Clients' experiences of psychodynamic therapies: A phenomenological study

Jodie Louise Fellows[1], Camilla Watters[2] and Amanda Gatherer[3]*

1. Birmingham and Solihull Mental Health NHS Foundation Trust
2. Coventry University
3. Birmingham and Solihull Mental Health NHS Foundation Trust

* Correspondence should be addressed to Dr. Jodie Fellows, Small Heath Health Centre, 42 Chapman Road, Small Heath, Birmingham, B10 0PG

Abstract

This study aimed to explore clients' experiences of psychodynamic therapies. Six adults were interviewed about their experiences of psychodynamic/brief psychodynamic therapy at varying stages of the process. Interpretative Phenomenological Analysis with peer review was used to analyse the transcripts. The therapeutic relationship was central to the experience of therapy, and a number of other factors were highlighted as contributing to the experience. Participants also described their journeys through therapy; from initial anxiety to developing trust, exploring difficulties and developing understanding of these. The process of making change in line with the new understanding was experienced as difficult and frustrating, but ultimately worthwhile. Ending therapy for all participants was associated with intense feelings such as, terror, anger and abandonment. This was followed by a development of self-reliance once therapy had terminated. The potential clinical benefits of detailed knowledge of clients' experiences are discussed and potential future research options are considered.

Introduction

Background

Psychodynamic and Brief Psychodynamic Therapy

Psychodynamic theories underpin both Psychodynamic Therapy (PDT) and Brief Psychodynamic Therapy (BPT). These theories have many defining features, but the importance of early childhood experiences in repeating relationship patterns are central to these approaches.

A primary aim of Psychodynamic (PDT) and Brief Psychodynamic Therapy (BPT) is to increase clients' understanding of themselves in their relationships. It is theorised that this understanding will lead clients to change their interpersonal behaviour, thus facilitating the development of more adaptive relationships.

Experiences of psychodynamic therapy

The process clients undergo in PDT has been suggested as a number of stages involving unconscious experiences and feelings, these have been based upon practitioner/researcher perspectives (Mann, 1973; Leiper & Maltby, 2004). Psychotherapy process has also been widely researched, e.g., Høglend et al. (2006), Luborsky and Crits-Christoph (1990) but little of the published research into psychodynamic approaches has asked clients about their conscious experiences of PDT. Macran, Ross, Hardy and Shapiro (1999) suggest that "we cannot fully know about clients' experiences and therefore fully understand how psychotherapy facilitates change without asking them" (p. 330). Llewelyn (1988) provides support for this assertion and found that perceptions of the most frequently occurring aspects of therapy differed between clients and therapists. Clients perceived reassurance and problem solving as occurring most often, whereas therapists reported that moments of cognitive and affective insight occurred most frequently.

Qualitative studies of the experience of some models of therapy, have been conducted (e.g., CBT: Berg, Raminani, Greer, Harwood & Safren, 2008; Messari & Hallam 2003; Cognitive Therapy: Clarke, Rees & Hardy, 2004; and Solution Focussed: Metcalf & Thomas, 1994). Few qualitative studies have been conducted relating to the experience of PDT. A possible reason for this may be the assumption underlying qualitative methods that there is a link between what people say and how they feel (Smith & Osborn, 2003). This could be seen as juxtaposed to the traditional psychodynamic perspective, which may emphasise unconscious processes that the client cannot, by definition, be aware of. Traditional perspectives may also interpret clients' reported experiences as defensiveness, fantasy or transference (McLeod, 1990).

Interpretive Phenomenological Analysis (IPA) is a qualitative method that may strike a balance between these two positions, as the

researcher can remain open to the potential for defensiveness and transference to have some impact upon reported experience. Therefore this may be an appropriate method to study psychodynamic approaches.

Although research of its kind is unusual, four qualitative studies into clients' experiences of PDT or psychoanalytic therapy have been conducted that are closely linked to the aims of this research, and these are discussed below.

Merriman and Beale (2009) studied the experience of long term PDT (over two years) amongst clients with learning disabilities in the UK. They found that whilst clients were initially anxious about the process, it was found to be helpful to talk. Some reported what seemed to be a dependent alliance with their therapist, which appeared to impact on therapy endings. Participants were primarily positive about the experience of therapy and appeared not to want to say anything negative about therapy in case it was withdrawn. The following three studies were conducted in non-learning disability settings.

Bury, Raval and Lyon (2007) conducted an Interpretative Phenomenological Analysis (IPA: Smith & Osborn, 2003) study with six participants aged 16-21 years about their experiences of psychoanalytic therapy. They found that societal and media portrayal of therapy led to ambivalence in seeking help. Almost all participants reported finding the therapy stressful at times and the feeling of powerlessness was common. Some found it difficult to open up and described therapy as physically and emotionally exhausting. The ending of therapy led to a re-emergence of ambivalent feelings, including: feelings of loss and concerns about coping without therapy, as well as positive thoughts about moving on (Bury, Raval & Lyon, 2007).

Poulsen, Lunn and Sandros (2010) explored experiences of psychodynamic therapy in adult clients with Bulimia Nervosa. They found predominantly positive reports of the therapy once it was completed; however some reported difficulties with the approach as they felt alone with their struggle, or found the unstructured approach and the silences difficult. The therapist listening, taking them seriously or appropriately attuning to humour was seen as particularly helpful. The authors discussed these findings particularly in relation to the difficulties experienced by clients with a Bulimia Nervosa diagnosis.

Nilsson, Svensson, Sandell and Clinton (2007) used qualitative interviews to compare clients' experiences of change across two therapeutic models: PDT and Cognitive Behaviour Therapy (CBT). Participants described PDT as an open, sometimes painful exploration of their inner selves and described therapists providing connections and summaries, from a distanced position. Some clients thought this distance was appropriate, whereas others felt frustrated by it. Participants who were satisfied with PDT reported finding connections and patterns again and again and working through them to get to the root of things, whereas those who were unhappy with PDT reported frustration at the lack of structure. Overall, those in PDT were more ambivalent about the therapy and their therapist.

The above studies detail how participants experienced PDT or psychoanalytic therapy and no qualitative studies were found to report client experiences of BPT. In all but Merriman and Beale (2009), the experiences of therapy were reported retrospectively between 3-24 months after therapy had completed. Therefore clients had a significant amount of time to process and reflect, the reported experiences may not fully represent the emotional intensity of the experience at the time. Given that the aim is to further understanding of how it is experienced whilst clients are still processing and making sense of therapy, it seems appropriate to develop an enquire about experiences during and shortly after therapy has completed.

Aims

The following study aims to explