects of Psychotherapy Scale (PANEPS). Data were analysed quantitatively through Factor Analysis and non-parametric tests (Spearman's Rho).	(n=135) Community Sample. Participants in this study had to have experienced a past or current depressive episode and completed at least one course of face to face psychotherapy. All participants had to be between the ages of 18 to 65+ years with no co-morbid psychotic or manic experiences or abnormal responses during screening. The sample recruited consisted of 135 participants, all scoring mild to moderate symptoms on the Patient Health Questionnaire (PHQ-9). Ages ranged between 20 and 67 years old, with 99 participants identifying as female. Therapy took place in both outpatient and inpatient settings.	Approximately half of the sample noted at least one adverse event (52.6%). Among these, side effects (38.5%) and malpractice (26.7%) were significantly more prevalent than unethical conduct (8.1%).

Rozental, A., Kottorp, A., Boettcher, J., Andersson, G., & Carlbring, P.	2016	Sweden	The study used the Negative Effects Questionnaire: which monitors and reports the incidence and impact of negative effects. This was developed in conjunction with researchers, self-reports by patients and literature review. Data were analysed quantitatively, using exploratory factor analysis with principal axis factoring.	(n=464) Community sample responding to an advert in a morning newspaper and radio show. Participants had to have undergone or be currently in psychological treatment during the last two years. Of the sample recruited, 354 identified as female with an overall mean age of 38 years. Participants described experiencing a range of mental health difficulties, including: anxiety (127), anxiety and depression (92), depression (66) and other (170).	Unpleasant memories, stress, and anxiety were each experienced by more than one-third of the participants in the study. Perceiving the treatment or therapeutic relationship as deficient, or experiencing different types of symptoms could be harmful for the patient- linked to highest self-rated negative impact by patients

Summary of the Reviewed Studies' Characteristics

The eight studies described in Table I highlight three different approaches to data collection including, survey, interview, and a Delphi panel methodology. Qualitative studies tended to use semi-structured interviewing techniques with associated data primarily analysed using thematic analysis. Quantitative methodology included survey methods, or previously validated questionnaires, with factor analysis employed to examine responses. Of the studies that reported participant demographic information, samples were primarily female, and of white ethnicity and across the age spectrum of 18-75. Four of the studies report results from a UK based population, whilst the remaining studies' samples consisted primarily of populations in Sweden, Germany and the US. The sample sizes of each study differ significantly depending on the method of data collection and analysis, with the smallest sample size comprising of 10 participants, and the largest consisting of 14, 587 participants. The majority of studies were rated as high and medium quality, with well reported sample and methodological information, and the analyses clearly derived from the data. However, one of the studies (Grunebaum, 1986) was a clear outlier, both with regards to the time period the study was carried out, and the information reported in the study, generating queries regarding whether it was methodologically sound, valid or reliable. The heterogeneity of the studies reviewed will be referred to and discussed in the following synthesis and discussion.

What were the adverse effects associated with psychological therapy from the perspectives of people who access it? Synthesis.

The following section presents the data synthesis of the eight studies that were reviewed, making reference to prevalence, type and the consequences associated with the experience of harm, negative effects or adverse events as a result of engaging in individual psychological therapy.

How harm and negative effects are experienced

Participants in the eight reviewed studies reported harmful and negative effects of engaging in psychological therapy. Crawford et al.'s, (2016) study in England and Wales reported that approximately one in twenty people receiving psychological treatment think that it has had a lasting bad effect. In the study by McGlanaghy et al. (2021), 34% of experts by experience reported dissatisfaction with the therapy they had received. They described increased feelings of pressure, emotional and physical lability and vulnerabilities relating to greater use of negative coping strategies, for example self-harm and suicidal ideation during and following psychological intervention. Four more of the reviewed studies highlighted experiences of deterioration and distress increasing, and in some cases, developing new difficulties (including anger, anxiety and loss of self-esteem) which were not associated with the target problem for which people had sought help (Rozental, Kottorp, Boettcher, Andersson & Carlbring, 2016; Moritz et al., 2015; Crawford et al., 2016; Moritz et al., 2019). In the studies by Moritz et al., (2015, 2019), participants reported increased or new interpersonal problems (intimate relationships, families and friendships) and difficulties relating to their engagement in psychological therapy.

Participants in the reviewed studies reported difficulties that were associated with feelings of failure, dependency hopelessness and low confidence (Hardy et al., 2019; Rozental et al., 2016; Bowie, McLeod & McLeod, 2016) which left them feeling 'emotionally injured', compounded by concerns around how and whether to complain. The study by Hardy et al. (2019) suggested that on its own, an experience which has been negative or adverse may have little effect, however risk of harm increases as more of the factors highlighted above come into play. Bowie, McLeod and McLeod (2016) highlighted that those who had engaged in psychological therapy and experienced adverse or negative events rated their involvement as having a medium-term negative impact on their overall wellbeing following psychological therapy.

The studies reviewed outlined how harm and negative effects are experienced by people who engage in psychological therapy. Previous studies have explored the impact of therapeutic models, therapeutic relationships and ‘patient’ factors (Lilienfeld, 2007; Pope & Vetter, 1991, Fonagy & Bateman, 2006). There are similar findings in this review, however some information relating to service and process provisions were also highlighted by those who engage in psychological therapy.

Therapist-related factors

A number of the reviewed studies investigated therapist related factors and harm. Moritz et al. (2019) explored both malpractice and unethical behaviour experienced by people who engaged in psychological intervention. Whilst unethical behaviour was endorsed less than malpractice and side effects, it is notable that two participants in this study reported experiencing sexual harassment by their therapist. The study by Grunebaum (1986) also highlighted harms that occurred through being involved in sexual relationships with a therapist or what Grunebaum termed as ‘emotionally seductive’ relationships. These findings support previous studies which have reported incidences whereby those who have engaged in psychological intervention have experienced sexual advances and abuse by their therapist (Pope & Vetter, 1991). Associated consequences of this have been linked to suicidal ideation and increased self-harm (Masson, 2012). McGlanaghy et al.'s, (2021) study also highlights the risk of abuse by the therapist as harmful practice.

Several of the reviewed studies reported the impact of therapeutic relationships as significant in contributing to negative experiences or adverse events in the process of psychological intervention. Participants in the Grunebaum (1986) study described a variety of harms experienced associated with the therapeutic relationship, including therapists who were 'overinvolved', and those who maintained an emotional distance and rigidity towards those engaging in psychological therapy. Participants rated experiencing moderate, serious and severe harm as a consequence of this. Bowie, McLeod and McLeod (2016) reported the therapeutic relationship as a central aspect of unhelpful therapy, characterised by the therapist being unresponsive, following their own agenda, or lacking warmth and authenticity. This was perceived as non-collaboration, whereby the therapist would not seek feedback or discussion regarding the 'helpfulness' of therapy. Hardy et al.'s (2019) study supported these findings, highlighting the risk of being 'stuck' in a negative interaction style which excludes communication about the relationship, providing no opportunity for resolution. The study by Rozental, Kottorp, Boettcher, Andersson and Carlbring (2016) suggested that perceiving the therapeutic relationship as deficient in some way was linked to the highest self-rated negative impact by participants.

In the study by McGlanaghy et al. (2021), several factors relating to the therapeutic relationship, that had not been previously found, were highlighted by experts by experience. These included issues of the power dynamic between the therapist and person engaging in psychological therapy. Participants reported that feeling unable to disagree or criticise the process, and feeling under pressure to give the right answers, and improve, had a detrimental effect on the way therapy was experienced and perceived by them.

Service/ process issues

Some important factors relating to service and process issues were key findings of the studies reviewed.

In the study by Moritz et al. (2019), the most common concern from participants was that therapy was aimed only at eliminating the target problem as opposed to having a positive goal orientation. This might be more likely to be associated with specific therapeutic models, or a consequence of therapist skills, however 16.9% of participants endorsed statements suggesting they believed that the applied therapeutic techniques were wrong. Similarly, studies by McGlanaghy et al. (2021), Moritz et al. (2015), and Crawford et al. (2016), highlighted therapeutic content and information received about the therapy as important to participants in relation to their experience of psychological therapy. McGlanaghy et al. (2021) reported that 47% of participants were dissatisfied with the amount of information they received. Crawford et al. (2016) found that people were less likely to report lasting bad effects of interventions if they felt they had been given sufficient information about the therapy before it started. The studies reviewed were carried out internationally, and therefore health care models and treatment are likely to differ in terms of approaches and offer. However, this raises questions about systems which mandate certain types of therapies over others, offering patients little choice as to how and whether to engage. The study by Hardy et al. (2019) proposes service structures ("lack of fit") as a fundamental feature in their model of risk factors for negative experiences in psychotherapy.

Other features of the studies reviewed relating to service and process included risks of misdiagnosis, the time-limited nature of therapy and the therapeutic relationship, the practical burden of attending therapy, and the costs associated with therapy not working, for example, stigma (McGlanaghy et al., 2021; Grunebaum, 1986; Moritz et al., 2015).

There was little information in the majority of studies regarding experiences of those who may self-identify as being from a minoritized group. Indeed, as previously stated, sample characteristics across the reviewed studies were made up (for the most part) of primarily white females. Moritz et al. (2015) reported that no participant endorsed a category relating to unwanted effects based on language comprehension difficulties or religion. Despite this, in the study by Crawford et al. (2016) it was noted that people from the Global Majority and LGBTQ community were more likely to report negative effects from therapy.

Finally, the study by Bowie, McLeod and McLeod (2016) reported that participants found it difficult to complain about an unhelpful or harmful therapy experience. They linked this to prolonging the experiences that had led them to seek therapy in the first place. Different health care services, private practice or other organisations are likely to vary with regards to the process of managing and responding to complaints, which has important implications with regards to safeguarding those who engage in psychological therapy and experience adverse or negative effects.

Consequences associated with negative experiences in psychological therapy

All of the studies reviewed suggest that negative experiences, adverse events or harm as a consequence of engaging in psychological therapy have an impact on wellbeing. Feelings of guilt, failure, hopelessness and self-blame were common (Grunebaum, 1986; Bowie, McLeod & McLeod, 2016; Hardy et al., 2019). Little opportunity to communicate about therapy 'failing' or at the least being unhelpful, equally made it difficult for people to seek resolution or get the help they needed with regards to the reason they attended therapy in the first place

(Bowie, McLeod & McLeod, 2015; Hardy et al., 2016; McGlanaghy et al., 2021). Importantly, Moritz et al. (2015) reported that every fifth participant lost hope in therapy in general as a consequence of their experiences. This has important implications for practice when considering that side effects were negatively correlated with the positive effects of treatment. Moritz et al. (2015) argue that removing preventable adverse events could foster treatment outcome.

2.6 Discussion

This narrative review aimed to explore the literature on the adverse impacts, negative events, and harms experienced by people in relation to their engagement in psychological therapy. A total of eight studies were reviewed. The studies differed significantly, in relation to sample (both characteristics and size), approach to data collection, and analysis. However, they were all underpinned by the same overall research aim, which was to explore the harm, negative effects or adverse events associated with engaging in psychological therapy. Attempts to understand the phenomena from the perspectives of those involved in interventions, both in relation to prevalence, experience and consequence, were common to all the studies reviewed. A significant factor in relation to the heterogeneity of the studies reviewed is underpinned by definitional problems, for example, a lack of consensus as to what constitutes harm, negative effects or adverse impacts in wider psychological literature (Parry, Crawford & Duggan, 2018). These problems provide some understanding of why empirical studies differ with regards to approaches, language, and samples used to examine harm in psychological therapy, and makes it difficult to compare the studies' findings. Results from the eight studies reviewed, suggest that harm as a consequence of engaging in psychological therapy, is nuanced. That it can occur in circumstances that are perhaps more well defined, for example overt abuses of power, alongside, service settings and other processes which contribute to the overall experience of harmful psychological therapy. This was highlighted in, for example, the findings that increased information giving in relation to psychological therapy was associated with decreased reports of harmful or negative psychotherapy experiences. This would seem to suggest that informed consent, whereby, both the benefits and risks associated with psychological therapy are discussed is fundamental. It could provide people with a comprehensive sense of what to expect, an open space for discussion should negative effects start to be experienced throughout the process of therapy, and offer those who engage in it, a more transparent rationale regarding the potential benefits. Psychological professionals need to be supported to recognise that all systems (including their own) have components that can be experienced as harmful and be supported to foster review of their work to bring sufficient clarity for the people they work with therapeutically.

The lack of information in the studies reviewed regarding experiences of those from minoritized backgrounds is not unexpected, but disheartening. One of the studies suggested that people from minoritized backgrounds are three times more likely to experience harmful or negative effects in psychological therapy (Crawford et al., 2016). This needs further exploration to ensure psychological professionals are cognisant of what leads to harm for people accessing psychological therapy and what might be done to prevent it.

Findings from the studies reviewed also indicate that people find it difficult to complain or disagree with the therapist they are working with. This has important implications for practice with regards to safe-guarding. Ensuring there are processes in place to discuss and report harm or adverse events when they occur is essential. More understanding about the influence of power in therapeutic relationships could also help to identify ways in which psychological professionals might mitigate and prevent disenfranchisement in the context of psychological therapy.

2.6.1 Strengths and Limitations

This narrative review offers insight into how harm, negative effects and adverse events are experienced in psychological therapy, from the perspectives of those who access it. The methods in this review are in line with quality standards and care has been taken to ensure transparency and to test agreement, for example, additional raters being employed for both inclusion and quality aspects of appraisal. The studies included in the review were rated as high or medium quality, with only one exception which was rated as low quality.

A key limitation is the reviewed studies' substantial heterogeneity, both with regards to the sample types and size, and methodological flaws. For this reason, a narrative review of the literature was undertaken to take into account the disparities. Accordingly, conclusions drawn are tentative, but hopefully help to progress exploration of this important, and under-researched aspect of the experience of psychological therapy.

2.6.2 Clinical and Service Implications

Despite the disparities across the literature, there are some key findings from this review in relation to the experience of harm and negative effects in psychological therapy, which emphasise preventative measures which could be put in place to minimise the occurrence of harm. For example, information giving and choice relating to therapist and therapeutic model in services offering psychological therapy, could support the seeking of true informed consent for intervention, and offer people agency with regards to whether and how they engage in psychological therapy. Barnett, Wise, Johnson-Greene and Bucky (2007) suggest informed consent promotes autonomy and collaboration, as well as reducing the likelihood of exploitation or harm. Furthermore, the monitoring of harms, negative effects or adverse events could be critical in ensuring safe practice, and provide those who engage in psychological therapy, opportunities and space to share their experience both during and following the process. Measures have been developed to monitor harms occurring in psychological therapy (Linden,2013; Rozental et al., 2019). However, the lack of agreement with regards to theoretical concepts relating to defining, classifying and assessing negative effects in psychological therapy, indicate, that outcome measures alone, may not be enough, if not inclusive of direct communication between the therapist and person engaging in the therapy. Additionally, people who have experienced harm in the context of psychological therapy should be involved in the development of monitoring measures, to ensure researchers, and clinicians are not excluding experiences of harm. Finally, services would benefit from putting in place, transparent and inclusive processes, whereby people can report any harmful experiences, and have this listened to and acted upon. Studies which referenced the power differential in the therapeutic relationship (McGlanaghy et al.,(2021), suggest that additional means of reporting experiences, outside of the direct therapeutic relationship are necessary.

2.6.3 Future Research

The lack of agreement regarding conceptual and definitional paradigms relating to harm and negative effects, should not exclude further investigation into this under-researched area. Future research would benefit from hearing the voices of those who have experienced harm in the context of engaging in psychological therapy, and in particular, those who may self-identify as being from a minoritized group to establish the prevalence of experiencing harm, and the mechanisms by which it occurs through the process of engaging in psychological therapy.

2.7 Conclusions

A key finding of this narrative review is that harm and negative effects occur in the context of engaging in psychological therapy. The reviewed studies also demonstrate that the harm and negative effects can be experienced in idiographic ways, both through acts of commission and acts of omission. The review highlights the limited nature of the literature and gaps in both conceptual understanding and agreement, as well as, approaches to investigate, which limits comparisons and conclusions. Many studies investigating harm in psychological therapy have consisted of discussion or theoretical papers. Increased attention to clarifying gaps in definition and greater attention given to the investigation of harm across interventions would advance the literature and guide future research.

2.8 References

Barlow, D. H. (2010). Negative effects from psychological treatments: A perspective. *American Psychologist, 65*(1), 13. https://doi.org/10.1037/a0015643

Barnett, J. E., Wise, E. H., Johnson-Greene, D., & Bucky, S. F. (2007). Informed consent: Too much of a good thing or not enough?. *Professional Psychology: Research and Practice, 38*(2), 179a. https://doi.org/10.1037/0735-7028.38.2.179

Berk, M., & Parker, G. (2009). The elephant on the couch: Side-effects of psychotherapy. *Australian & New Zealand Journal of Psychiatry, 43*(9), 787-794. https://doi.org/10.1080/00048670903107559

Bowie, C., McLeod, J., & McLeod, J. (2016). 'It was almost like the opposite of what I needed': A qualitative exploration of client experiences of unhelpful therapy. *Counselling and Psychotherapy Research, 16*(2), 79-87. https://doi.org/10.1002/capr.12066

Crawford, M. J., Thana, L., Farquharson, L., Palmer, L., Hancock, E., Bassett, P., ... & Parry, G. D. (2016). Patient experience of negative effects of psychological treatment: Results of a national survey. *The British Journal of Psychiatry, 208*(3), 260-265. https://doi.org/10.1192/bjp.bp.114.162628

Dimidjian, S., & Hollon, S. D. (2010). How would we know if psychotherapy were harmful?. *American Psychologist, 65*(1), 21. https://doi.org/10.1037/a0017299

Fonagy, P., & Bateman, A. (2006). Progress in the treatment of borderline personality disorder. *The British Journal of Psychiatry, 188*(1), 1-3. https://doi.org/10.1192/bjp.bp.105.012088

Grunebaum, H. (1986). Harmful psychotherapy experience. *American Journal of Psychotherapy, 40*(2), 165-176. https://doi.org/10.1176/appi.psychotherapy.1986.40.2.165

Hardy, G. E., Bishop-Edwards, L., Chambers, E., Connell, J., Dent-Brown, K., Kothari, G., … & Parry, G. D. (2019). Risk factors for negative experiences during psychotherapy. *Psychotherapy Research, 29*(3), 403-414. https://doi.org/10.1080/10503307.2017.1393575

Hong, Q. N., Fabregues, S., Bartlett, G., Boardman, F., Cargo, M., Dagenais, P., … & Pluye, P. (2018). The mixed methods appraisal tool (MMAT) version 2018 for information professionals and researchers. *Education for Information, 34*(4), 285-291. https://doi.org/10.3233/efi-180221

Jonsson, U., Alaie, I., Parling, T., & Arnberg, F. K. (2014). Reporting of harms in randomized controlled trials of psychological interventions for mental and behavioral disorders: A review of current practice. *Contemporary Clinical Trials, 38*(1), 1-8. https://doi.org/10.1016/j.cct.2014.02.005

Klatte, R., Strauss, B., Flückiger, C., & Rosendahl, J. (2018). Adverse effects of psychotherapy: Protocol for systematic review and meta-analysis. *Systematic Reviews, 7*(1), 1-7. https://doi.org/10.1186/s13643-018-0802-x

Knox, J. (2019). The harmful effects of psychotherapy: When the therapeutic alliance fails. *British Journal of Psychotherapy, 35*(2), 245-262. https://doi.org/10.1111/bjp.12445

Lilienfeld, S. O. (2007). Psychological treatments that cause harm. *Perspectives on Psychological Science, 2*(1), 53-70. https://doi.org/10.1111/j.1745-6916.2007.00029.x

Linden, M. (2013). How to define, find and classify side-effects in psychotherapy: From unwanted events to adverse treatment reactions. *Clinical Psychology & Psychotherapy, 20*(4), 286-296. https://doi.org/10.1002/cpp.1765

Masson, J. M. (2012). *Against therapy: Emotional tyranny and the myth of psychological healing.* Untreed Reads. https://doi.org/10.5860/choice.26-2960

McGlanaghy, E., Jackson, J. L., Morris, P., Prentice, W., Dougall, N., & Hutton, P. (2022). Discerning the adverse effects of psychological therapy: Consensus between experts by experience and therapists. *Clinical Psychology & Psychotherapy, 29*(2), 579-589. https://doi.org/10.1002/cpp.2648

Mercer, J. (2017). Evidence of potentially harmful psychological treatments for children and adolescents. *Child and Adolescent Social Work Journal, 34*(2), 107-125. https://doi.org/10.1007/s10560-016-0480-2

Mollon, P. (2009). The NICE guidelines are misleading, unscientific, and potentially impede good psychological care and help. *Psychodynamic Practice, 15*(1), 9-24. https://doi.org/10.1080/14753630802614457

Moritz, S., Fieker, M., Hottenrott, B., Seeralan, T., Cludius, B., Kolbeck, K., … & Nestoriuc, Y. (2015). No pain, no gain? Adverse effects of psychotherapy in obsessive-compulsive disorder and its relationship to treatment gains. *Journal of Obsessive-Compulsive and Related Disorders, 5,* 61-66. https://doi.org/10.1016/j.jocrd.2015.02.002

Moritz, S., Nestoriuc, Y., Rief, W., Klein, J. P., Jelinek, L., & Peth, J. (2019). It can’t hurt right? Adverse effects of psychotherapy in patients with depression. *European Archives of Psychiatry and Clinical Neuroscience, 269*(5), 577-586. https://doi.org/10.1007/s00406-018-0931-1

NHS. (2019). *NHS mental health implementation plan 2019/20-2023/24.* Retrieved from: NHS Mental Health Implementation Plan 2019/20 – 2023/24 (longtermplan.nhs.uk)

Parry, G. D., Crawford, M. J., & Duggan, C. (2016). Iatrogenic harm from psychological therapies- time to move on. *The British Journal of Psychiatry, 208*(3), 210-212. https://doi.org/10.1192/bjp.bp.115.163618

Pope, K. S., & Vetter, V. A. (1991). Prior therapist-patient sexual involvement among patients seen by psychologists. *Psychotherapy: Theory, Research, Practice, Training, 28*(3), 429. https://doi.org/10.1037/0033-3204.28.3.429

Psychological Professions Network. (2019). *PPN long term plan.* Retrieved from: PPN_Long_Term_Plan_Online_Single_compressed.pdf (nwppn.nhs.uk)

Public Health Scotland. (2022). *Psychological therapies waiting times.* Retrieved from: Psychological therapies waiting times - Quarter ending December 2021 - Psychological therapies waiting times - Publications - Public Health Scotland

Rozental, A., Kottorp, A., Boettcher, J., Andersson, G., & Carlbring, P. (2016). Negative effects of psychological treatments: An exploratory factor analysis of the negative effects questionnaire for monitoring and reporting adverse and unwanted events. *PloS One, 11*(6), e0157503. https://doi.org/10.1371/journal.pone.0157503

Rozental, A., Kottorp, A., Forsström, D., Mansson, K., Boettcher, J., Andersson, G., … & Carlbring, P. (2019). The negative effects questionnaire: Psychometric properties of an instrument for assessing negative effects in psychological treatments. *Behavioural and Cognitive Psychotherapy, 47*(5), 559-572. https://doi.org/10.1017/s1352465819000018

Schermuly-Haupt, M. L., Linden, M., & Rush, A. J. (2018). Unwanted events and side effects in cognitive behaviour therapy. *Cognitive Therapy and Research, 42*(3), 219-229. https://doi.org/10.1007/s10608-018-9904-y

2. Chapter Two: Empirical Paper*

Helping or harming in clinical psychology: Exploring clinical psychologists' experiences of helping, harming and seeking consent in their practice.

*To be submitted to: The Journal of Critical Psychology, Counselling and Psychotherapy. Author guidelines are outlined in Appendix IIII. The journal word count is 4000 words, however in writing this paper, the word count has been extended to provide sufficient detail for viva examination.

3.1 Abstract

Background

Research highlights the potential for harm to occur in clinical psychology practice, within the therapeutic relationship and interventions. Lack of engagement with the literature on harm by clinical psychologists (Bystedt *et al*., 2014) brings into question whether, or the extent to which, informed consent is sought for the interventions provided. This study explores the relationship between helping, harm and consent from the perspectives of practising clinical psychologists.

Method

Six clinical psychologists participated in single interviews. In keeping with Narrative Inquiry (NI) each interview included four open-ended questions and further prompts then dependent on the conversations that emerged. Interviews were audio recorded, transcribed and analysed. Attention was given to the content (what stories were told) and performance (how stories were told) before being situated in the local and broader social contexts within which the narratives exist.

Results

Findings are presented through brief global impressions of the individual narratives and discussion of one major storyline, consisting of four subplots. The analysis offers the following storyline: 1.) 'There's always another story: Multiple selves'. The storyline and subplots are considered alongside dominant social and cultural narratives.

Conclusions

The findings of this study are discussed in relation to clinical implications, with regards to both the training of clinical psychologists and suggestions for practice. Strengths, limitations and directions for future research are also offered.

3.2 Introduction

The following section is a synthesised approach to organising the literature with regards to harm and consent in clinical psychology in the context of professional identity.

3.2.1 Clinical Psychology as a Helping Profession

Clinical psychologists aim to promote and support psychological wellbeing and alleviate distress (Goodbody and Burns, 2011). They provide assessment and intervention across a variety of health care services to individuals, families, and groups, whilst supporting multidisciplinary teams and organisations through supervision and consultation. There are currently 12,500 clinical psychologists in the UK, with a further 1600 clinical psychologists in training (Association of Clinical Psychologists-UK: ACP-UK). Entering the clinical psychology profession in the UK requires individuals to undertake a British Psychological Society (BPS) accredited undergraduate degree in psychology, followed by BPS accredited and Health and Care Professions Council (HCPC) approved training at doctoral level. Doctoral trainees carry out psychological research and clinical practice across a range of settings, alongside university education to meet requirements, with continuing professional development post-qualification. In the UK, the profession has a highly regarded reputation which is reflected in the high earning potential of the profession in public and private services.

Clinical psychologists often self-identify as 'helping' professionals, whereby communication is the mode through which problem solving and perspective-taking become central elements of helping another grow (Graf, Sator and Spranz-Fogasy, 2015). Kernes and Kinnier (2008) reported that psychologists generally view the meaning of life as loving, helping and showing compassion towards others. When asked 'what matters most in their work?', 90% of psychologists indicated "helping others lead more satisfying lives". Holland (1959), explaining career theory, suggests that people seek out environments that allow them to express their attitudes and values. Norcross and Farber (2005) suggest that therapists' needs for healing others and healing the self, play out in interpersonal relationships.

Critics of clinical psychology as a helping profession highlight the emphasis of the discipline in creating a 'self' outside of a collective which has led to the categorisation and separation of individuals based on labels (Newnes, 2014). Cameron (2020, p.86) suggests, "there is a danger in trying to help the 'other', 'we' practise a kind of cultural imperialism by subtly imposing our own worldview or understanding of what is real, what is important, what is right and what is healthy". Parker (2007) proposes that this increases power for some and supports political agendas. Others emphasise clinical psychology's influence in social control and inequality, whilst modulating the impact of social contexts and circumstances to understand mental distress (Johnstone, 2021; Foucault, 2003; Boyle, 2011). This suggests that the ontology of clinical psychology as an approach should be considered, given the underpinnings of methodological individualism. The use of 'therapeutic' approaches whereby thoughts, feelings and behaviour are located 'in' a person and described as dysfunctional (or at the very least unwelcome) brings into question how much clinical psychology 'helps' people, whose distress cannot be separated from the systems that trigger and maintain them.

3.2.2 Harm in Psychology

"If you can, help others; if you cannot do that, at least do not harm them" -Dalai Lama XIV

Harm is defined as damage to something or a person, which makes them less effective than they were, caused by a particular course of action (Collins English Dictionary). Medicalised mental health settings subscribe to the phrase, 'primum non nocere' ('first do no harm') to guide ethical practice. Our understanding of harm is influenced over time and setting, making it difficult to provide a fixed definition of how individuals might experience harm. Defining harm then, (whether physical, psychological or other) becomes problematic when we are attempting to 'represent life in scientific work' (Coopmans *et al*., 2014).

Research exploring harm in clinical psychology largely focuses on adverse impacts of psychotherapies and overt forms of harm by clinicians, such as pursuing sexual relationships with service users (Lilienfeld, 2007; Pope and Vetter, 1991). Anecdotal accounts from service users highlight harmful acts or experiences within therapeutic relationships and psychotherapies (Curran *et al*., 2019). The potential for harm has generally transpired whilst researching the efficacy of therapies; whereby any adverse effects have then been attributed to impacting only a limited number of individuals, and little information provided about how or why this might have occurred (Wilhelm *et al*., 2019). Approximately 10% of service users deteriorate following psychological therapy (Jarret, 2008). Lilienfeld (2007) compiled a list of potentially harmful psychotherapies suggesting that they should be avoided or implemented with caution. In a study of harmful behaviour by the therapist, Pope and Vetter (1991) surveyed 1320 psychologists, and found 958 service users had been sexually involved with a therapist, of which 90% reported being harmed, where suicide attempts and hospitalisation were some of the associated consequences. Berk and Parker (2009) propose that psychotherapy can induce adverse outcomes, both as a consequence of the therapist's behaviour and the therapy itself.

Harm is multifaceted and within mental health services can take many forms. An increase in distress or reduced functioning have been highlighted as indicators that some psychotherapies cause harm, but little has been investigated regarding 'new' experiences of distress, or other difficulties that may have arisen as a result of engagement in psychological interventions. Clinical psychologists' role in working within systems which may be considered unintentionally harmful, (for example, those aligned with a dominant medicalised paradigm for emotional distress) further indicates a need to explore the impact of this. Newnes (2018, p.15) suggests, those that work within 'Psy' complexes are "bystanders in the face of harm perpetrated on patients in the same system within which they work". Corrigan (2007) highlights how diagnosis can inadvertently exacerbate the stigma of mental illness, impacting employment, access to services and social support. Therefore, working in systems that label distress as disordered, or individuals as 'treatment resistant', could negatively impact a person's sense of self and wellbeing. Newnes (2018, p.16) suggests how clinical psychology plays a role in this, articulating, "Clinical Psychologists use psychometrics and interviews to arrive at a diagnosis supporting psychiatric nosology and praxis".

Lilienfeld (2007) proposes that clinical psychologists should be more robust in assessing treatments and vigilant regarding the potential for harm they can cause, in the same way that medical practitioners routinely subject physical health treatments to safety monitoring and quality control. Boisvert and Faust (2006) found a significant number of practicing psychologists (28%) were unaware of negative effects in psychotherapy. Those that do recognise negative effects are unaware of the research findings or how they might prevent them (Bystedt *et al*., 2014). Jones (2007) suggests that practitioners need to be open to the possibility that their interventions can cause harm, and that an understanding of the hazards of engagement might be important in obtaining what is considered to be informed consent.

3.2.3 Consent in Health Care

Consent has been described as "making permissible a wide range of conduct that would otherwise be wrongful" (Miller and Wertheimer, 2010). "Informed consent is a process of sharing information with patients that is essential to their ability to make rational choices among multiple options in their perceived best interest" (Simon, 1992). Beahrs and Gutheil (2001) suggest "clients should be informed about the relative efficacy, efficiency, and safety of the recommended treatment and its primary alternatives as well as the likely consequences of no treatment".

The HCPC (statutory regulator of UK clinical psychologists) sets Standards of Proficiency for its registrants. These include 'knowing the limits of practice and when to seek advice', 'understanding the importance of and be able to obtain informed consent', 'assure the quality of practice', 'understand the impact of clinical interventions on service users' and 'establish safe environments, which minimise risk to service users and others' (HCPC, 2020). In clinical psychology, key ethical principles include: Respect, Competence, Integrity and Responsibility, emphasising evidence-based practice, accountability, inclusivity and openness. The BPS code of conduct stresses the potential for individuals to be compromised ethically where conformity, resistance, power, social norms, organisational pressures and self-identity interact (BPS, 2021). Laws and codes of practice relating to healthcare professionals must also be compatible with the Human Rights Act (HRA; 1998). Professionals have an obligation to 'respect', 'protect' and 'fulfil' an individual's human rights, which includes article 3: the right to be free from inhuman or degrading treatment. This right covers serious harm, abuse or neglect, including unintentional harm (British Institute of Human Rights, 2020). Article 8 of the HRA (1998) notes the importance of individuals being given the appropriate information relating to their treatment. If an individual consents but has not been given sufficient information to suggest it is a fully informed decision, then consent is not valid and their human rights have been breached (Department of Health, 2020).

The difficulties in gaining informed consent for potential harm in clinical psychology is considered by Newnes (2018) who emphasised, "relationships are unique so neither the therapist nor patient can reliably predict what will happen". Gaining informed consent in its truest form then, could be hindered by the interpersonal process that occurs in therapeutic relationships.

3.2.4 Relevance for Clinical Practice

Literature demonstrates that harm can occur in clinical psychology practice, through both the therapeutic relationship and interventions. However, clinical psychologists' roles are varied and extend beyond facilitating individual or group therapies. It is important to consider how clinical psychologists understand harm in their own practice. This could include acts of commission, such as boundary violations which places the client or therapeutic process at risk (Simon, 1992) or acts of omission (service accessibility, resources etc.) which result in individuals being denied psychological intervention (Chouliara *et al*., 2011).

The focus of this research is to explore clinical psychologists' construction of their power and stories in relation to harm as a means of addressing biases within the profession and, where they may be absent, create new narratives regarding their capacity to harm. Having clinical psychologists involved in this research, both as researchers and participants is needed to extend the existing literature. The research could inform clinical practice by increasing understanding about the ways clinical psychologists relate to the possibility of causing harm. It may also inform the training and supervision of clinical psychologists and therapists, by encouraging future practitioners to engage with the literature on harm and increase the routine seeking of informed consent to psychological interventions.

3.2.5 Research Aims

This research seeks to explore clinical psychologists' experiences of helping, harming and consent in their practice via the following questions:

1. How do clinical psychologists relate to the possibility of causing harm in their work?
2. How do the stories clinical psychologists tell about helping and harming connect to how they understand and gain informed consent for their interventions?
3. How do the stories clinical psychologists narrate about helping, harming and consent reflect or resist dominant identity narratives about helping professions in health care?

3.3 Methodology

3.3.1 Design

The study used Narrative Inquiry and analysis to explore the stories told by clinical psychologists about helping and harming in their practice. Narrative Inquiry is a qualitative approach to research that provides a flexible means of understanding and describing experience and making sense of that experience (Yardley and Smith, 2008). RCTs are perceived as the 'gold standard' in science-practitioner communities; a paradigm which clinical psychology positions itself within. There is a risk then, that qualitative outcomes research risks being devalued. In deciding on an appropriate method for this research, careful consideration was given to the epistemological stances, processes and ways in which the research questions could be answered, as suggested by Smith (1998). Grounded Theory (Strauss and Corbin, 1998) and Interpretive Phenomenological Analysis (Smith and Shinebourne, 2012) were considered as methods explicitly concerned with the content of narratives, but Narrative Inquiry was judged to be the most appropriate methodology to address the research question because of the emphasis on identity construction within social and cultural contexts. The limitations in previous literature are hampered by the lack of standardisation of 'harm' as a concept. However, operationalisation of what could be considered a subjective social construct contradicts the epistemological position of this research. For these reasons, in this study, 'harm' is not defined by the researcher.

3.3.2 Epistemological Position

This study is situated within a social constructionist perspective, adopting the postmodern focus of multiple views, multiple possibilities and multiple lives. It assumes that knowledge is constructed (in relation to self, others and systems) as opposed to created (Gergen and Gergen, 2006). Burr (2003) and Steedman (2000) suggest that identities originate within social realms, whereby significant others mediate realities and meanings. Language is the means through which construction takes place. This paper supposes features such as circularity (that people are connected and what happens within and between these relationships affects all), and context (at micro, macro and meso levels). The study focuses on meaning making rather than ontological or causation questions. Freeman (2015) argues that people are affected by the things that happen around them. The 'personal' stories told by the participants in this study are, therefore, understood within the wider socio-cultural contexts within which they were produced and heard, and identities understood as fluid and changeable rather than a single self. Riessman (2002) suggests that narrativizing one's life and experiences brings about continuity over past, present and future selves. Participants in this study are invited to define (and redefine) the value and importance they place on the concept of harm in the context of their work. Consequently, this research (much like other forms of investigation) and the writing up are a form of social action.

3.3.3 The Case for Narrative Inquiry

"Some people say when we are born, we're born into stories. I say we're also born from stories." -Ben Okri

Stories are used by all individuals across the lifespan, irrespective of social background or setting. Narrative Inquiry places stories as its primary source of data and examines content, structure, performance and context as a whole (Wells, 2011). Reissman (1993) suggests that, when there is a breach between our ideal and real self and society, we tend to narrativize; that is to story tell as means of sense-making. Furthermore, we construct past events and experiences to claim identities. This is an important concept relating to this research. For example, are clinical psychologists helpful or harmful? Good or bad? Hero or villain? And are they able to hold a narrative and counter narrative in order to explore their capacity to harm? In health care settings, culturally defined narratives for illness, recovery and harm may influence the decision to seek consent, which has important implications for clinical psychologists in their practice.

There are several benefits for employing Narrative Inquiry for this proposed research including: the research is interested in how people talk about harm and consent, about their identities as helpers or harmers, and in which broader historical, sociological and political narratives participants are drawing on when they tell their stories. Narrative Inquiry is a good fit for consideration of these matters and relating meaning at both micro and macro levels and the consequence of this interaction. Narrative Inquiry assumes the position that, whilst individuals know and can narrate their own experience, there are multiple realities and no single truth (Burr, 2003). Aligned with the epistemological position of this research, Narrative Inquiry recognises the impact of the identity, biases and ideas of the researcher in the co-construction of narratives and subsequent interpretation. Further exploration of this is set out in section 3.3.8. The use of Narrative Inquiry is therefore consistent with both the epistemological position of the study and as an appropriate method with which to explore the phenomena being investigated.

3.3.4 Sample

Six clinical psychologists were recruited via purposive sampling between May and November 2021; participants volunteered to take part on the basis that they self-identified with the phenomenon under inquiry. A sample set of six to eight participants was proposed to gain an in depth understanding of the topic area, which could incorporate multiple truths and positions. Wells (2011) suggests that Narrative Inquiry is an extensive examination of a phenomenon in its idiographic context and therefore the researcher believed that a minimum sample size of six would be sufficient.

A Twitter account was set up and used to advertise the study and recruit. The tweets included a flyer about the study and the contact details of the researcher, as well as information about the inclusion criteria for participants (see appendix V). Through this initial source, four participants were recruited. Snowball recruitment followed and information about the study was forwarded on to others which resulted in the recruitment of two further participants. All participants were HCPC registered clinical psychologists and working with individuals over the age of 18, who could consent explicitly to their involvement with psychological interventions. No other parameters were set out in relation to inclusion and exclusion criteria.

3.3.5 Ethical Considerations

Ethical approval was sought and gained from the University of Liverpool's Committee of Research Ethics (CORE) in April 2021 (Reference 8153: Appendix VI). Consideration was given to the following themes of the ethical issues relating to this research:

Potential Distress

Participants were alerted to some questions being potentially more difficult to reflect upon than others at the beginning of the interview. They were encouraged to let the researcher know if they were becoming distressed, and that the interview would be stopped. Post interview, participants were offered a debrief regarding how they found the interview and whether they had any concerns. They were forwarded information via a debrief sheet (appendix VII) encouraging them to seek support from clinical supervisors if necessary, or access a list of support numbers from useful organisations that had been provided. None of the participants highlighted any concerns during, or post interview.

Informed Consent

Participants who approached the researcher via email to express an interest in taking part were provided with a participant information sheet with details about the study (see appendix VIII). They were encouraged during this time to ask any questions about the research or share any concerns. All participants who expressed an interest, agreed to proceed to being interviewed, and were provided with a consent form which they were asked to sign prior to the agreed date of interview (appendix VIIII). The participant information sheet and consent form included information about participants' right to withdraw from the study, anonymity and explained that transcripts may be outsourced to a professional transcription service who would also be asked to sign a confidentiality agreement. None of the participants withdrew from the study during or post interview. The researcher transcribed all of the interviews so no transcripts were outsourced for transcribing.

Anonymity

Participants were informed that direct quotes used in the write up of this thesis would not be linked to any personal identifiers and no other demographic information was requested. They were asked to provide a pseudonym for their story, as the researcher wanted to acknowledge that names can be an important part of people's identities and connections to their communities and wanted them to have ownership of that. Participants were also told they had the option not to pick one and ask the researcher to choose one instead. One participant provided a pseudonym, four participants requested the researcher choose one and one participant did not respond to the request and the researcher therefore chose an alias.

Data Storage

Participants were informed that data would be recorded on a university approved iPad and stored on the secure university drive, with files protected via password security. Transcript data were stored with a numerical identifier until pseudonyms were established and files updated. Data are kept in accordance with the University of Liverpool's regulations and will be destroyed after 10 years. Identifying information (HCPC numbers) were deleted following appropriate checks being completed.

3.3.6 Interview Procedure

A semi structured interview schedule was developed in conjunction with Experts by Experience involved with the University of Liverpool Doctorate in Clinical Psychology programme. Experts by Experience are individuals with lived experience of mental health difficulties, or carers and family members, all of whom have had contact with mental health services. Their role is to support the design and delivery of the training. An interview schedule was developed with four open ended questions with limited additional prompts and can be found in appendix X. In narrative interviewing, Wells (2011) suggests the schedule should provide open questions which allow the interviewee to respond in their own words. In the interview schedule for this study, there was a slightly more closed question related to consent included. Following discussion with experts by experience (who identified this as a significant factor in their experience of harm), it was thought to be fundamental to include this in the schedule.

Follow up prompts were used uniquely depending on the story being narrated as is conducive to narrative interviewing. Interviews lasted between 50 and 90 minutes and the researcher took the decision to transcribe all interviews to support getting closer to the data and enhance analysis. After each interview, and during transcription, field notes were completed with the researcher's reflections on the interviews.

3.3.7 Analysis of the Narratives

Narrative Inquiry does not instruct a single way to complete analysis. However, the researcher undertook the analysis process by means of the guiding principles which underpin qualitative research.

The researcher read through each transcript multiple times, whilst listening to the audio recording of the interview. Attention to the content, structure and performance of the narratives (appendix XI for details), alongside making notes and highlighting text was undertaken (appendix XII includes Jamie's transcript and analysis). At this point the researcher explored events that occurred, turning points and how narrators developed meaning of the events; what Riessman (2008) describes as the "soul of the narrative". An MS Word document was created alongside this to incorporate any reflections of the researcher whilst being immersed with the transcripts, particularly highlighting storylines, shared narratives and any distinctions from local and wider contexts, for example counter-narratives to dominant paradigms. A counter-narrative includes a story (however small) that offers an alternative to a dominant story told and are of great interest and relevance to identity construction. In line with ‘small stories’ (Bamberg and Georgakapoulou, 2008), the researcher focused on details of the interactions between participants and the interviewer. Following this, the researcher developed a ’Global Impression’ (Lieblich, 1998) for each participant, highlighting notable aspects of the narrative and predominant storylines and performance. Finally, all transcripts were read again a number of times and the researcher moved from individual data to the construction of a meta narrative; with a focus on highlighting comparisons between the narratives, distinctions and missing stories and developed the main plots and sub-plots discussed below (Polkinghorne, 1995; Kramp, 2004).

3.3.8 Reflexivity

“We do not see things as they are. We see them as we are.”- Anais Nin

To support rigour and credibility, I held in mind how my position shaped the process and creation of narratives. I self-identify as a person from various minoritized backgrounds, particularly in relation to clinical psychology and more widely societally. I am a female from a working class background with Romany Gypsy ethnicity and part of the LGBTQ community. I have had over a decade’s experience working in mental health services, across a wide range of settings and in various roles. I spent a considerable period of time working in high secure clinical forensic settings whereby psychological ‘treatment’ is mandated, alongside detention. I have a strong interest in critical psychology and in evaluating mental health service provision in our society, which led to the development of the research question. I was met with mixed responses when discussing the proposed project idea with practicing clinical psychologists. Some expressed disbelief that harm could be equated with clinical psychological practice. Others talked about the harm caused in psychiatry, which appeared to be a way of defending or deflecting from the harm caused by psychological interventions. Several spoke of being pleased that what they considered to be an under-researched area was being thought about. These differences felt telling and perhaps spoke to the ways in which clinical psychologists might construct their professional identities within local, social and political contexts. I acknowledge the difficulties inherent in balancing professional and personal identities in the context of powerful systems that have the capacity to both help and harm. I hoped that potential interviewees would not be deterred by the polemic nature of the research question. In that respect, the word 'harm' was used purposefully as a means of avoiding professional language that might gloss over the real-life experiences' that individuals have spoken to, with regards to feeling harmed.

These themes were considered throughout the research process, both in reflective introspection and through discussion with my research supervisors. I kept a reflective log throughout the research process, with salient themes discussed to help aid with analysis. This was particularly important following interviews with participants, whereby conversations included how aspects of my identity, shared characteristics and values, or felt sense of connections with participants, may have influenced how the participants and I related to each other and shaped the process of interviewing and subsequent analysis (Frank, 2012; Bamberg, 2011). My supervisors and I agreed that I would interview participants who I did not know, and had no personal connection with outside of the research.

3.3.9 Credibility and Rigour

Reissman (2008) purports that there are two levels of ‘validity’ in narrative research: the story told by the participants and the story told by the researcher or analysis and that quality does not pertain to “truthfulness” but “trustworthiness”. This is in line with the epistemological position of this research which held space for multiple truths. Credibility refers to whether the interpretations are plausible and meaningful. Measures taken to ensure credibility of the data were undertaken by situating this research in context, highlighting the researcher’s position and creating spaces for individual and shared reflections with supervisors regarding the analysis. Rigour refers to whether the interpretations made by the researcher are supported in the original data. Sections 3.3.3 and 3.3.7 highlight the rationale for using Narrative Inquiry to analyse the data and provide a detailed summary of the steps the researcher took in carrying this out. The secondary supervisor had previous experience of carrying out and supervising narrative research, which also supported the analysis of findings to avoid interpretations that were not rooted in the interview data.

In order to ensure the research is publicised, the researcher intends to submit the research to relevant journals for publication. Participants will be given a copy of the findings prior to this. The researcher plans to present the study’s findings in a number of forums which could facilitate ‘audience validation’ (Patton, 2002) including the University of Liverpool’s annual Doctorate in Clinical Psychology programme research conference. It is hoped that this will further enhance the credibility and rigour of the research and respond to further criteria which denotes pragmatic use to support and inform clinical psychology.

3.4 Results

The following section reports the analysis of the six interviews carried out. In narrative tradition, the inquirer is interested in how stories are constructed and the meanings given

(Riessman, 1993). The analysis is therefore presented in two parts. Part one incorporates global impressions' (Lieblich, 1998) of each individual narrative, including performance aspects (Herman and Vervaeck, 2019) and basic demographic information relating to the interview setting to provide context for the reader and highlight the researcher's overall impression of the story telling. The second part presents the overall storylines interpreted alongside participant's quotes. In keeping with qualitative tradition, discussion will be incorporated into the reporting of the analysis, including references to relevant literature.

3.4.1 Introduction to Participants and Global Impressions

All identifying details have been removed or changed to protect anonymity of the participants and others in their stories. Six clinical psychologists were interviewed, all of whom worked in a range of clinical settings including pain management, community mental health and clinical forensic settings. Participants were working in the NHS and additional sectors.

Jamie

Jamie is a clinical psychologist whose role includes direct clinical work, liaison with the multi-disciplinary team and teaching and training on university courses. The interview took place virtually with Jamie at home and lasted approximately one hour and 27 minutes.

Global Impression

Jamie's story began by acknowledging how difficult it can be to recruit for research studies and her desire to help if it would be useful. Being helpful was a theme that ran throughout Jamie's narrative. Jamie's strongest narrative was that of being a role model or guide for people and having something of value to offer others. Her story was told by conveying her perception of being in “an honoured position” and gaining internal rewards related to the job role. Jamie’s account started rich in detail, generally based in the present, with extended monologues in response to questions. This was in contrast to reflections on her journey with potential harm in her work, which seemed not as easily told, observed in increased utterances, pauses and use of metaphor. Jamie’s account positioned her situation as being both an expert and limited in what they can do, inviting the audience to understand that helping involves change and change can be experienced as harmful despite intentions. The consequences of not getting it right were linked to “leaving someone worse than you found them” and damaging the reputation of clinical psychology, for example, “…harm their (.) perception of what psychology or psychological help could be”. Jamie’s account was fairly balanced in tone and pace throughout, however, she expressed some emotion when telling stories about potential harm caused to another.

Robin

Robin has been qualified for nine years and works in community mental health services and the third sector. Robin took part in the interview virtually while in her home environment. The interview lasted approximately 50 minutes.

Global Impression

Robin’s strongest narrative was that of curiosity and going on a “learning experience” both in her work and during the interview, for example, “gosh this is ((laughs)) a bit of a ((laughs)) an awakening in itself”. Her story conveyed the frustrations associated with working in systems and limitations with what they do as a clinical psychologist, for example, “My husband often says… that “it’s not about the bottles of water, it’s about the well”. And um, I’m like “I hate you for saying that, you’re right” because I think I’m giving people bottles of water right now…”. Robin’s account was richly detailed using lots of expressive language and changes in pitch and tone throughout. She used the interviewer’s name a lot in conversation inviting the audience in to her world and extending her curiosity by asking questions about theirs. Robin’s account transitioned between the past, present and future, positioning her situation as being complicit in enacting harm, “everybody’s part of it, everybody’s got a role to play in it”, alongside others, but all of whose journeys are paved with good intentions, for example, “I think I need to believe it’s unintentional (.) I need to believe that”. Growing awareness of harm, both within clinical psychology and wider social contexts, for example, following the Black Lives Matter protests in 2021 was linked to tentativeness and uncertainty in her tone and story, with increased pauses and sighs in speech, and repetition regarding intentions. She conveyed a sense of being changed by what she had learned in her job role and life and was navigating what to do with that learning.

Ash

Ash is a clinical psychologist working with adults with severe and enduring mental health difficulties in the community. She was in her home environment when the virtual interview took place, lasting approximately one hour.

Global Impression

Ash’s account was coherently narrated with a clear structure of a beginning, middle and end in their clinical psychology journey over time. She began her story by expressing her disappointment that clinical psychology had not lived up to what she had wanted it to be, for example describing her drive to do it as “unhealthy” and the journey through training and post qualification as a “downhill trajectory” which required actions that at times, sat outside her personal values. Her strongest narrative was that of searching for a consistent identity and grappling with experiencing herself in multiple roles. She painted a rich picture to highlight these struggles and described her internal sense of pressure as, “treading water”. A strong narrative in Ash’s account was around hiding within the veneer of perfectionism in clinical psychology. Ash’s story questioned whether a profession that hides mistakes, failings and power can allow space for people to be human. She conveyed a sense of uncertainty that she could exist in this system as both a person with lived experience of mental health difficulties and a clinical psychologist who helps people. She supported this storyline with personal examples in her work of how people are labelled in medicalised ways, discussed in multi-disciplinary team meetings and assessed in ways that make people “feel invaded”. Ash’s account was not detailed in content, however her use of emotive language and verbal and non-verbal cues invites the audience to understand her regret or guilt, for example “I kind of wish I could be honest, and just say…this is not me (.) but I am colluding in that system”.

Stevie

Stevie is a consultant clinical forensic psychologist who works in the community supporting men who have previously harmed others through violent and sexual offences. Her interview took place virtually whilst she was in her work office and lasted approximately one hour and 20 minutes.

Global Impression

Stevie’s strongest storyline was about connecting through relationships and “making sense”. This thread continued throughout her account, and incorporated sense making of people, the world, clinical psychology, and Stevie’s position in relation to these things. Stevie used wider local and broader contexts to situate her account, expressing themes of patriarchy, feminism, class, power and capitalism. Her account was narrated coherently, with a steady pace and tone. Stevie’s account started with her providing context for her decision to choose clinical psychology as a career describing herself as “definitely someone who tries to make things better”. Her account reflected on ‘helping harmers’ and her belief that “people aren’t bad, monsters and stuff” and her storyline incorporated a sense of holding onto good and bad in herself and others throughout the account. Another significant storyline centred around hope and this was told through examples of repair and the belief that harm does not characterise the end of something, for example, “when someone breaks your trust intentionally or not (.) it doesn’t mean that relationship has to be damaged, you can build things, that’s what life’s about I guess”. Stevie’s account reflected on the impact of uncertainty in the work of a clinical psychologist, for example “it feels quite experimental really” and conveyed her position as unknowing, expressing “I don’t know who I’ve harmed. I don’t think there’s many people that I’ve done significant harm to (.) but the reality is I don’t know”. Her story was told in a way that was engaging and relational inviting the audience to tolerate some of the uncertainty and discomfort that can occur when we are holding or engaging with the more difficult or shadow parts of ourselves.

David

David is a consultant clinical psychologist working in acute mental health services. His interview lasted approximately one hour and 20 minutes and took place virtually.

Global Impression

David's dominant storyline was around the value of clinical psychology and the responsibility it has in leading change in systems to better support the people accessing them. His story was difficult to follow at times, with frequent changes in topics and pace. David presented his story in the form of a list of the different ways clinical psychology can harm, populating information with personal anecdotes at times, but in a form which appeared to be discrete accounts that had occurred to David in the moment. His account was engaging and he used humour and a lot of non-verbal expressions and checking in with the researcher to ascertain whether he had given sufficient information for the research aims. David's narrative conveyed a mission statement whereby he was positioned as driven to influence change through supporting other professionals to adopt changes. This story of responsibility existed alongside a less visible story of uncertainty and the unknown in relation to harm. Here, David's account shifted to consider feeling unequipped, unsupported in systems, not being what people need and, fear of making mistakes within the blame culture in mental health services. Consideration of harm was associated with increased cautiousness in practice. Whilst David's account lacked personal detail, a turning point in his account came when considering his own identity and the potential for clinical psychology to harm in relation to difference.

Alex

Alex is a clinical psychologist working with people with severe and enduring mental health difficulties in the NHS and private practice. Alex was in her home environment when the interview took place and it lasted approximately one hour.

Global Impression

Alex started her account by describing her journey into clinical psychology, reflecting on her early experiences and desire to make sense of things that had happened. Her strongest storyline was that of distance as a result of a growing self-awareness that developed during training. This theme of separation threaded throughout Alex's narrative in relation to her experience of relationships in her personal life, in multidisciplinary teams and mental health services. Alex's speech was slow paced with a lot of pauses and other utterances. This impacted the flow of the narrative, and there was a distinct lack of detail leading the researcher to wonder if there were stories they were not allowed access to or imagined audiences that may be critical. The storyline of distance was notable in the separation of people into good or bad psychologists and smaller stories reflected this, for example, "There are some really amazing psychologists and therapists who help and there are some who are just quite bad". This theme of harm exists in others but not me, highlighted the tentativeness of the account Alex told and some fears around the impact on her work should they engage in reflecting on this, "I certainly have an instinct to not want to think about it very much". The way she told her account invited the audience not to question further.

3.4.2 The Story of Helping and Harming in Clinical Psychology

This section encompasses the researcher's interpretation of the storylines as a collective. The researcher identified one main plot with related sub-plots with regards to the research question. The storyline is presented in the following ways: a table providing a breakdown of the plot, subplots, and the transcripts referenced in the following narrative (Table II). Finally, a narrative discussing the plot is provided, with associated quotes from the accounts of participants relating to identity construction and the wider local and broader context in which they were situated.

Table II: *Overview of the Plot*

Main Plot	***Sub-Plot***	***Transcripts Referenced***
Plot 1: ***There's Always Another Story: Multiple Selves***	*Harmers and Victims*	1,2,3,4,5,6
	Powerful and Powerless	2,3,4,5,6
	Together and Alone	1,2,3,6
	Experts and Learners	1,2,3,4,5,6

3.4.3 Plot 1: There's Always Another Story: Multiple Selves

"The single story creates stereotypes, and the problem with stereotypes is not that they are untrue, but that they are incomplete. They make one story become the only story".- Chimamanda Ngozi Adichie

Basic narrative structures consist of a beginning, middle and end. In the beginning a main character or problem is introduced, followed by a set of actions or obstacles that lead to a turning point. The end of a narrative often denotes a resolution that states an individual's current position (Barker, Pistrang and Elliot, 1994). Themes are less global than in the impression and are frequently stated in terms of opposites that are repeated throughout the stories (Wells, 2011). In Narrative Inquiry, space is left open to the prospect of other possibilities, interpretations and explanations of the stories told. The findings are presented in ways which acknowledge the subjective co-construction and moments of interaction between both the researcher and participants (Lock and Strong, 2010). The researcher encourages the reader to consider this in the next section.

McAdams (1993) suggests that people create identities through the stories they tell. Lancaster and Smith (2002) propose that as a profession, clinical psychology has suffered from a crisis of identity; an insecure identity base characterised by a lack of knowledge and confusion among the general public about the role (Hopson and Cunningham, 1995). Abbott (1988) reports a struggle for control between clinical psychology and other health professions. The following section of the analysis focuses on the relationship with identity and experiences over time. It does so through the construction of stories co-created between the researcher and participants during interviews. The research topic pitched an either/or enquiry with the opening question asking participants to tell the researcher about being a clinical psychologist. The participants' responses were positioned in the context of help and harm being polemic. This is important context and something that was invited by the research question itself. The main plot: 'There's always another story-multiple selves' will explore this.

The researcher identified four sub-plots which highlight identity themes within the stories that narrators chose to tell: 'harmer and victim', 'powerful and powerless', 'together and alone', and 'experts and learners'. The focus on these identity experiences arose across all narratives, and perhaps, speak to the opportunity some participants took to move away from a 'harmful' identity and story a preferred sense of self which may not always be visible alongside their professional identity. Lieblich (1998, pg.47) suggest that "narrators create memories and construct them to reflect their current needs". The six participants of this study provided rich, and multi-faceted stories to narrate their experiences, not all of which, are presented in this storyline. However, the researcher aims to articulate their interpretation of both the idiographic, and collective stories, paying attention to the emotional and identity work that took place through the following sub-plots.

Harmers and Victims

The first of the subplots considers stories of clinical psychologists as both harmers in the context of therapeutic work and victims of clinical psychology themselves. Newnes (2014, p.29) suggests “everyone tries to be good…the cultural context ensures no shortage of role models…to reinforce whatever your notion of ‘being good’ happens to be”. Narratives about what it means to be a harmer or harmful are influenced by socially framed stereotypes and ideas. In this cultural context, being harmful is generally depicted as ‘madness’ or ‘badness’ with the associated consequences resulting in exclusion (for example psychiatric and prison settings) or publicly shamed (media representation) in contrast to cultures where community based decision making and restorative practices of repair may occur when harm has been done (Foucault, 2003; Newnes, 2014; Zehr, 1990).

Masson (2012, p.298) suggests that the very nature of psychotherapy cannot be reformed because it is, in essence, harmful. He references the “lies, the flaws, the harm, the imbalance in power, the arrogance, the condescension” that underpin the constitution of psychotherapy. With only one exception, participants’ accounts in the current study contained stories about their first noticed or remembered harming experience during therapy. Presser (2013) references how stories can justify harm and make others’ suffering appear inevitable by reducing victims to one dimensional characters or antagonists and the harmer as powerless to act in a different way. Stories about harm in this research were typified by use of metaphor, for example, adopting children’s story book literature to describe the act of harming another. Within this, clinical psychologists were positioned as ‘helpers’ in the context of inevitable harm, perhaps as an attempt to move away from the socially available narratives that characterise people as either ‘good’ or ‘bad’, as demonstrated by Jamie and Robin:

> Jamie: *I just like the analogy of like you, "if you wanna go on this bear hunt and you wanna get to the end, you've got to go through it, you can't go over it, you can't go under it, you've gotta go through it".*

> Robin: *"there's a fire in the cellar and the only way out is like the steel staircase, and the steel staircase, every time you grip hold of it, you're gonna want to let go (.) and that's a bit like what therapy's like".*

The stories told position the narrators as leading protagonists who provide the necessary means to support people to move on from their distress or as Jamie said, *"this year has brought out the rescuer in all of us hasn't it?".* Bamberg (2020) suggests that storytellers position themselves in relation to dominant storylines. By using a children's story book and metaphor, Jamie and Robin seemed to be attempting to convey a sense of who they are, both to themselves and their imagined audiences. People use language and voice to convey what they are trying to share. Jamie and Robin's use of repetitive language, for example, 'honoured position' (which was said six times in her description of being a clinical psychologist) and 'intention' (the role of intention was brought in ten times across the entirety of Robin's narrative) respectively, seemed to be a means of promoting another identity they did not want lost in the context of considering themselves 'harmful'. This might be influenced by the fact that there are no socially available narratives for psychologists to be harmful people. Even contemplating themselves as something other than supportive or helpful seemed to be difficult, highlighted by Robin, who when sharing a story of working with some people whispered *"uh god this is so hard"* perhaps aware this was not a socially acceptable feeling in her role. Goffman (1981) suggests we make decisions to perform 'desirable' selves in response to responses of audiences to portray an identity.

The story of harm to others that narrators told were characterised by associated emotions of guilt, fear and uncertainty.

> Jamie, *"I think there's, yeah, still a sense of loneliness and sadness, um, that was there still ((tearful/voice break)) (.) which I feel guilty about".*

Bamberg (2004) suggests a change in tone, language or fluidity can signify narrating unfamiliar material or material outside of someone's preferred identity. In this study, laughter often occurred in the context of participants talking about harm which could suggest less certainty about their stated position. In Jamie's account, her story of harm reflected a pause, whereby her pitch rose, and there were increased utterances and questions asked of the researcher, for example, *"People are quite resilient aren't they?".* This seemed to denote a shift in her dominant narrative, whereby skills and expertise could not be relied on. Bruner (1990) suggests that when there is conflict between our ideal and real self and society, we seek to organise the narratives we tell. Participants made attempts to move themselves away from a harmer position, reflecting on intentions, severity of harm (Jamie: *"it's not like a <u>'harm'</u>, <u>'harm'</u> one (.)")* and bringing others into the story (Stevie: *"I've had people crying in handcuffs and stuff and that, that's harmful, that's absolutely harmful sending people, but it's not just my decision").* These stories move harm out of a clinical psychology discourse and introduce a wider storyline.

All of the participants in this study told stories of being good people in harmful contexts. They seemed to be unable to deny the existence of harm and the part they play in that but there was an absence of stories where participants placed themselves as directly, or solely responsible for causing harm. Hayden, Browne and Van Der Riet (2018) suggest that individual narratives are situated in wider social narratives, and that as social norms change, so to do the individual narratives. It is important to note the social context during the time these narratives were told. Issues of harm, oppression and inequality were more pronounced in the media and political discourse and this is likely to have influenced the narrators' stories. Palmonari, Pombeni and Kirchler (1992) highlight the human need to search for and find identities, however they note that this experience is often painful and requires people to give up other possibilities and choose one over another. Talking about harm in the context of their work appeared to be painful at times for the participants in this study. It seemed to parallel experiences akin to engaging in anti-racism work, whereby starting to consider yourself as the 'other', for example, racist, becomes intolerable and the role of intention or other characters are employed as a means to move towards a preferred sense of self. Cameron (2020, p.126) explores Helm's (1984) 'White Racial Identity Theory' in her work noting two phases that people might experience when considering themselves as the 'other'. These include disintegration: "this all feels difficult and confusing, I don't like thinking about it" to pseudo-independence, where understanding of harm is about external people, outside of their own lives and themselves. Narratives from David, Ash and Alex incorporated 'harmful' others in the form of professionals, models and systems to re-position themselves, perhaps highlighting the pseudo-independence phase.

> David: *“you know as soon as you say you’re a psychologist people get scared, I mean why they get scared I dunno, when there’s psychiatrists in the building ((laughs)), it doesn’t make sense”.*

> Ash: *“…people come in and say, “what do you want me to do then, do you want me to kill myself, and then I can get, like a session?”, and you’re like, “yeah, kind of, that is the service model”.*

> Alex: *“and I think lots of the campaigns for mental health are really unhelpful, like (.) you’re having a bad day , or you’re low, or whatever it might be, go and get therapy and that’s absolutely the end of the conversation, like it will magically be better, and it won’t”.*

Bamberg (2020) suggests that how narrators position their story characters in relation to one another and how they position themselves in relation to their audience is important. Following stories of ‘harmers’, participants in this study invited the audience to understand what had been done to them at the hands of clinical psychology, altering the emphasis of the stories. Taylor (1983) argues that events or situations in which we feel victimised demand an explanation in our life stories. Stories of being harmed typically occurred in the past during training and were characterised by feelings of isolation from the wider professional group and feelings of pain.

> Robin: *“…I trained in [city], it’s a really diverse area. Do I remember anything about like these conversations?...um, and so I think that is quite harmful for*

> *someone who's not white, who is working in [city], who's working with lots of non-white clients, um (.) and it's interesting because there's a lump in my throat as I'm talking about this".*

> Ash: *"oh I really held people up to a high standard (.) um and (.) had lots of discussions about this with the people that I trained with, but how like, I think there were some things that were (.) I think we've all hesitated to use the word slightly borderline kind of abusive, or an abuse of power".*

The researcher was positioned as a 'helper' in this instance, helping participants to process and talk about their experiences of harm. 'Difference' was offered as a sense of meaning-making for why people experienced distance from others in clinical psychology. Whilst participants may have subscribed to a facet of the majority group (for example being a white, cis gendered female in clinical psychology), the myriad of cultural, racial and other minoritized identities were brought to the forefront of narratives. This seemed to highlight other important aspects of their identity and allowed participants to reflect on the potential harm they could encounter should they access clinical psychology services for their own needs. This re-narration is highlighted in the below quote from David:

> David: *"so you know, if I was to go and see a therapist, um, I'm a single gay man,...Um and I don't live a conventional life at all. Um and I don't think I'd be helped by seeing someone who's not able to kind of, to understand how my life is different".*

This quote by David seemed to highlight where he moves from harmer to victim, talking of experiencing alienation and perceived lack of understanding from others (Pemberton, Mulder and Aarten, 2019). The stories told about being harmed or potentially harmed by participants seemed to be told as pivotal events, richly narrated with creative language use, such as "abusive", perhaps as a means of growing this aspect of their storyline and convincing the audience of their identity as 'harmed' as opposed to 'harmer'.

Powerful and Powerless

The second of the subplots describes four of the narrators' relationships with power. Participants acknowledged the power they held in therapeutic relationships with people who use services, whilst offering a counternarrative of feeling powerless in relationships with multi-professional colleagues.

Winslade (2002) argues that a clinical psychologist's identity is often powerful. Relationships to power and the influence of power with regards to harm was considered across these narratives. Robin and Stevie highlighted this early on in their stories, offering examples of how they understand their power in the context of their work.

> Robin: *"he said um, "remember that the word therapist broken down is the rapist". Um and so I was just like woah".*

> Stevie :*"(.) um (.) think that we know best (.) um (.) be very certain about things, write these reports that, can have a majorly powerful impact upon people's lives".*

Robin's use of language in the quote above, whereby she used increased emphasis in her tone, was delivered in a sharp way and in the voice of a previous supervising clinical psychologist (a powerful 'other'). Using the words and adopting voices of other characters can offer legitimacy to the claims people make about their lives (Bamberg, Da Fina and Schiffrin, 2011), helping the audience to be convinced of the identity claim being made.

Atkinson and Delamont (2006, pg.43) say "the narratives of the powerless…as well as the powerful equally deserve close analytic attention". Interestingly, all narratives talked to experiencing a lack of power in relation to their role, with an impact on their capacity to help. Festinger (1954) highlights needs of professional groups to believe in their value in comparison with other groups. Alex and Ash introduce stories of clinical psychologists being under valued in services and lacking voice or power in the context of powerful professional others.

> Alex: *"also how willing people are to hear what we're saying (.) I think people kind of want us there sometimes to just take difficulty away…".*

> Ash: *"there isn't enough of a kind of (…) almost like buy in to what a psychological approach could offer. It's either like, you do it (.) or we're just completely removed from it".*

Interestingly, participants drew on a range of descriptive language depicting war terms including, 'wounded healers', 'traumatising', 'invaded', 'minefield', and 'battle'. This appeared to invite the audience to empathise with their experiences, creating powerful images of clinical psychologists besieged under a harmful system and under threat. They appeared to align themselves with a 'soldier' identity. Soldiers have a contested identity; in that they are often seen as 'heroes' who do harmful things for the 'greater good'. In addition, soldiers often have to undergo socialisation into the military in order to achieve what is expected from them or fulfil the tasks that have been ordered of them (Kümmel, 2018). By bringing other characters into stories with the use of creative language, for example, "brainwashed" (David), participants in this study appeared to be constructing a sense of who they were and what is demanded of them, both for themselves, and the audiences.

In relation to powerlessness, stories of silence (in the context of professional meetings or challenge) arose across all narratives, positioned as a significant factor in how harm occurs in clinical psychology. Interestingly, participants chose silence which could be considered a passive act, rather than reflect on more overt forms of harm. Robin and Ash provide examples below.

> Robin: *"maybe not even voicing (.) something that might be helpful in MDT to think about people,…whether that's cos I feel powerless, the dynamics of the team um".*

> Ash: "*Yeah so I-I can think in my kind of team (.) sometimes feel we are harmful through our silence in a way (.) because we don't want more referrals".*

Ash's story of silence pervaded her account and she verbalised this in a way that appeared to be an apology to the audience, as though there was a ghost audience of service users she may have known in the past or will know in the future. Ash repeated the word 'explicit' to highlight where she experiences the gap between her reality and what service users are told. Bamberg (2020) suggests that stories about actions are ways of practicing the navigation of identities in relation to passivity and agency.

Together and Alone

The third of the subplots contains stories of protection from others within clinical supervisory relationships and counter-narratives of separation from wider community relationships.

Supervision in clinical psychology is considered a core component of continuing professional development. There is an ethical and professional expectation for professionals to engage in supervision to support effective practice (BPS, 2017). Pakdaman, Shafranske and Falender (2015) suggest the supervisor's first obligation is to ensure client welfare. In this study, the researcher did not ask any questions to participants directly about supervision. However, protection from others through supervision featured significantly in the narratives. In these stories, others were positioned as 'gatekeepers' for preventing harm from occurring or reassurance that appropriate practice had been carried out. In this context, others and systems provided safety in setting out boundaries and procedures.

> Jamie: *"honestly I'm still not sure if there was any way I could have done something so that our relationship was more helpful and less harmful (…) but yeah, yeah, my supervisor couldn't come up with anything in particular, and I kind of lean back on that ((laughs))".*

Jamie's use of laughter in the above quote orients the audience to the ambiguity involved in determining and preventing harm and perhaps represents both an intention to be forthcoming and her discomfort in sharing this part of her story (Bamberg, 2020).

Whilst being sheltered through relationships with others was a strong narrative, counter-narratives describing a sense of separation from others was offered highlighting another 'self'. Growing self-awareness through training and the journey of clinical psychology as a qualified professional was associated with distance from themselves and important others, including family, friends and other professionals as highlighted below:

> Alex: *"it comes in waves but I think there can be a feeling of a little bit of distance between you (.) and particularly family (.) and other people, but when you start to see things differently (.) and have a different perspective and (.) that's not a perspective they share (.) so you feel like you've changed".*
>
> Ash: *"So, it's probably like a very big part of my identity as a clinical psychologist but it's also very hidden, like, I haven't shared it at work, I don't really talk about it".*
>
> Robin: "*I actually felt quite separate from my faith actually during training, and I even thought to myself if someone told me this was going to happen, I don't know if I would have trained".*

Ash's use of the word 'hidden' in the above quote is interesting with regards to the idea that we are the stories we tell ourselves and each other. Martin (2010) proposes that dominant discourses in healthcare and popular culture decide what stories are acceptable and those which are not. "We tell our stories, and a person without a story does not exist" (Kapur, 2010) Ash verbalising fears about telling work about her own experiences with mental illness and choosing instead, to hide that part of her identity (despite communicating its significance) paints a picture of a hostile or unwelcome environment for those with both lived experience and clinical expertise.

Experts and Learners

Common discourse presents clinical psychologists as 'experts' in mental health professions (Nel, 2012). In this respect clinical psychology is a highly sought-after occupation which purports to have a specialised body of knowledge in the area of mental health. 'Expert' identities were apparent across most of the narratives when discussing consent. Health care professionals as experts are socially available narratives which could explain why this was present (Turner, 2001). Here denoted moments where participants seemingly exited their story through intellectualising the process, with a distinct lack of emotion. Horrocks and Callahan (2006) suggest there are tensions that exist between expressing emotions though storytelling and maintaining acceptable professional images, as highlighted by Robin: *"Yeah, I'm mindful of my registration".* Perhaps the legal requirements associated with gaining informed consent provoked a need for narrators to provide a socially acceptable answer in contrast to accounts of harm whereby the definition was not necessarily quantifiable or subjective in nature. Alex and David's account highlights this as a difficult task.

> Alex: "*and my experience of it is-is probably like I'm (.) what I'm trying to say really is that, I probably haven't asked enough people you know for consent in, or been explicit enough about the potential for harm in psychological therapy. So I almost feel like I need to do a bit more research".*

> David*: "My first-year trainees are gonna ask me what to do around this ((laughs)) (.) next week ((laughs)) (.) I'm dreading it. Um, because I just find it so, I judge it in the moment now".*

In stories telling of gaining consent, themes of protecting others by withholding information were apparent. Lack of clarity was linked to not overloading patients with information and giving people only what they might need to know. Newnes (2018, p.26) points out "relationships are unique so neither the therapist nor patient can reliably predict what will happen". Masson (2012, p.224) queries whether patients will be given genuine informed consent to psychotherapy; questioning whether they will they be told that the chances of female patients being sexually abused by their therapist is at least 15%. To integrate both the legal, and clinical aspects in clinical psychology, in something so changeable as the interpersonal processes in psychotherapy, could be a barrier to gaining informed consent in its truest form and this was reflected in the narratives.

> Jamie: *"I do sort of share different levels of information based on the kind of person in front of me sometimes, so much is, is it gonna scare them off? Or is it gonna be useful?".*

> Stevie: *"we share a leaflet with people that other participants have helped to create. Um, and also we share a letter from a current participant, but that's just one person's experience that wanted to share a letter. You know, it's not someone who's saying "this place is rubbish ((laughs)), don't come".*

> Alex: *"…the informed bit is so difficult because (.) um (.) people don't (.) people don't (.) they don't know how they're going to feel and they kinda don't (.) believe you I think when you say this could make you worse um (.)".*

The above quote by Stevie, whereby she used a 'patient' voice to narrate placed herself outside of the experience of seeking consent and instead invoked a character that may convince the audience of the truth of her position. Interestingly, patients were not placed in a passive role during the stories of consent but given agency over the decision to engage as highlighted in Robin, David and Ash's accounts.

> Robin: *"it's an assumption, consent. They attend the appointments, they continue".*

> David: *"Usually where I work, if somebody's withdrawn their consent (.) they leave the room ((laughs))…".*

> Ash: *"I mean people don't come back if they don't like it, that is one thing".*

These quotes were delivered in a matter-of-fact way which invited no questioning from the audience which could denote the participants surety about this position. Whilst an 'expert' identity was notable during the stories of consent, more generally participants spoke to being learners with associated feelings of anxiety and uncertainty. Robin and David both reflected on wider discourses on mental health and social justice in relation to clinical psychology and feeling unequipped in their role to respond to current themes.

> Robin: "*I think that's the thing that's been brought to the forefront of my, like last year, George Floyd and the anti-racism movement and just like colonial, kind of uh, colonialization and I think I've been (.) if I'm honest I think I was kind of deadened to it all, um you know I, I didn't think about any of this and then as soon as like, I had a bit of an awakening last year".*

> David: "*Well I trained at [university] and nobody, ever, introduced me to the social graces. We did not have any training in that and I just think (.) you know when I kind of read that chapter and started to kind of think*

> *about (.) visible and invisible differences um (.) you know things started to kind of broaden in my mind obviously".*

Bamberg (2020) suggests that agency and passivity are a practice of identity navigation supposing it is part of people's internal experience and represents how and why they do things. Giving characters 'agency' and assuming they live that agency is relevant for constructions of accountability, for example, being blameworthy or responsible for wrongdoing or in terms of mastery and success. He suggests that stories about past actions are used to practice navigations like this and Robin and David's stories might reflect this.

The major storyline of this study, 'There's always another story: Multiple-selves', highlights the participants' narration of other, or preferred identities alongside considering themselves as harmful in the context of their work. Within these stories, participants drew on a range of social and political discourses, including power, inequality, feminism, and oppression to narrate aspects of past selves and emerging selves with regards to their understanding of harm. Recognition that both the systems they work in, and themselves as professionals and people within those systems, could be experienced as harmful appeared difficult to balance alongside strongly held identities of clinical psychologists as 'helpers', and in the midst of personal, and sometimes painful reasons for entering the profession.

3.5 Discussion and Conclusions

3.5.1 Summary of Findings

This study aimed to explore the relationship between helping, harming and consent in clinical psychology practice. Six clinical psychologists were interviewed, and their stories analysed using a Narrative Inquiry approach. Results have been discussed, with reference to the relevant literature in section 3.4. The following section will present a summary of the findings, organised in relation to the three main questions of the research:

1. How do clinical psychologists relate to the possibility of causing harm in their work?

   The study found that most of the participants were able to reflect on their capacity to harm the people that access psychological services. Participants referenced the range of ways people could be harmed through their actions or inactions within mental health services generally, and through psychological therapy. Through the narratives of harm, participants offered other parts of their lives and identities, perhaps as a way of meaning making. Reflecting on harm appeared to be a painful experience for most participants, with one participant expressing that they were unable or reluctant to do so, despite the topic of the research. Considering themselves as the ‘other’, for example as ‘harmful’ alongside a professional ‘helper’ identity, proved to be an emotional experience for participants. This was evident through some of the participants being tearful during the interviews. Perhaps as a result of this, the role of others and relationships with and to others featured heavily across all narratives. Family, colleagues and wider communities were brought in through various roles (gatekeepers, harmers, powerful), that typically hindered participants from being able to act in accordance with their personal values.

2. How do the stories clinical psychologists tell about helping and harming connect to how they understand and gain informed consent for their interventions?

Rowe (2003), suggests that “psychologists, like therapists and counsellors, want to be able to think of themselves as being good at their job. Unless they are completely honest with themselves they can easily allow themselves to use the jargon of management and of therapy to condemn people who fail to get better”. Participants in this study typically told stories which gave service users agency in the decision to engage with their services. Stories relating to harm and consent were characterised by themes of protection, expertise, and best interests. Whether or not the information given during consent conversations was adequate was not narrativized by all participants, and those who did, offered counter-narratives that consent is implied if service users continue to turn up to appointments. Themes of power, harm, and collaboration which typified other storylines were noticeably absent when considering consent. Perhaps this denoted the uncertainty participants experienced when considering a theme which has a legal implication and a construct which is more readily defined and measured in mental health services.

3. How do the stories clinical psychologists narrate about helping, harming and consent reflect or resist dominant identity narratives about helping professions in health care?

Masson (2012, p.211) suggests “the very fact of investing in therapy, both financially and emotionally means that one is bound to protect it from criticism”.

Typically, participants in this study narrated stories which reflected 'helping' narratives about their roles. In stories, whereby harm was considered, participants brought in others to demonstrate how their practice is hindered by other professionals, systems and wider society, and reflected on intentions and constraints in relation to their roles. One participant's account could be viewed as a counternarrative to more commonly told stories of clinical psychologists as benevolent and well intentioned. Perhaps her role in forensic settings, whereby stories of people being both 'good' and 'bad', 'victim' and 'perpetrator' are told more readily, she was able to resist being positioned in a societal discourse which suggests that if we have harmed, we are bad people.

3.5.2 Implications for Clinical Practice

This research was carried out with a view to understanding how clinical psychologists respond to the possibility of causing harm with an aim of highlighting the implications for both training and clinical practice.

Training

Participants narrated a lack of awareness regarding the potential to harm, typically referencing their clinical training as having been a lost opportunity to consider harm in the context of psychological practice and how it might occur. Typically, harm is not considered as a core component of clinical psychologists' pre-qualification training. Newnes (2004) highlights the lack of academic lectures considering harm in the context of clinical psychology, developed for trainees. He considers the implications for practice once qualified without this information being shared with trainees. Individuals who are training to be clinical psychologists, should be given and encouraged to seek out critiques of their chosen profession. They need to engage with the literature regarding the history of clinical psychology and the papers considering the effectiveness of specific therapies in order to be truly informed individuals regarding the nature of their work. This would, in turn, support and enable clinical psychologists to provide accurate information for service users and allow them to seek and gain true informed consent for their interventions. Trainee clinical psychologists should be encouraged to listen and seek out anecdotal accounts from those who have used services to inform them of the ways in which people experience harm in order to prevent it from happening. Statutory regulatory and accrediting bodies including the HCPC and the BPS require the involvement of Experts by Experience in all stages of clinical psychology training (HCPC, 2017; BPS, 2019). Clinical psychology should also consider the training experiences of marginalised clinicians. Cameron (2020, p.122) suggests that "we fail to be professions in which marginalised clinicians and trainees feel welcome and adequately supported". Participants spoke to these stories during this study and it is an important consideration when thinking about creating a culture of openness and transparency. If people find it difficult to speak up for themselves in powerful systems, how might they manage in speaking up for others in the face of challenge?

Clinical Practice

Previous research has demonstrated that there is a lack of engagement with literature on harm by clinical psychologists (Bystedt *et al*., 2014) and this study supports those findings. Spaces to consider harm, for example in clinical supervision, reflective practice, and within psychological therapy should be standard to ensure clinical psychologists are informed and able to reflect on this capacity. Participants spoke of silence being one of the ways they may cause harm to the people they work with, highlighting multi-professional team meetings, referrals, and specific therapeutic models used. Cultures which limit expression and difference and that are characterised by blame or silencing, do not provide the optimum environment for those to engage with the literature and consider other stories about themselves. This has important implications for those who engage with services, if professionals are reluctant to consider harm they may have cause through fear of blame and shame.

3.5.3 Strengths and Limitations

There are a number of strengths and limitations of this study.

Strengths

A key strength of this study is the novel approach taken to explore harm in clinical psychology with regards to the existing literature. Exploring stories of clinical psychologists in relation to their experiences of helping and harming provided rich and detailed narratives which have the potential to inform both the training of clinical psychologists and their practice. Understanding aspects of identity construction in relation to the theme provides the opportunity to develop ways in which discussion of harm and prevention of harm to those who use services can be implemented in the profession. The outcome of this could be that professionals are more willing to hear the voices of service users, even if the concerns raised are difficult to hear.

The sample size for the study was small however, a diverse range of clinical psychologists were recruited including in length of time qualified, work experiences and other identity characteristics.

Limitations

The researcher's identity was explored in section 3.3.8. It is important to note how this may have influenced both the interviews, questions asked and what aspects were chosen to be highlighted in the analysis. This is likely to have shaped what and how stories were shared and silenced others. Although this can be viewed as a potential limitation, a number of measures were put in place to address this as every stage of the study.

The use of Twitter to recruit participants may have limited the sample who volunteered to take part. Whilst care was taken to request re-tweets from professional clinical psychology bodies to reach a wider audience, use of social media could be considered a restricted network.

3.5.4 Suggestions for Future Research

The inclusion criteria for this study meant clinical psychologists had to be working primarily with individuals over the age of 18 who could explicitly consent to their engagement with psychological intervention. Future research exploring stories of those who work with children and young people, or those who have been deemed to lack capacity could provide further understanding or additional themes (particularly in relation to consent).

The existing literature on harm is limited. Research exploring the voices of both clinicians and service users which could provide further learning which informs preventative practice, would be valuable and important. This may add to creating counternarratives to the idea that clinical psychology as a profession is solely benevolent and acknowledge the voices of those who have experienced harm in varying ways. Newnes (2014, p.60) states “clinical psychology remains a profession bound by the context of a largely medical discourse”. Use of qualitative analysis provides opportunities to move away from the pathologizing of human experiences.

3.5.5 Final Reflections

This thesis has felt like a labour of love, a huge responsibility, a strain on my wellbeing, and a test of both endurance and compassion at different points over the course of the last three years. Emerging and changeable feelings, perhaps paralleling emerging and changeable selves. Like the participants in this study, I found it difficult to balance thinking, investigating and writing about harm in clinical psychology in the context of a shifting identity. To hear and read stories of harm from qualified peers and people who use services, as a trainee, has left me open to despondency and doubt about the profession I wanted to enter. I am, however, inherently grateful that I stuck with it, and tolerated all of the feelings that have been generated. I began this process, I think, in a world of dichotomy; ‘good’ or ‘bad’, ‘hero’ or ‘villain’, ‘helpful’ or ‘harmful. I end it with a greater appreciation and compassion for the nuance and complexity of considering harm in the context of clinical psychology, and of what it means to be human and exist in the systems we are confronted with. If possible, I think I also end it with an even greater drive to continue to reflect, act, and take responsibility for ensuring that people’s experiences of clinical psychology, whether good, or bad, are heard and met with openness, care, transparency and accountability.

3.6 References

Abbott, A. (2014). *The system of professions: An essay on the division of expert labor*. University of Chicago press. https://doi.org/10.7208/chicago/9780226189666.001.0001

Ahern, K. (1999). 'Ten tips for reflexive bracketing', *Qualitative Health Research*, 9(3), pp.407-411. https://doi.org/10.1177/104973299129121947

ACP UK (2022) *Association of Clinical Psychologists UK (ACP-UK)*. Available at: https://acpuk.org.uk/ (Accessed: 19 May 2022).

Atkinson, P. and Delamont, S. (2006). 'Rescuing narrative from qualitative research', *Narrative Inquiry*, *16*(1), pp.164-172. https://doi.org/10.1075/ni.16.1.21atk

Bamberg, M. (2004). 'Talk, small stories, and adolescent identities', *Human Development*, 47(6), pp.366–369. https://doi.org/10.1159/000081039

Bamberg, M. (2011). 'Who am I? Narration and its contribution to self and identity', *Theory & Psychology*, *21*(1), pp.3-24. https://doi.org/10.1177/0959354309355852

Bamberg, M. (2020). 'Narrative analysis: An integrative approach' in Järvinen, M. and Mik-Meyer, N. (eds). *Qualitative Analysis: Eight approaches for the social sciences*. SAGE, pp.243-264.

Bamberg, M., Fina, A.D. and Schiffrin, D. (2011). 'Discourse and identity construction' in Schwartz, S, J., Luyckx, K. and Vignoles, V, L. *Handbook of identity theory and research.* New York: Springer, pp.177-199.

Bamberg, M. and Georgakopoulou, A. (2008). 'Small stories as a new perspective in narrative and identity analysis', *Text & Talk*, 28(3). https://doi.org/10.1515/text.2008.018

Barker, C., Pistrang, N. and Elliot, R. (1994). *Research methods in clinical and counselling psychology*. John Wiley & Sons.

Beahrs, J.O. and Gutheil, T.G. (2001). 'Informed consent in psychotherapy', *American Journal of Psychiatry*, *158*(1), pp.4-10. https://doi.org/10.1176/appi.ajp.158.1.4

Berk, M. and Parker, G. (2009). ‘The elephant on the couch: Side-effects of psychotherapy’, *Australian & New Zealand Journal of Psychiatry*, *43*(9), pp.787-794. https://doi.org/10.1080/00048670903107559

Boisvert, C.M. and Faust, D. (2006). ‘Practicing psychologists' knowledge of general psychotherapy research findings: Implications for science-practice relations’, *Professional Psychology: Research and Practice*, *37*(6), p.708. https://doi.org/10.1037/0735-7028.37.6.708

Boyle, M. (2011). ‘Making the world go away, and how psychology and psychiatry benefit’ in Rapley, M., Moncrieff, J. and Dillon, J. (eds). *De-medicalizing misery.* London: Palgrave Macmillan, pp. 27-43. https://doi.org/10.1057/9780230342507_3

British Institute of Human Rights (no date) *The human rights act.* Available at: The Human Rights Act | British Institute of Human Rights (bihr.org.uk) (Accessed August 2020).

British Psychological Society (2017) *Practice guidelines third edition.* Available at: BPS Practice Guidelines (Third Edition).pdf (Accessed: 5 February 2022).

British Psychological Society (2019) *Clinical accreditation handbook.* Available at: Clinical Accreditation Handbook 2019.pdf (bps.org.uk) (Accessed October 2021).

British Psychological Society (2021) *Code of ethics and conduct.* Available at: BPS Code of Ethics and Conduct.pdf (Accessed: 19 May 2022).

Bruner, J. (1990). *Acts of meaning*. Harvard University Press.

Burr, V. (2003). *Social constructionism*. London: Routledge. https://doi.org/10.4324/9780203694992

Bystedt, S., Rozental, A., Andersson, G., Boettcher, J. and Carlbring, P. (2014). ‘Clinicians' perspectives on negative effects of psychological treatments’, *Cognitive Behaviour Therapy*, *43*(4), pp.319-331. https://doi.org/10.1080/16506073.2014.939593

Cameron, R. (2020). *Working with difference and diversity in counselling and psychotherapy*. London: SAGE.

Chouliara, Z., Karatzias, T., Scott-Brien, G., Macdonald, A., MacArthur, J. and Frazer, N. (2011). 'Talking therapy services for adult survivors of childhood sexual abuse (CSA) in Scotland: Perspectives of service users and professionals', *Journal of Child Sexual Abuse*, *20*(2), pp.128-156. https://doi.org/10.1080/10538712.2011.554340

Collins English Dictionary (no date) *Harm.* Available at: Harm definition and meaning | Collins English Dictionary (collinsdictionary.com) (Accessed: July 2021).

Coopmans, C., Vertesi, J., Lynch, M.E. and Woolgar, S. (2014). *Representation in scientific practice revisited*. Eds. MIT Press.

https://doi.org/10.7551/mitpress/9780262525381.003.0001

Corrigan, P.W. (2007). 'How clinical diagnosis might exacerbate the stigma of mental illness', *Social Work*, 52(1), pp.31–39. https://doi.org/10.1093/sw/52.1.31

Curran, J., Parry, G.D., Hardy, G.E., Darling, J., Mason, A.M. and Chambers, E. (2019). 'How does therapy harm? A model of adverse process using task analysis in the meta-synthesis of service users' experience', *Frontiers in Psychology*, *10*, p.347. https://doi.org/10.3389/fpsyg.2019.00347

Dalai Lama XIV (no date) www.goodreads.com. (n.d.). *A quote by Dalai Lama XIV*. Available at: https://www.goodreads.com/quotes/172067-if-you-can-help-others-if-you-cannot-do-that (Accessed 19 May 2022).

Department of Health (no date) *Human rights act 1998.* Available at: The Human Rights Act 1998 | Department of Health (health-ni.gov.uk) (Accessed: August 2020).

Festinger, L. (1954). 'A theory of social comparison processes', *Human Relations*, 7(2), pp.117–140. https://doi.org/10.1177/001872675400700202

Foucault, M. (2003). *Madness and civilization*. Routledge.

Frank, A.W. (2012). 'Practicing dialogical narrative analysis' in Holstein, J, A. and Gubrium, J, F. (eds). *Varieties of Narrative Analysis*. SAGE, pp.33-52. https://doi.org/10.4135/9781506335117.n3

Fredman, G. (2006). 'Working Systemically with Intellectual Disability' in Baum, S. and Lynggaard, H. (eds) *Intellectual Disabilities: A Systemic Approach*. London: Karnac, pp. 1-20. https://doi.org/10.4324/9780429476037-1

Freeman, M. (2015). *Rewriting the self: History, memory, narrative*. Routledge.

Gergen, M.M. and Gergen, K.J. (2006). 'Narratives in action', *Narrative Inquiry*, *16*(1), pp.112-121. https://doi.org/10.1075/ni.16.1.15ger

Goffman, E. (1981). *Forms of talk*. University of Pennsylvania Press.

Goodbody, L. and Burns, J. (2011). 'Deconstructing personal-professional development in UK clinical psychology: Disciplining the interdisciplinarity of lived experience', *International Journal of Interdisciplinary Social Sciences*, *5*(9). https://doi.org/10.18848/1833-1882/cgp/v05i09/59310

Graf, E.M., Sator, M. and Spranz-Fogasy, T. (2015). 'Discourses of helping professions. Concepts and contextualization' in Graf, E, M., Sator, M. and Spranz-Fogasy, T. (eds). *Discourses of helping professions.* John Benjamins Publishing Company, pp. 1-12. https://doi.org/10.1075/pbns.252.01gra

Haydon, G., Browne, G. and van der Riet, P. (2018). 'Narrative inquiry as a research methodology exploring person centred care in nursing', *Collegian*, *25*(1), pp.125-129. https://doi.org/10.1016/j.colegn.2017.03.001

Health Care and Professions Council (2017) *Standards of education and training guidance.* Available at: standards-of-education-and-training-guidance.pdf (hcpc-uk.org) (Accessed: October 2021).

Health Care and Professions Council (2020) *Standards*. Available at: Standards | (hcpc-uk.org) (Accessed: December 2021).

Herman, L. and Vervaeck, B. (2019). *Handbook of narrative analysis*. University of Nebraska Press. https://doi.org/10.2307/j.ctvr43mhw

Holland, J.L. (1959). 'A theory of vocational choice', *Journal of Counseling Psychology*, 6(1), pp.35–45. https://doi.org/10.1037/h0040767

Hopson, K. and Cunningham, J.D. (1995). 'Community and client perceptions of psychologists and other health professionals', *Australian Psychologist*, *30*(3), pp.213-217. https://doi.org/10.1080/00050069508258937

Horrocks, A. and Callahan, J.L. (2006). 'The role of emotion and narrative in the reciprocal construction of identity', *Human Resource Development International*, *9*(1), pp.69-83. https://doi.org/10.1080/13678860600563382

Jarrett, C. (2008). 'When therapy causes harm', *Psychologist*, *21*(1), pp.10-12.

Johnstone, L. (2021). *Users and abusers of psychiatry: A critical look at psychiatric practice.* Routledge.

Jones, L.F. (2007). 'Iatrogenic interventions with personality disordered offenders', *Psychology, Crime & Law*, *13*(1), pp.69-79. https://doi.org/10.1080/10683160600869809

Kapur, S (2010) *We are the stories we tell ourselves. My talk at TED.com*. Available at: https://shekharkapur.com/blog/2010/03/we-are-the-stories-we-tell-ourselves-my-talk-at-ted-com/ (Accessed April 2022).

Kernes, J.L. and Kinnier, R.T. (2008). 'Meaning in psychologists' personal and professional lives', *Journal of Humanistic Psychology*, *48*(2), pp.196-220. https://doi.org/10.1177/0022167807300204

Kramp, M.K. (2004). 'Exploring life and experience through narrative inquiry' in DeMarrais, K, B. and Lapan, S. D. (eds). *Foundations for research: Methods of inquiry in education and the social sciences*. Routledge, pp.103-121.

Kümmel, G. (2018). 'Military identity and identity within the military' in Caforio, G. and Nuciari, M. (eds). *Handbook of the sociology of the military.* New York: Springer, pp. 477-493. https://doi.org/10.1007/978-3-319-71602-2_25

Lancaster, S. and Smith, D.I. (2002). 'What's in a name? The identity of clinical psychology as a specialty', *Australian Psychologist*, *37*(1), pp.48-51. https://doi.org/10.1080/00050060210001706666

Leiblich, A. (1998). 'Reading a life Story from a holistic-content perspective' in Leiblich, A., Tuval-Mashiach, R. and Zilber, T. *Narrative research: Reading, analysis, and interpretation*. SAGE. https://doi.org/10.4135/9781412985253.n4

Lilienfeld, S.O. (2007). 'Psychological treatments that cause harm', *Perspectives on Psychological Science*, 2(1), pp.53–70. https://doi.org/10.1111/j.1745-6916.2007.00029.x

Lock, A. and Strong, T. (2010). *Social constructionism: Sources and stirrings in theory and practice*. Cambridge University Press. https://doi.org/10.1017/cbo9780511815454

Martin, V. (2010). *Developing a narrative approach to healthcare research*. Radcliffe Publishing.

Masson, J.M. (2012). *Against therapy: Emotional tyranny and the myth of psychological healing*. Untreed Reads.

McAdams, D.P. (1993). *The stories we live by: Personal myths and the making of the self*. Guilford Press.

Miller, F. and Wertheimer, A. (2010). *The ethics of consent: theory and practice*. Oxford University Press. https://doi.org/10.1093/acprof:oso/9780195335149.001.0001

Nel, P.W. (2012). 'The trouble with clinical psychology' in *Clinical Psychology Forum*.

Newnes, C. (2004). 'Psychology and psychotherapy's potential for countering the medicalization of everything', *Journal of Humanistic Psychology*, *44*(3), pp.358-376. https://doi.org/10.1177/0022167804266180

Newnes, C. (2014). *Clinical psychology: A critical examination*. Pccs Books.

Newnes, C. (2018). *A critical history of electro-shock*. Real Press.

Ngozi Adichie, C (no date) www.goodreads.com. (n.d.). *A quote by Chimamanda Ngozi Adichie*. Available at: https://www.goodreads.com/quotes/522563-the-single-story-creates-stereotypes-and-the-problem-with-stereotypes (Accessed December 2021).

Nin, A (1958) quotecatalog.com. (n.d.). *Anaïs Nin Quote - Lillian was reminded of the talmudic wor... | Quote Catalog*. Available at: https://quotecatalog.com/quote/anais-nin-lillian-was-rem-Ya8eN51/ (Accessed: March 2022).

Norcross, J.C. and Farber, B.A. (2005). 'Choosing psychotherapy as a career: Beyond "I want to help people"', *Journal of Clinical Psychology*, *61*(8), pp.939-943. https://doi.org/10.1002/jclp.20175

Okri, B (no date) A-Z Quotes. (n.d.). *Ben Okri Quote*. Available at: https://www.azquotes.com/quote/1124068 (Accessed January 2022).

Pakdaman, S., Shafranske, E. and Falender, C. (2015). 'Ethics in supervision: Consideration of the supervisory alliance and countertransference management of psychology doctoral students', *Ethics & Behavior*, *25*(5), pp.427-441. https://doi.org/10.1080/10508422.2014.947415

Palmonari, A., Pombeni, M.L. and Kirchler, E. (1992). 'Evolution of the self-concept in adolescence and social categorization processes', *European Review of Social Psychology*, *3*(1), pp.285-308. https://doi.org/10.1080/14792779243000096

Parker, M. (2007). 'Health politics: Power, populism and health', *Family & Community Health*, *30*(4), p.365. https://doi.org/10.1097/01.fch.0000290549.77971.57

Patton, M.Q. (2002). 'Two decades of developments in qualitative inquiry', *Qualitative Social Work: Research and Practice*, 1(3), pp.261–283. https://doi.org/10.1177/1473325002001003636

Pemberton, A., Mulder, E. and Aarten, P.G. (2019). 'Stories of injustice: Towards a narrative victimology', *European Journal of Criminology*, *16*(4), pp.391-412. https://doi.org/10.1177/1477370818770843

Polkinghorne, D.E. (1995). 'Narrative configuration in qualitative analysis', *International Journal of Qualitative Studies in Education*, 8(1), pp.5–23. https://doi.org/10.1080/0951839950080103

Pope, K.S. and Vetter, V.A. (1991). 'Prior therapist-patient sexual involvement among patients seen by psychologists', *Psychotherapy: Theory, Research, Practice, Training*, *28*(3), p.429. https://doi.org/10.1037/0033-3204.28.3.429

Presser, L. (2013). *Why we harm*. New Brunswick, NJ and London: Rutgers University Press. https://doi.org/10.36019/9780813562605

Riessman, C. (1993). 'Narrative analysis', *Qualitative Research Methods*, *30*, pp.1-79.

Riessman, C. (2002). 'Analysis of personal narratives' in Gubrium, J. and Holstein, J. (eds). *Handbook of interview research.* SAGE, pp.695-710. https://doi.org/10.4135/9781452218403.n26

Riessman, C.K. (2008). *Narrative methods for the human sciences*. SAGE.

Rowe, D. (2003). *Are you suitable for therapy?* Available at: Are You Suitable For Therapy? (Jan 2003) (dorothyrowe.com.au) (Accessed: February 2022).

Simon, R.I. (1992). 'Treatment boundary violations: Clinical, ethical, and legal considerations', *Journal of the American Academy of Psychiatry and the Law Online*, *20*(3), pp.269-288.

Smith, F. (1998). 'Health services research methods in pharmacy: Qualitative interviews', *International Journal of Pharmacy Practice*, 6(2), pp.97–108. https://doi.org/10.1111/j.2042-7174.1998.tb00923.x

Smith, J.A. and Shinebourne, P. (2012). *Interpretative phenomenological analysis*. American Psychological Association. https://doi.org/10.1037/13620-005

Squire, C. (2008). 'Experience-centred and culturally-oriented approaches to narrative', *Doing Narrative Research*, *1*, pp.41-63. https://doi.org/10.4135/9780857024992.d4

Steedman, P. (2000). 'On the relations between seeing, interpreting and knowing' in Steier, F. *Research and reflexivity.* SAGE, pp.53-62.

Strauss, A. and Corbin, J. (1998). *Basics of qualitative research techniques*. SAGE.

Taylor, S.E. (1983). 'Adjustment to threatening events: A theory of cognitive adaptation', *American Psychologist*, 38(11), pp.1161–1173. https://doi.org/10.1037/0003-066x.38.11.1161

Turner, S. (2001). 'What is the problem with experts?', *Social Studies of Science*, 31(1), pp.123–149. https://doi.org/10.1177/030631201031001007

Wells, K. (2011). *Narrative inquiry*. *Pocket guide to social work research methods.* Oxford University Press. https://doi.org/10.1093/acprof:oso/9780195385793.003.0001

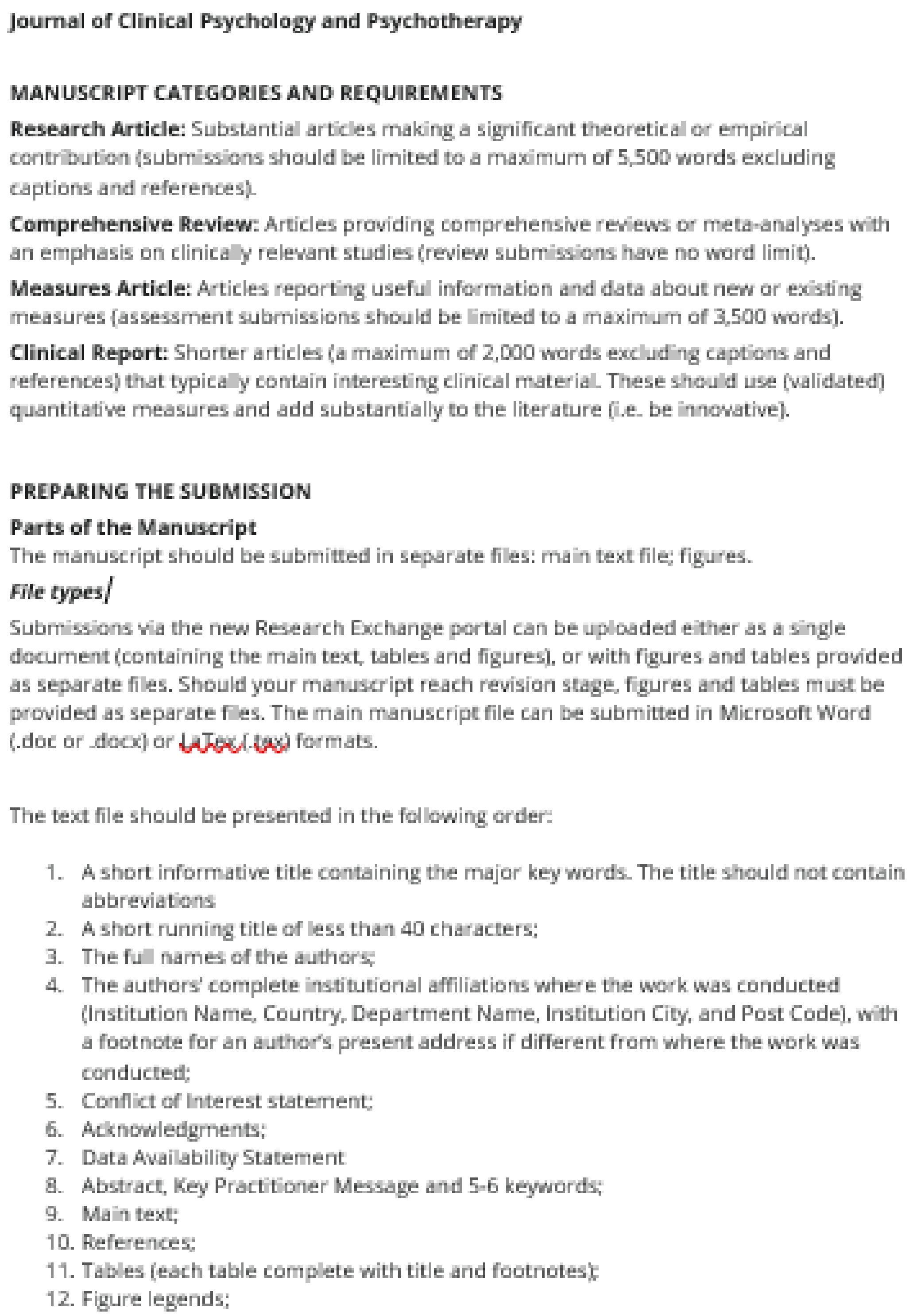
Wilhelm, S., Phillips, K.A., Greenberg, J.L., O'Keefe, S.M., Hoeppner, S.S., Keshaviah, A., Sarvode-Mothi, S. and Schoenfeld, D.A. (2019). 'Efficacy and posttreatment effects of therapist-delivered cognitive behavioral therapy vs supportive psychotherapy for adults with body dysmorphic disorder: A randomized clinical trial', *JAMA Psychiatry*, *76*(4), pp.363-373. https://doi.org/10.1001/jamapsychiatry.2018.4156

Winslade, J. (2002). 'Storying professional identity: From an interview with John Winslade', *International Journal of Narrative Therapy & Community Work*, *2002*(4), pp.33-38.

Yardley, L. and Smith, J.A. (2008). *Qualitative psychology: A practical guide to research methods*. SAGE.

Zehr, H. (1990). *Changing lenses*. Herald Press.

APPENDIX I: AUTHOR GUIDELINES



Journal of Clinical Psychology and Psychotherapy

MANUSCRIPT CATEGORIES AND REQUIREMENTS

Research Article: Substantial articles making a significant theoretical or empirical contribution (submissions should be limited to a maximum of 5,500 words excluding captions and references).

Comprehensive Review: Articles providing comprehensive reviews or meta-analyses with an emphasis on clinically relevant studies (review submissions have no word limit).

Measures Article: Articles reporting useful information and data about new or existing measures (assessment submissions should be limited to a maximum of 3,500 words).

Clinical Report: Shorter articles (a maximum of 2,000 words excluding captions and references) that typically contain interesting clinical material. These should use (validated) quantitative measures and add substantially to the literature (i.e. be innovative).

PREPARING THE SUBMISSION

Parts of the Manuscript

The manuscript should be submitted in separate files: main text file; figures.

File types

Submissions via the new Research Exchange portal can be uploaded either as a single document (containing the main text, tables and figures), or with figures and tables provided as separate files. Should your manuscript reach revision stage, figures and tables must be provided as separate files. The main manuscript file can be submitted in Microsoft Word (.doc or .docx) or LaTex (.tex) formats.

The text file should be presented in the following order:

1. A short informative title containing the major key words. The title should not contain abbreviations
2. A short running title of less than 40 characters;
3. The full names of the authors;
4. The authors' complete institutional affiliations where the work was conducted (Institution Name, Country, Department Name, Institution City, and Post Code), with a footnote for an author's present address if different from where the work was conducted;
5. Conflict of Interest statement;
6. Acknowledgments;
7. Data Availability Statement
8. Abstract, Key Practitioner Message and 5-6 keywords;
9. Main text;
10. References;
11. Tables (each table complete with title and footnotes);
12. Figure legends;

Figures and appendices and other supporting information should be supplied as separate files.

Abstract

Enter an abstract of no more than 250 words containing the major keywords. An abstract is a concise summary of the whole paper, not just the conclusions, and is understandable without reference to the rest of the paper. It should contain no citation to other published work.

Key Practitioner Message

All articles should include a Key Practitioner Message of 3-5 bullet points summarizing the relevance of the article to practice.

Keywords

Please provide five-six keywords

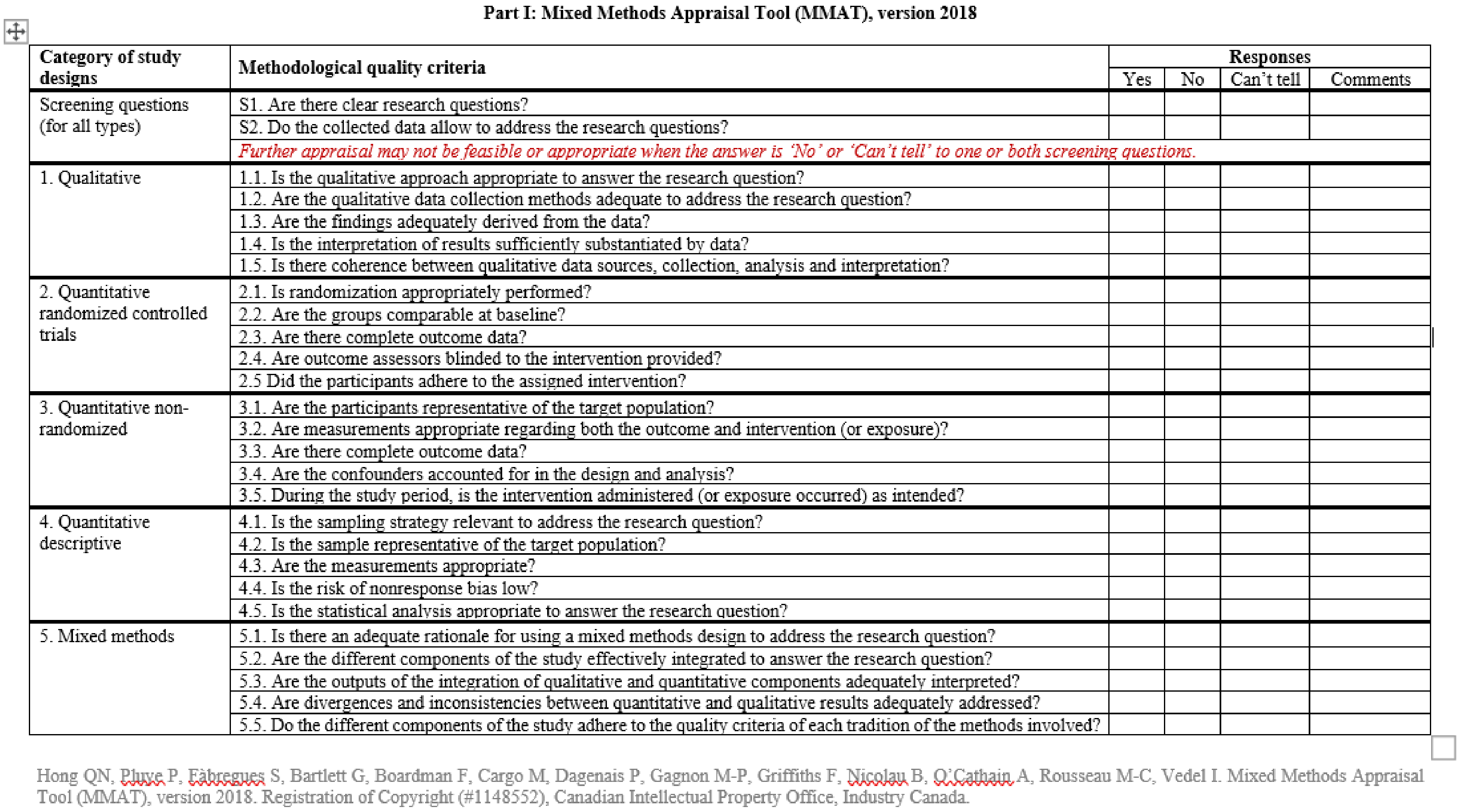
Main Text

1. The journal uses US spelling; however, authors may submit using either US or UK English, as spelling of accepted papers is converted during the production process.
2. Footnotes to the text are not allowed and any such material should be incorporated into the text as parenthetical matter.

References

References should be prepared according to the *Publication Manual of the American Psychological Association* (6th edition). This means in-text citations should follow the author-date method whereby the author's last name and the year of publication for the source should appear in the text, for example, (Jones, 1998). The complete reference list should appear alphabetically by name at the end of the paper. Please note that for journal articles, issue numbers are not included unless each issue in the volume begins with page 1, and a DOI should be provided for all references where available.

APPENDIX II: QUALITY APPRAISAL TOOL



Part I: Mixed Methods Appraisal Tool (MMAT), version 2018

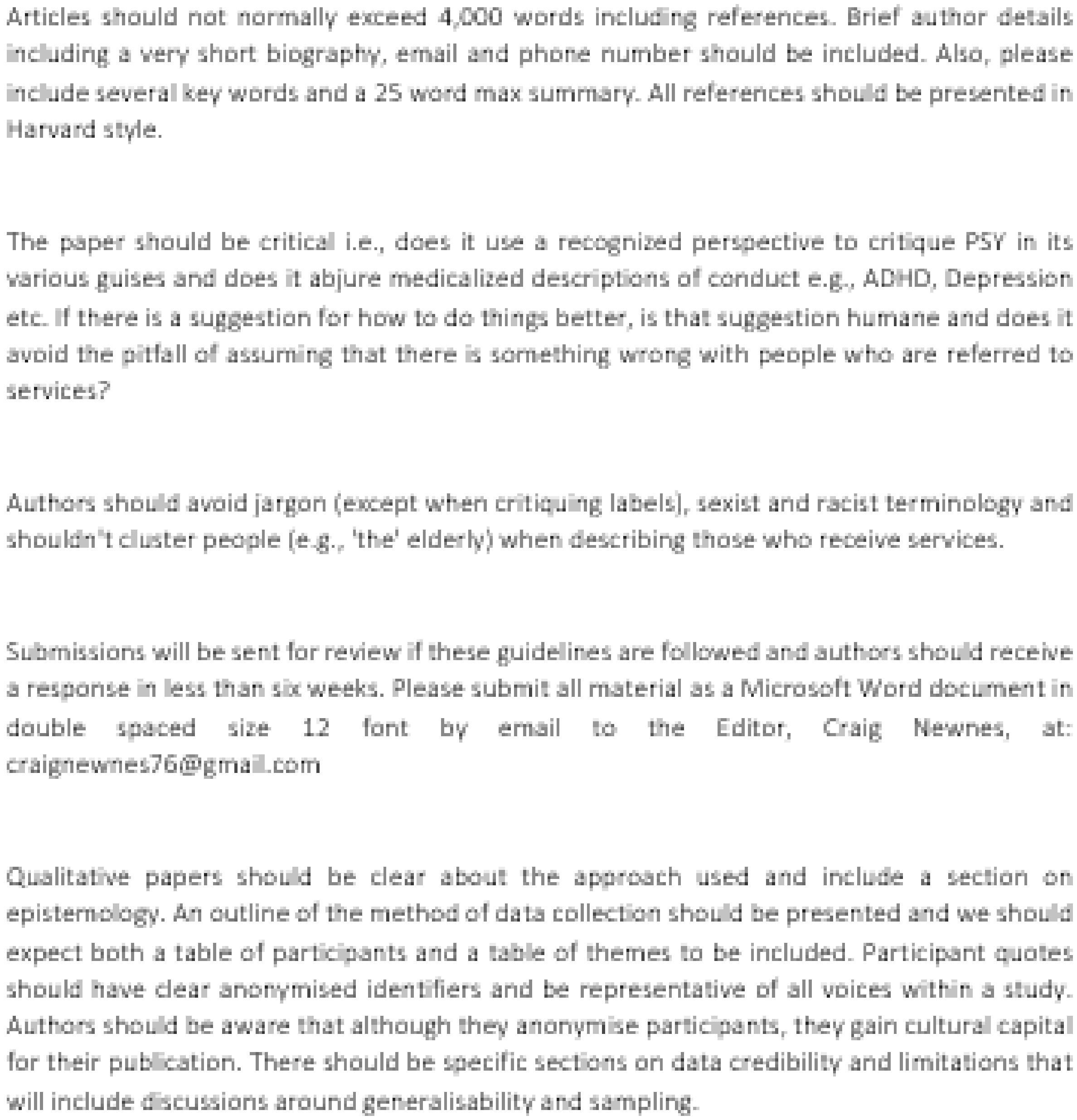
Category of study designs	**Methodological quality criteria**	**Responses**			
		Yes	No	Can't tell	Comments
Screening questions (for all types)	S1. Are there clear research questions?				
	S2. Do the collected data allow to address the research questions?				
	Further appraisal may not be feasible or appropriate when the answer is 'No' or 'Can't tell' to one or both screening questions.				
1. Qualitative	1.1. Is the qualitative approach appropriate to answer the research question?				
	1.2. Are the qualitative data collection methods adequate to address the research question?				
	1.3. Are the findings adequately derived from the data?				
	1.4. Is the interpretation of results sufficiently substantiated by data?				
	1.5. Is there coherence between qualitative data sources, collection, analysis and interpretation?				
2. Quantitative randomized controlled trials	2.1. Is randomization appropriately performed?				
	2.2. Are the groups comparable at baseline?				
	2.3. Are there complete outcome data?				
	2.4. Are outcome assessors blinded to the intervention provided?				
	2.5 Did the participants adhere to the assigned intervention?				
3. Quantitative non-randomized	3.1. Are the participants representative of the target population?				
	3.2. Are measurements appropriate regarding both the outcome and intervention (or exposure)?				
	3.3. Are there complete outcome data?				
	3.4. Are the confounders accounted for in the design and analysis?				
	3.5. During the study period, is the intervention administered (or exposure occurred) as intended?				
4. Quantitative descriptive	4.1. Is the sampling strategy relevant to address the research question?				
	4.2. Is the sample representative of the target population?				
	4.3. Are the measurements appropriate?				
	4.4. Is the risk of nonresponse bias low?				
	4.5. Is the statistical analysis appropriate to answer the research question?				
5. Mixed methods	5.1. Is there an adequate rationale for using a mixed methods design to address the research question?				
	5.2. Are the different components of the study effectively integrated to answer the research question?				
	5.3. Are the outputs of the integration of qualitative and quantitative components adequately interpreted?				
	5.4. Are divergences and inconsistencies between quantitative and qualitative results adequately addressed?				
	5.5. Do the different components of the study adhere to the quality criteria of each tradition of the methods involved?				

Hong QN, Pluye P, Fàbregues S, Bartlett G, Boardman F, Cargo M, Dagenais P, Gagnon M-P, Griffiths F, Nicolau B, O'Cathain A, Rousseau M-C, Vedel I. Mixed Methods Appraisal Tool (MMAT), version 2018. Registration of Copyright (#1148552), Canadian Intellectual Property Office, Industry Canada.

APPENDIX III: QUALITY APPRAISAL OUTCOMES

Study	Quality Appraisal	Reasons
Bowie, McLeod & McLeod 2016	High	Clear research question and appropriate methodology undertaken. Findings and interpretation appear relevant to collected data- however unsure about coherence in relation to switching? between concepts, e.g. 'harmful' and 'unhelpful'.
Crawford et al 2016	High	Adequate information and methodologically sound with regards to sample size and recruitment, design and analysis.
Grunebaum, H. 1986	Low	Appropriate design for the research question. However, limited sample and queries with regards to the process taken for analysis and therefore interpretation of results.
Hardy et al 2019	High	Appears methodologically sound and coherent with analysis information clearly derived from data and a lot of information regarding steps taken with regards to sample, method and analysis.
McGlanaghy et al 2021	High	Appropriate method for research question and qualitative data described adequately with methodologically sound steps taken. However, some queries regarding representativeness of sample (gender, ethnicity) and use of restricted recruitment, e.g. targeting specific groups online-potential risk of response bias.
Moritz et al 2015	High	Good use of previously validated measures. Well reported with limitations and strengths.
Moritz et al 2019	High	Replication of previous OCD study with sample of patients with depression. Similar results found- anomalies discussed in relation to differences in diagnosis etc.
Rozental et al 2016	Medium	Appropriate methodology for research question and quantitative methodology elements appear sound. However, use of lit review and open ended questions to develop measure and lack of reporting with regards to the development of this.

APPENDIX IIII: JCPCP AUTHOR GUIDELINES



Articles should not normally exceed 4,000 words including references. Brief author details including a very short biography, email and phone number should be included. Also, please include several key words and a 25 word max summary. All references should be presented in Harvard style.

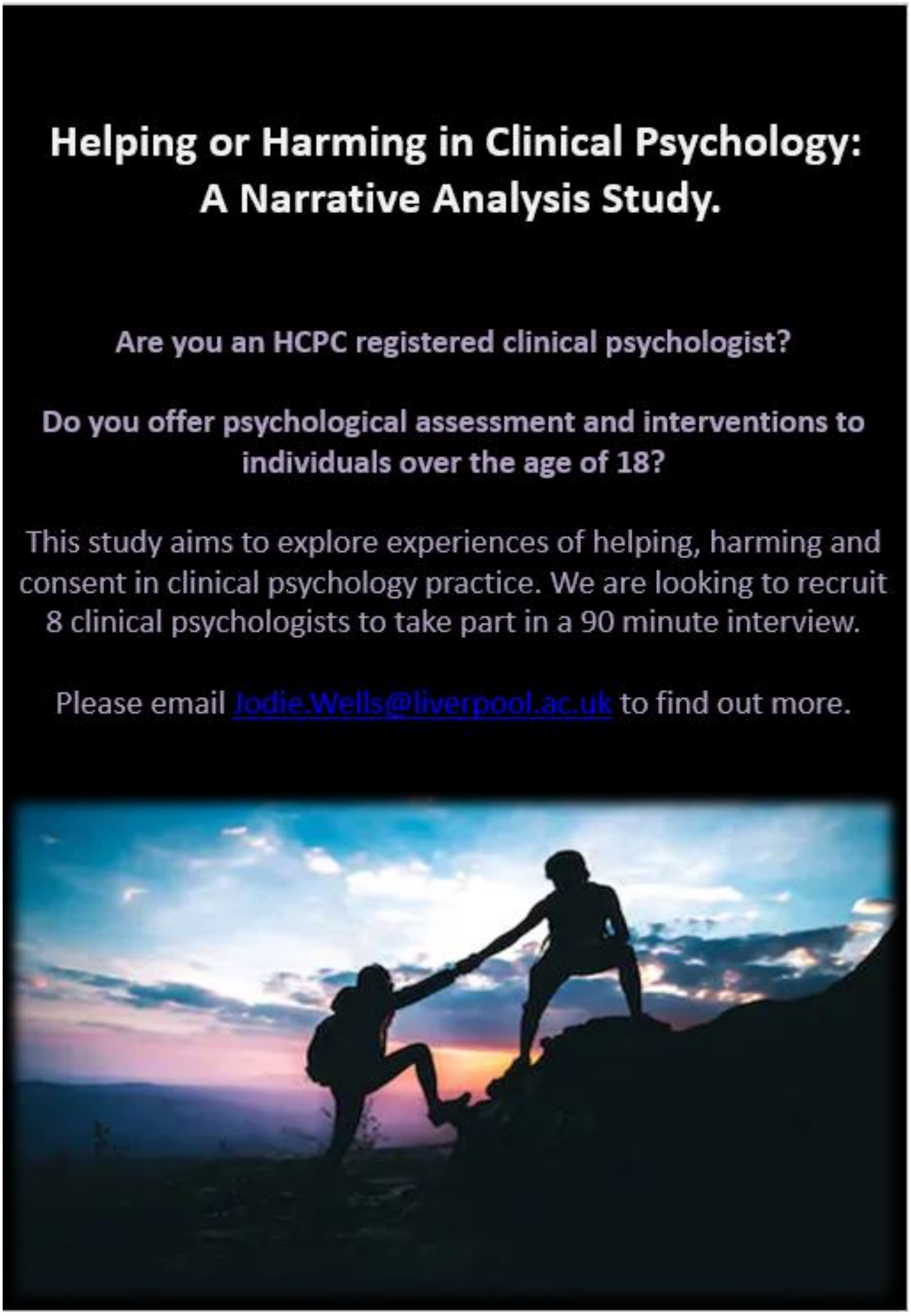
The paper should be critical i.e., does it use a recognized perspective to critique PSY in its various guises and does it abjure medicalized descriptions of conduct e.g., ADHD, Depression etc. If there is a suggestion for how to do things better, is that suggestion humane and does it avoid the pitfall of assuming that there is something wrong with people who are referred to services?

Authors should avoid jargon (except when critiquing labels), sexist and racist terminology and shouldn't cluster people (e.g., 'the' elderly) when describing those who receive services.

Submissions will be sent for review if these guidelines are followed and authors should receive a response in less than six weeks. Please submit all material as a Microsoft Word document in double spaced size 12 font by email to the Editor, Craig Newnes, at: craignewnes76@gmail.com

Qualitative papers should be clear about the approach used and include a section on epistemology. An outline of the method of data collection should be presented and we should expect both a table of participants and a table of themes to be included. Participant quotes should have clear anonymised identifiers and be representative of all voices within a study. Authors should be aware that although they anonymise participants, they gain cultural capital for their publication. There should be specific sections on data credibility and limitations that will include discussions around generalisability and sampling.

APPENDIX V: STUDY ADVERTISEMENT



Helping or Harming in Clinical Psychology: A Narrative Analysis Study.

Are you an HCPC registered clinical psychologist?

Do you offer psychological assessment and interventions to individuals over the age of 18?

This study aims to explore experiences of helping, harming and consent in clinical psychology practice. We are looking to recruit 8 clinical psychologists to take part in a 90 minute interview.

Please email Jodie.Wells@liverpool.ac.uk to find out more.

UNIVERSITY OF LIVERPOOL

Helping or Harming in Clinical Psychology:

A Narrative Analysis Study.

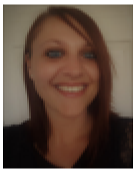
The University of Liverpool is conducting research exploring clinical psychologists' experiences of helping and harming in their clinical practice.

Why take part?
The proposed study aims to explore the relationship between harm and consent from the perspectives of practising clinical psychologists. It is hoped that this will be a novel way of exploring identity, harm and consent which could support further learning about how to prevent harm from occurring and improve the experiences of people accessing psychological interventions.

Eligibility
To take part, you must be an HCPC registered Clinical Psychologist who is actively engaged in carrying out psychological assessment and interventions with individuals over the age of 18. The individuals you work with must have capacity to consent to their engagement with the intervention you provide.

What will I be asked to do?
If you take part, you will be invited to an interview for 90 minutes about your experiences as practising clinical psychologists. The interview will take place via virtual video consultation.

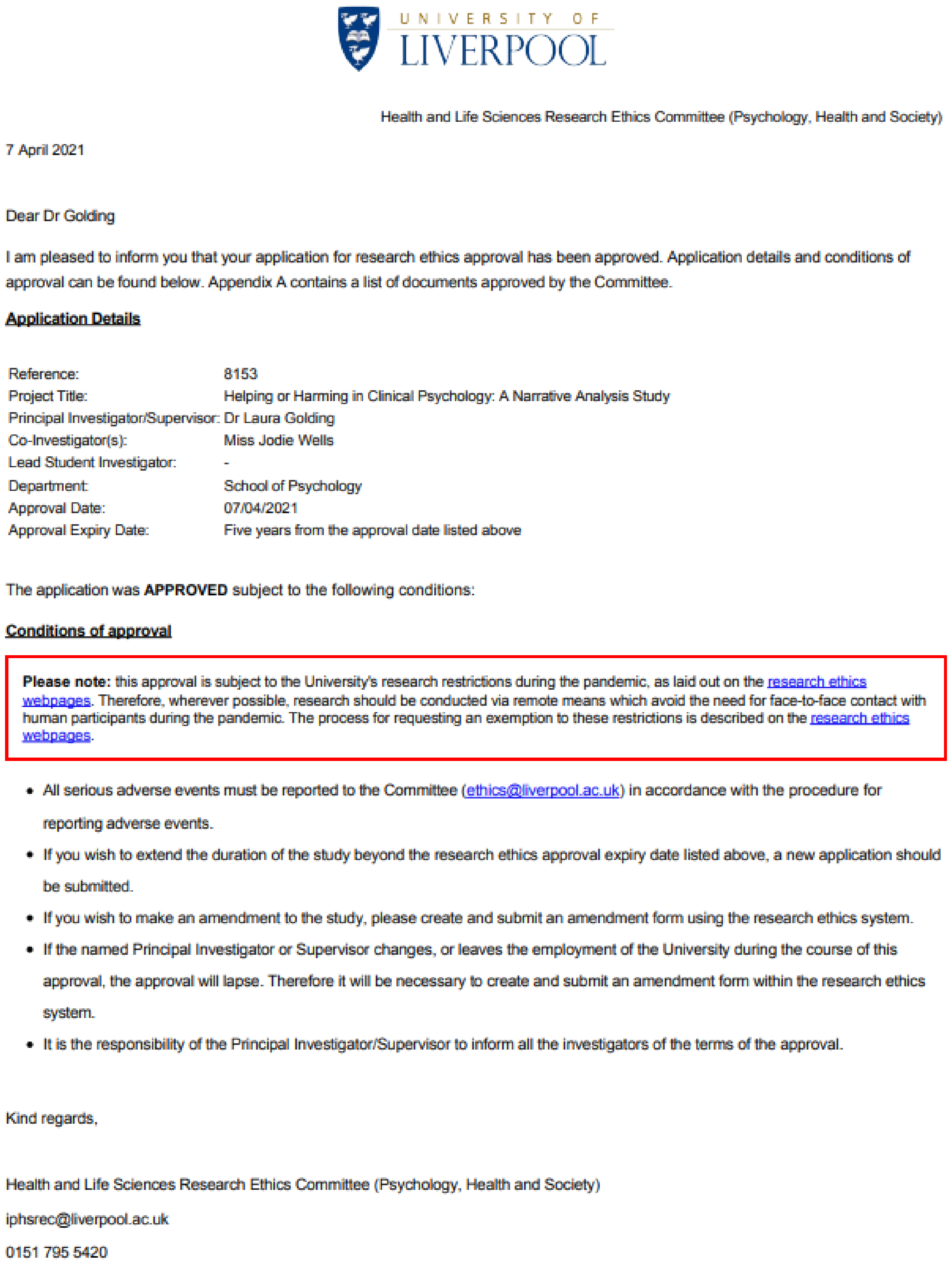
Expression of Interest
To find out more about the study or to express interest in taking part, please contact Jodie Wells (trainee clinical psychologist and student researcher) via:



Jodie.Wells@liverpool.ac.uk

Thank you

APPENDIX VI: ETHICAL APPROVAL



UNIVERSITY OF
LIVERPOOL

Health and Life Sciences Research Ethics Committee (Psychology, Health and Society)

7 April 2021

Dear Dr Golding

I am pleased to inform you that your application for research ethics approval has been approved. Application details and conditions of approval can be found below. Appendix A contains a list of documents approved by the Committee.

Application Details

Reference: 8153
Project Title: Helping or Harming in Clinical Psychology: A Narrative Analysis Study
Principal Investigator/Supervisor: Dr Laura Golding
Co-Investigator(s): Miss Jodie Wells
Lead Student Investigator: -
Department: School of Psychology
Approval Date: 07/04/2021
Approval Expiry Date: Five years from the approval date listed above

The application was **APPROVED** subject to the following conditions:

Conditions of approval

Please note: this approval is subject to the University's research restrictions during the pandemic, as laid out on the research ethics webpages. Therefore, wherever possible, research should be conducted via remote means which avoid the need for face-to-face contact with human participants during the pandemic. The process for requesting an exemption to these restrictions is described on the research ethics webpages.

- All serious adverse events must be reported to the Committee (ethics@liverpool.ac.uk) in accordance with the procedure for reporting adverse events.
- If you wish to extend the duration of the study beyond the research ethics approval expiry date listed above, a new application should be submitted.
- If you wish to make an amendment to the study, please create and submit an amendment form using the research ethics system.
- If the named Principal Investigator or Supervisor changes, or leaves the employment of the University during the course of this approval, the approval will lapse. Therefore it will be necessary to create and submit an amendment form within the research ethics system.
- It is the responsibility of the Principal Investigator/Supervisor to inform all the investigators of the terms of the approval.

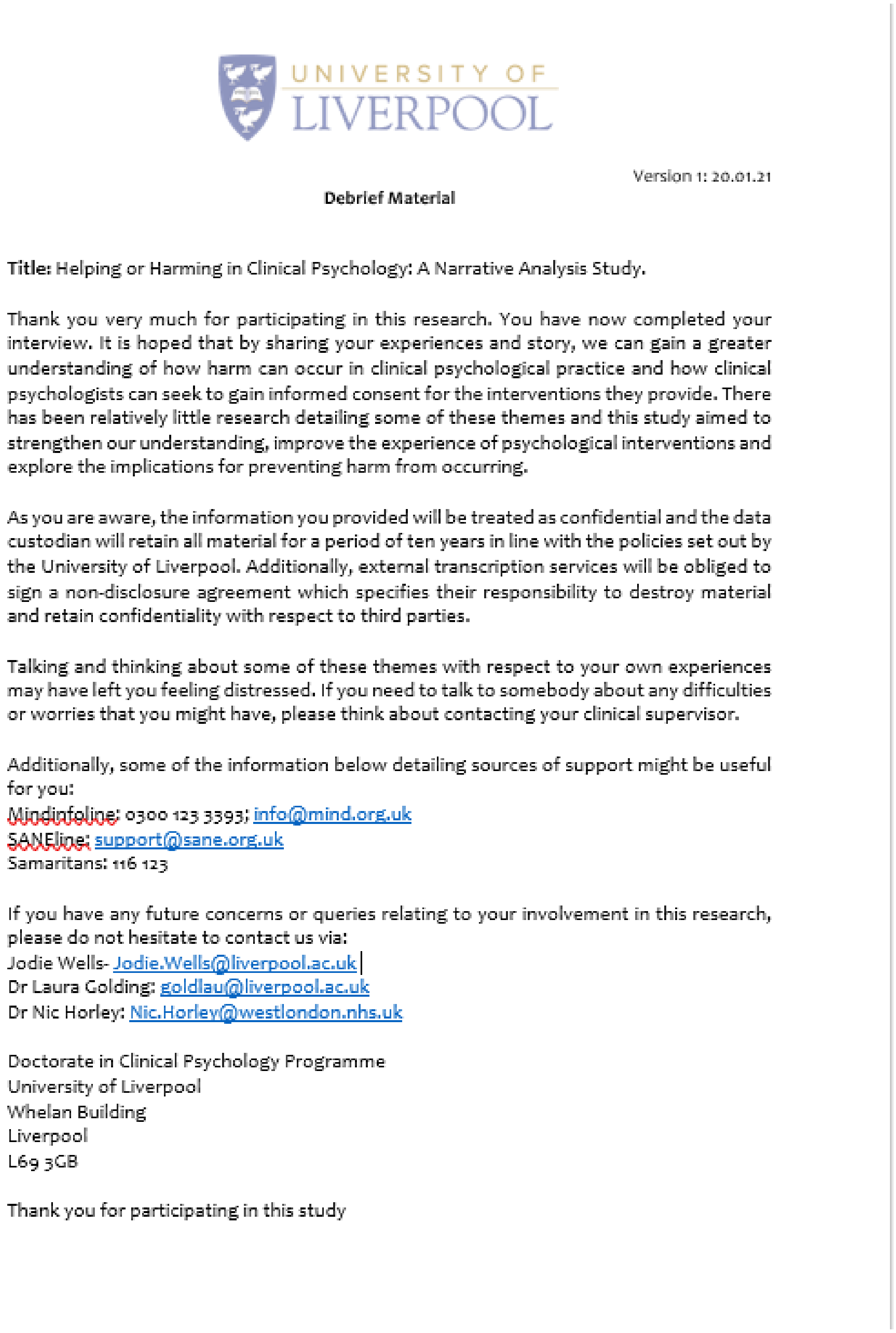
Kind regards,

Health and Life Sciences Research Ethics Committee (Psychology, Health and Society)

iphsrec@liverpool.ac.uk

0151 795 5420

APPENDIX VII: DEBRIEF INFORMATION



Version 1: 20.01.21

Debrief Material

Title: Helping or Harming in Clinical Psychology: A Narrative Analysis Study.

Thank you very much for participating in this research. You have now completed your interview. It is hoped that by sharing your experiences and story, we can gain a greater understanding of how harm can occur in clinical psychological practice and how clinical psychologists can seek to gain informed consent for the interventions they provide. There has been relatively little research detailing some of these themes and this study aimed to strengthen our understanding, improve the experience of psychological interventions and explore the implications for preventing harm from occurring.

As you are aware, the information you provided will be treated as confidential and the data custodian will retain all material for a period of ten years in line with the policies set out by the University of Liverpool. Additionally, external transcription services will be obliged to sign a non-disclosure agreement which specifies their responsibility to destroy material and retain confidentiality with respect to third parties.

Talking and thinking about some of these themes with respect to your own experiences may have left you feeling distressed. If you need to talk to somebody about any difficulties or worries that you might have, please think about contacting your clinical supervisor.

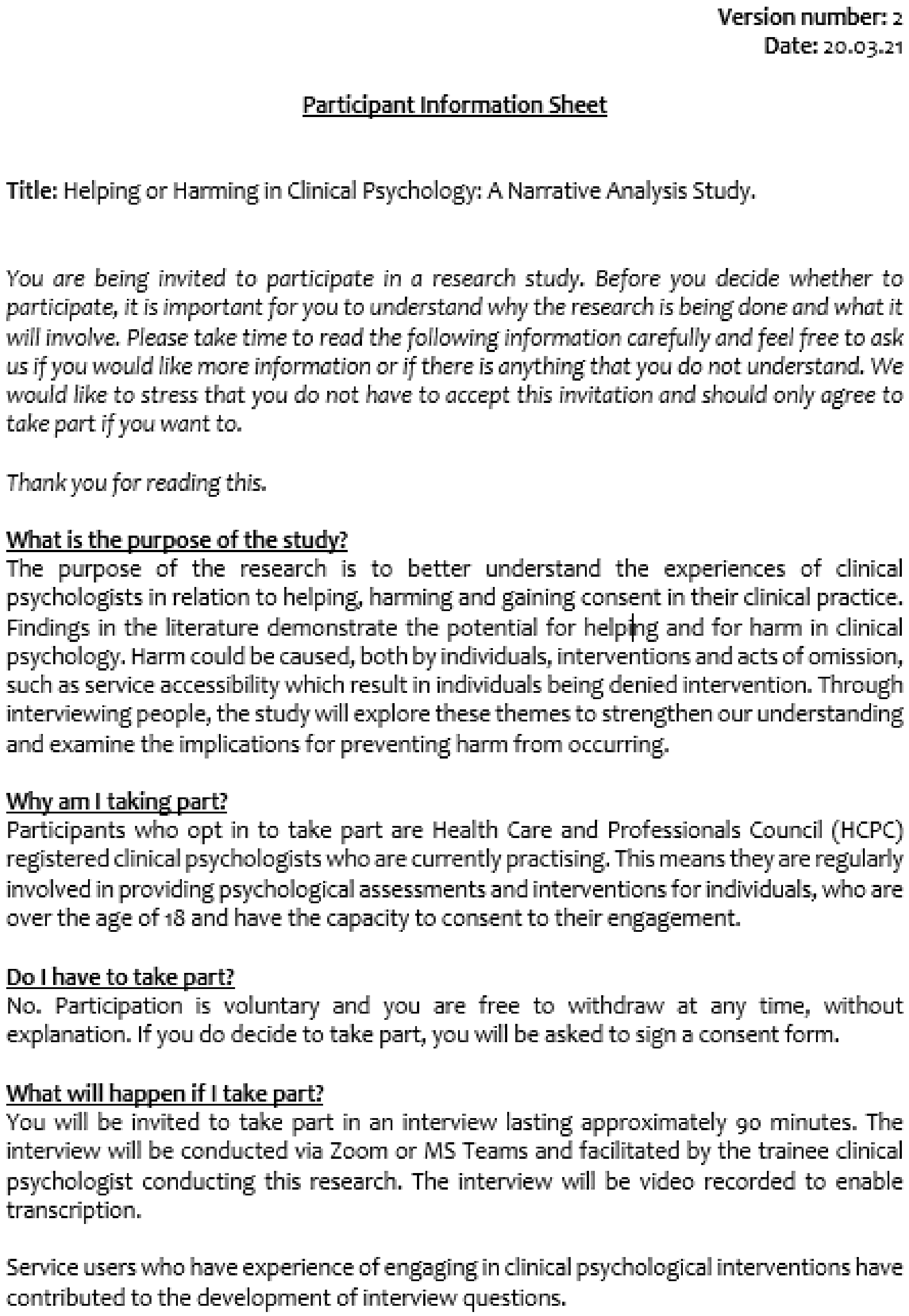
Additionally, some of the information below detailing sources of support might be useful for you:
Mindinfoline: 0300 123 3393; info@mind.org.uk
SANEline: support@sane.org.uk
Samaritans: 116 123

If you have any future concerns or queries relating to your involvement in this research, please do not hesitate to contact us via:
Jodie Wells- Jodie.Wells@liverpool.ac.uk
Dr Laura Golding: goldlau@liverpool.ac.uk
Dr Nic Horley: Nic.Horley@westlondon.nhs.uk

Doctorate in Clinical Psychology Programme
University of Liverpool
Whelan Building
Liverpool
L69 3GB

Thank you for participating in this study

APPENDIX VIII: INFORMATION SHEET



Version number: 2
Date: 20.03.21

Participant Information Sheet

Title: Helping or Harming in Clinical Psychology: A Narrative Analysis Study.

You are being invited to participate in a research study. Before you decide whether to participate, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and feel free to ask us if you would like more information or if there is anything that you do not understand. We would like to stress that you do not have to accept this invitation and should only agree to take part if you want to.

Thank you for reading this.

What is the purpose of the study?

The purpose of the research is to better understand the experiences of clinical psychologists in relation to helping, harming and gaining consent in their clinical practice. Findings in the literature demonstrate the potential for helping and for harm in clinical psychology. Harm could be caused, both by individuals, interventions and acts of omission, such as service accessibility which result in individuals being denied intervention. Through interviewing people, the study will explore these themes to strengthen our understanding and examine the implications for preventing harm from occurring.

Why am I taking part?

Participants who opt in to take part are Health Care and Professionals Council (HCPC) registered clinical psychologists who are currently practising. This means they are regularly involved in providing psychological assessments and interventions for individuals, who are over the age of 18 and have the capacity to consent to their engagement.

Do I have to take part?

No. Participation is voluntary and you are free to withdraw at any time, without explanation. If you do decide to take part, you will be asked to sign a consent form.

What will happen if I take part?

You will be invited to take part in an interview lasting approximately 90 minutes. The interview will be conducted via Zoom or MS Teams and facilitated by the trainee clinical psychologist conducting this research. The interview will be video recorded to enable transcription.

Service users who have experience of engaging in clinical psychological interventions have contributed to the development of interview questions.

How will my data be used?

The university processes personal data as part of its research and teaching activities with the lawful basis of 'public task' and in accordance with the University's purpose of advancing education, learning and research for public benefit. Under UK data protection legislation, the University acts as the Data Controller for personal data collected as part of the University's research. Dr Laura Golding acts as the data custodian for this study, and any queries relating to the handling of your personal data can be sent to: goldlau@liverpool.ac.uk.

Further information on how your data will be used can be found in the table below:

How will my data be collected?	Through a recorded video consultation interview
How will my data be stored?	Data will be stored on the University of Liverpool's secure drive in a password protected folder.
How long will my data be stored for?	Data will be stored for 10 years, following which it will be destroyed in line with the University of Liverpool policies.
What measures are in place to protect the security and confidentiality of my data?	The following steps have been taken to protect the security and confidentiality of your data: • Data will be stored on a secure drive and password protected. • Anonymised data will be used wherever possible • Confidential information will not be used for marketing or insurance purposes. • It is made clear why and how data is being used. • We will respect your decision if you decide to opt out. • We will only use information about you, where allowed by law.
Will my data be anonymised?	Yes- following one month post interview, your data will be anonymised
How will my data be used?	Data will be used for the purposes described within this information sheet and for no other purpose.

Who will have access to my data?	The lead researcher and members of the supervisory team, with a specific need can access the data. Some recordings will be outsourced to an external transcription service. In this instance, the transcribers will be required to sign a non-disclosure agreement that protects anonymity, and requires recordings to be destroyed once transcribed.
Will my data be archived for use in other research projects in the future?	No. Your data will be archived and stored but will not be used for future research projects.
How will my data be destroyed?	All data will be transferred to the secure University drive, password protected and destroyed from the recording device after interviews. After 10 years, all electronic files will be deleted.

<u>What are the risks and benefits to taking part?</u>
We see no foreseeable risks to you taking part in this study. You will be asked some questions on themes which could potentially be experienced as distressing, however there is no obligation to share any information beyond what you feel comfortable with. If you should experience any emotional distress, please inform the interviewer, who will pause the interview and discuss this with you.

In the event of a disclosure of an incident of harm, whereby there is identification of serious risk to the participant or others, confidentiality may be breached. In this instance, the researcher will disclose the information to the supervisory team. Should further measures be necessary to safeguard against harm, you will be informed that confidentiality will be breached and appropriate agencies will be informed of the concerns.

Participant interviews could contribute to research which improves our understanding of safe and effective interventions in clinical psychological practice and identify potential areas that could improve the experience of any person accessing a psychological intervention.

<u>What will happen to the results of the study?</u>
The data and results will be written up in partial fulfilment of the University of Liverpool's Doctorate in Clinical Psychology. No participant identifiable data will be included. Publication will also be sought from a peer reviewed journal and ideas for disseminating findings will be discussed with experts by experience. Findings may be presented at academic conferences or practise-based events.

What if I want to stop taking part?

You can withdraw from taking part and request any data gathered be destroyed and no further use be made of it, up to one month after your interview. Following this period, data will be transcribed and anonymised and it will not be possible to withdraw data after anonymisation.

Please contact a member of the research team to withdraw from the study.

What if I'm unhappy or if there is a problem?

Please feel free to let us know by contacting Dr Laura Golding (email address below) and we will try to help. If you remain unhappy or have a complaint which you feel you cannot come to us with then you should contact the Research Ethics and Integrity Office at ethics@live.ac.uk . When contacting the Research Ethics and Integrity Office, please provide details of the name or description of the study (so that it can be identified), the researchers involved, and the details of the complaint you wish to make.

The university strives to maintain the highest standards of rigour in the processing of your data. However, if you have any concerns about the way in which the University processes your personal data, it is important that you are aware of your right to lodge a complaint with the Information Commissioner's Office by calling 0303 123 1113

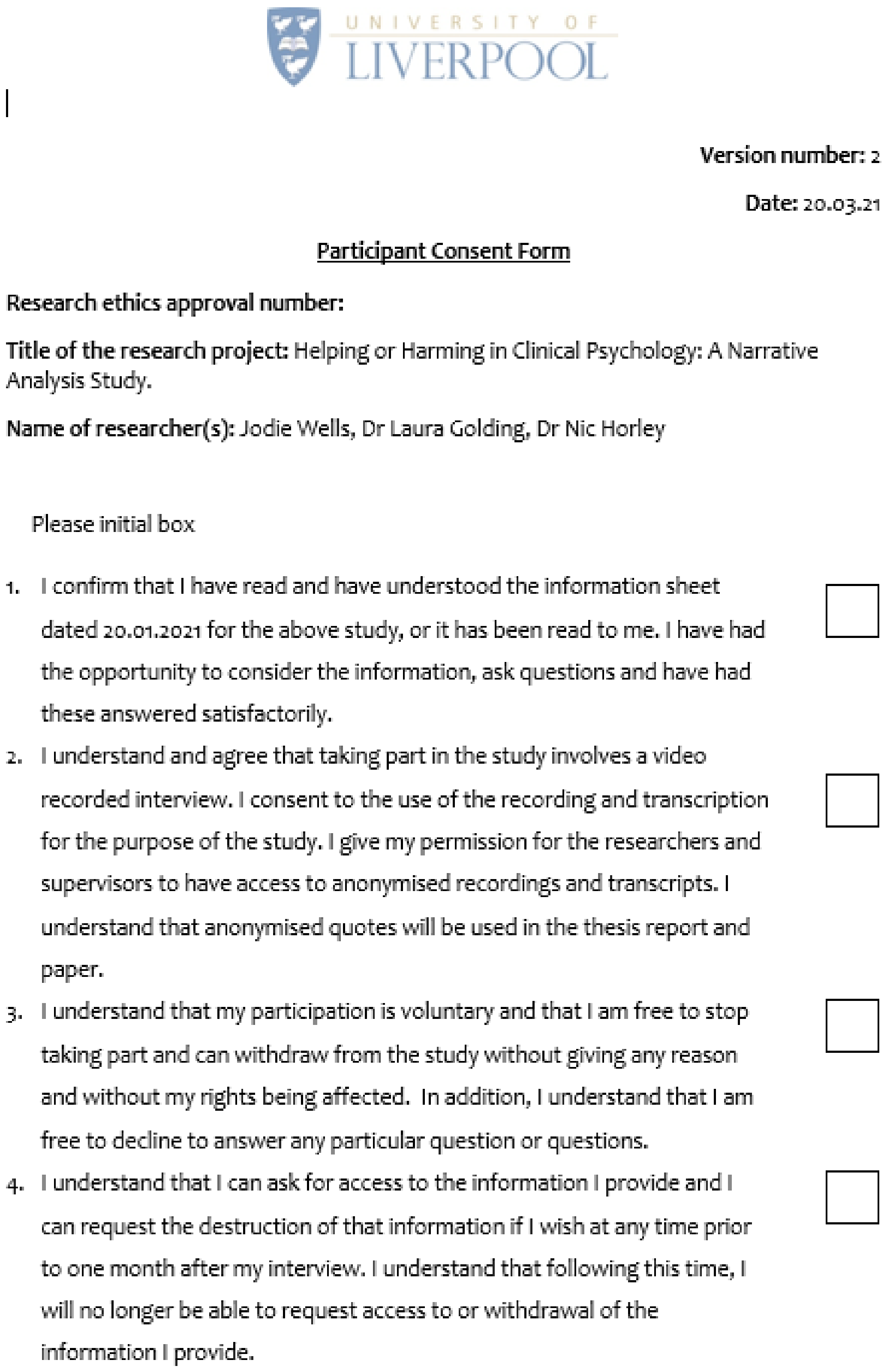
Who can I contact if I have further questions?

Please contact the research team via email:

Jodie Wells: Jodie.Wells@liverpool.ac.uk
Dr Laura Golding: goldlau@liverpool.ac.uk.
Dr Nic Horley: Nic.Horley@westlondon.nhs.uk

Thank You

APPENDIX VIIII: CONSENT FORM



Version number: 2

Date: 20.03.21

Participant Consent Form

Research ethics approval number:

Title of the research project: Helping or Harming in Clinical Psychology: A Narrative Analysis Study.

Name of researcher(s): Jodie Wells, Dr Laura Golding, Dr Nic Horley

Please initial box

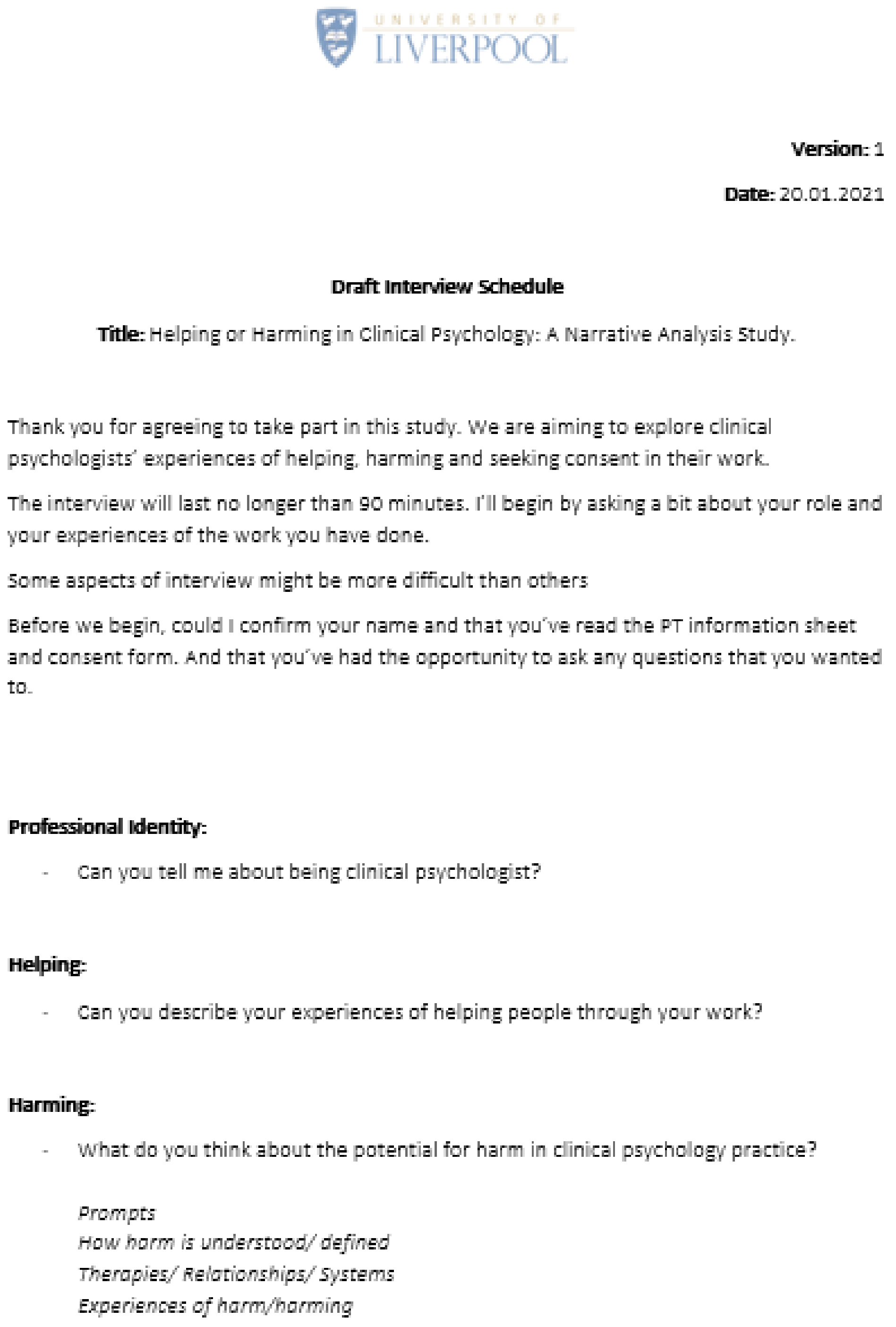
1. I confirm that I have read and have understood the information sheet dated 20.01.2021 for the above study, or it has been read to me. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐
2. I understand and agree that taking part in the study involves a video recorded interview. I consent to the use of the recording and transcription for the purpose of the study. I give my permission for the researchers and supervisors to have access to anonymised recordings and transcripts. I understand that anonymised quotes will be used in the thesis report and paper. ☐
3. I understand that my participation is voluntary and that I am free to stop taking part and can withdraw from the study without giving any reason and without my rights being affected. In addition, I understand that I am free to decline to answer any particular question or questions. ☐
4. I understand that I can ask for access to the information I provide and I can request the destruction of that information if I wish at any time prior to one month after my interview. I understand that following this time, I will no longer be able to request access to or withdrawal of the information I provide. ☐

5. I understand that the information I provide will be held securely and in line with data protection requirements at the University of Liverpool and handled in accordance with the provisions of the Data Protection Act. ☐
6. I understand that signed consent forms, original video recordings and a transcript of my interview will be retained in a password protected file until anonymisation. ☐
7. I understand that my data may be outsourced to an external transcription service. I understand that they will be required to sign a non-disclosure agreement that protects anonymity and requires recordings to be deleted following transcription. I consent to my data being used in this way. ☐
8. I agree to take part in the above study. ☐

Participant name	Date	Signature
Name of person taking consent	Date	Signature

Principal Investigator	**Student Investigator**
Dr Laura Golding	Jodie Wells
University of Liverpool Whelan Building Liverpool L69 3GB	University of Liverpool Whelan Building Liverpool L69 3GB
goldlau@liverpool.ac.uk	Jodie.Wells@liverpool.ac.uk

APPENDIX X: INTERVIEW SCHEDULE



Version: 1

Date: 20.01.2021

Draft Interview Schedule

Title: Helping or Harming in Clinical Psychology: A Narrative Analysis Study.

Thank you for agreeing to take part in this study. We are aiming to explore clinical psychologists' experiences of helping, harming and seeking consent in their work.

The interview will last no longer than 90 minutes. I'll begin by asking a bit about your role and your experiences of the work you have done.

Some aspects of interview might be more difficult than others

Before we begin, could I confirm your name and that you've read the PT information sheet and consent form. And that you've had the opportunity to ask any questions that you wanted to.

Professional Identity:

- Can you tell me about being clinical psychologist?

Helping:

- Can you describe your experiences of helping people through your work?

Harming:

- What do you think about the potential for harm in clinical psychology practice?

  Prompts
  How harm is understood/ defined
  Therapies/ Relationships/ Systems
  Experiences of harm/harming

Consent:

- What is your experience of seeking consent for psychological interventions?

  Prompts
  Decision-making about what information to give
  What's reasonable and why
  Client feedback/ reviewing outcomes

That's all of my questions
Do you have any other thoughts about this topic?

How did the interview feel for you?

Do you have any questions for me?

Would you like to be contacted to speak about dissemination of this project?

Thank you very much for taking part in this interview. You are welcome to contact me at any time in the future if you have any more thoughts about this study. I will send all interviewees a debrief sheet with some information about support should you need any, and my contact details.

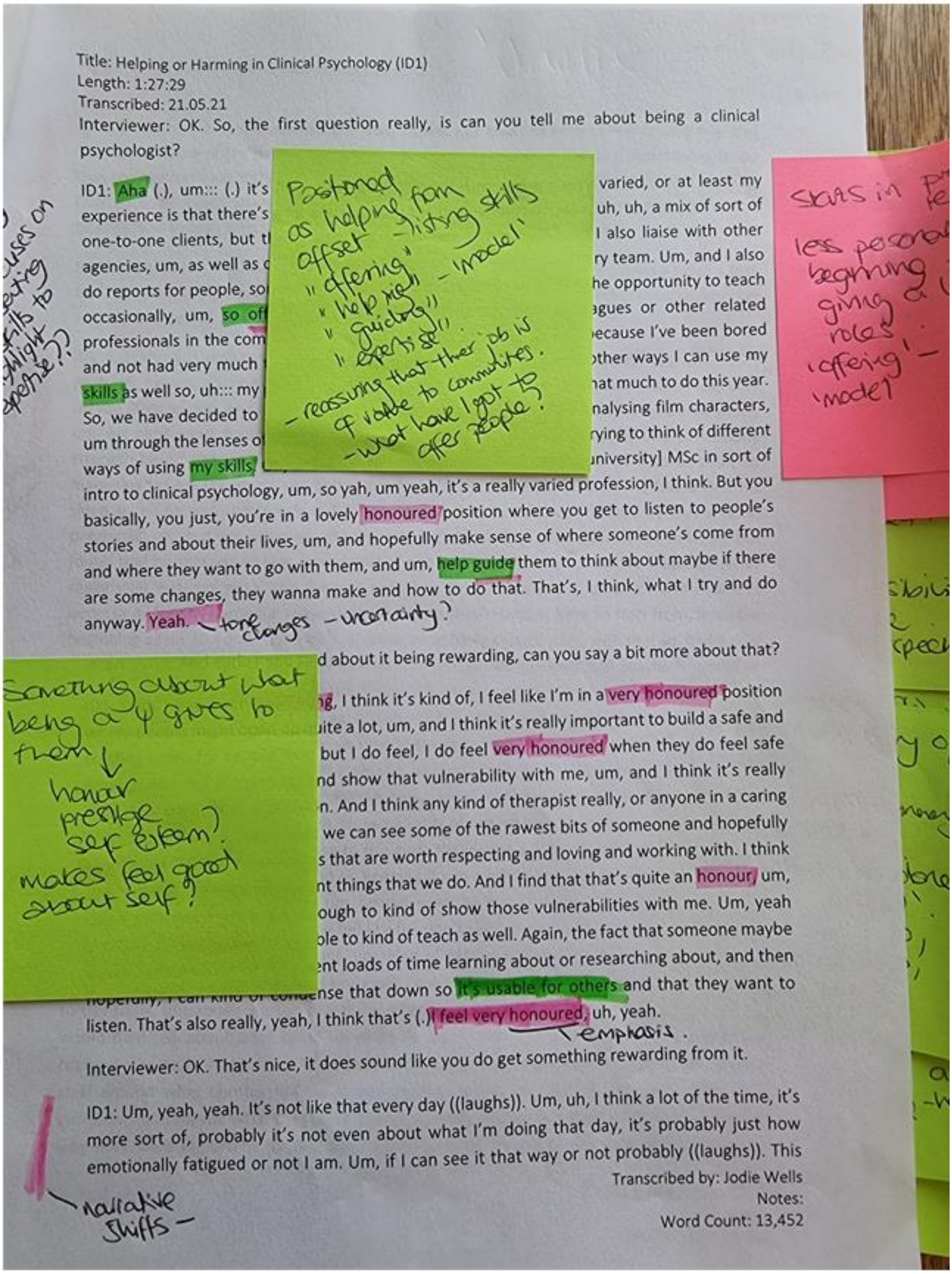
Summary letter?

Summary of main findings?

APPENDIX XI: CODING INFORMATION

Content **Themes/ Storylines/ Events** "what is the effect of this on the narrators self- construct?" What is it aiming to do? What happens as a result of telling it?	**Performance (structure, language, audience)** Who is it being told for? Where does it shift/ change?	**Local and wider cultural contexts** Identity construction

APPENDIX XII: TRANSCRIPT AND ANALYSIS



Title: Helping or Harming in Clinical Psychology (ID1)
Length: 1:27:29
Transcribed: 21.05.21

Interviewer: OK. So, the first question really, is can you tell me about being a clinical psychologist?

ID1: Aha (.), um::: (.) it's … varied, or at least my
experience is that there's … uh, uh, a mix of sort of
one-to-one clients, but t… I also liaise with other
agencies, um, as well as … ry team. Um, and I also
do reports for people, so… he opportunity to teach
occasionally, um, so of… agues or other related
professionals in the com… ecause I've been bored
and not had very much … other ways I can use my
skills as well so, uh::: my … hat much to do this year.
So, we have decided to … nalysing film characters,
um through the lenses o… rying to think of different
ways of using my skills … niversity] MSc in sort of
intro to clinical psychology, um, so yah, um yeah, it's a really varied profession, I think. But you basically, you just, you're in a lovely honoured position where you get to listen to people's stories and about their lives, um, and hopefully make sense of where someone's come from and where they want to go with them, and um, help guide them to think about maybe if there are some changes, they wanna make and how to do that. That's, I think, what I try and do anyway. Yeah.

…d about it being rewarding, can you say a bit more about that?

…ng, I think it's kind of, I feel like I'm in a very honoured position
…ite a lot, um, and I think it's really important to build a safe and
… but I do feel, I do feel very honoured when they do feel safe
…nd show that vulnerability with me, um, and I think it's really
…n. And I think any kind of therapist really, or anyone in a caring
… we can see some of the rawest bits of someone and hopefully
…s that are worth respecting and loving and working with. I think
…nt things that we do. And I find that that's quite an honour, um,
…ough to kind of show those vulnerabilities with me. Um, yeah
…ble to kind of teach as well. Again, the fact that someone maybe
…nt loads of time learning about or researching about, and then
…nse that down so it's usable for others and that they want to
listen. That's also really, yeah, I think that's (.) I feel very honoured, uh, yeah.

Interviewer: OK. That's nice, it does sound like you do get something rewarding from it.

ID1: Um, yeah, yeah. It's not like that every day ((laughs)). Um, uh, I think a lot of the time, it's more sort of, probably it's not even about what I'm doing that day, it's probably just how emotionally fatigued or not I am. Um, if I can see it that way or not probably ((laughs)). This

Transcribed by: Jodie Wells
Notes:
Word Count: 13,452

Positioned
as helping from
offset – listing skills
"offering"
"help rich" – 'model'
" guiding"
" expertise"
– reassuring that their job is
of value to communities.
– what have I got to
offer people?

uses on
eting
skills to
highlight
expertise??

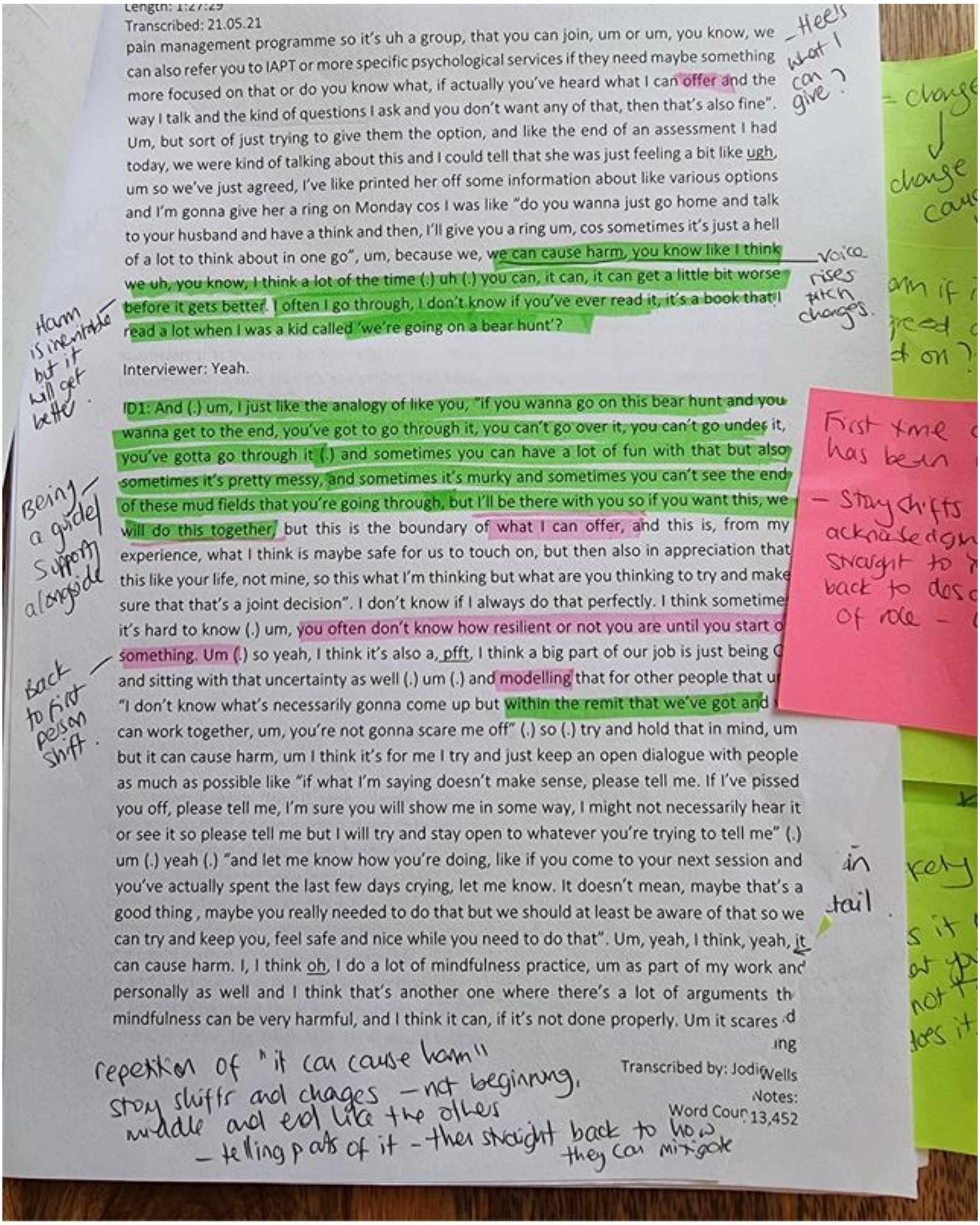
Starts in
less personal
beginning
giving a
roles
'offering' –
'model'

tone changes – uncertainty?

Something about what
being a ψ gives to
them
↓
honour
prestige
self esteem?
makes feel good
about self?

emphasis.

narrative
shifts –



Length: 1:27:29
Transcribed: 21.05.21

pain management programme so it's uh a group, that you can join, um or um, you know, we can also refer you to IAPT or more specific psychological services if they need maybe something more focused on that or do you know what, if actually you've heard what I can offer and the way I talk and the kind of questions I ask and you don't want any of that, then that's also fine". Um, but sort of just trying to give them the option, and like the end of an assessment I had today, we were kind of talking about this and I could tell that she was just feeling a bit like ugh, um so we've just agreed, I've like printed her off some information about like various options and I'm gonna give her a ring on Monday cos I was like "do you wanna just go home and talk to your husband and have a think and then, I'll give you a ring um, cos sometimes it's just a hell of a lot to think about in one go", um, because we, we can cause harm, you know like I think we uh, you know, I think a lot of the time (.) uh (.) you can, it can, it can get a little bit worse before it gets better. I often I go through, I don't know if you've ever read it, it's a book that I read a lot when I was a kid called 'we're going on a bear hunt'?

Interviewer: Yeah.

ID1: And (.) um, I just like the analogy of like you, "if you wanna go on this bear hunt and you wanna get to the end, you've got to go through it, you can't go over it, you can't go under it, you've gotta go through it (.) and sometimes you can have a lot of fun with that but also sometimes it's pretty messy, and sometimes it's murky and sometimes you can't see the end of these mud fields that you're going through, but I'll be there with you so if you want this, we will do this together, but this is the boundary of what I can offer, and this is, from my experience, what I think is maybe safe for us to touch on, but then also in appreciation that this like your life, not mine, so this what I'm thinking but what are you thinking to try and make sure that that's a joint decision". I don't know if I always do that perfectly. I think sometime it's hard to know (.) um, you often don't know how resilient or not you are until you start o something. Um (.) so yeah, I think it's also a, pfft, I think a big part of our job is just being C and sitting with that uncertainty as well (.) um (.) and modelling that for other people that u "I don't know what's necessarily gonna come up but within the remit that we've got and can work together, um, you're not gonna scare me off" (.) so (.) try and hold that in mind, um but it can cause harm, um I think it's for me I try and just keep an open dialogue with people as much as possible like "if what I'm saying doesn't make sense, please tell me. If I've pissed you off, please tell me, I'm sure you will show me in some way, I might not necessarily hear it or see it so please tell me but I will try and stay open to whatever you're trying to tell me" (.) um (.) yeah (.) "and let me know how you're doing, like if you come to your next session and you've actually spent the last few days crying, let me know. It doesn't mean, maybe that's a good thing , maybe you really needed to do that but we should at least be aware of that so we can try and keep you, feel safe and nice while you need to do that". Um, yeah, I think, yeah, it can cause harm. I, I think oh, I do a lot of mindfulness practice, um as part of my work and personally as well and I think that's another one where there's a lot of arguments th mindfulness can be very harmful, and I think it can, if it's not done properly. Um it scares d

ing

Transcribed by: Jodie Wells
Notes:
Word Coun 13,452

– Here's what I can give ?

Voice rises pitch changes.

Harm is inevitable but it will get better.

Being a guide/ support alongside

Back to first person shift.

in
tail.

= change
↓
change
cau

om if
reed
d on ?

First time
has been

– Story shifts
acknowledgm
straight to
back to desc
of role –

kely
s it
at yo
not
does it

repetition of "it can cause harm"
story shifts and changes – not beginning, middle and end like the others
– telling parts of it – then straight back to how they can mitigate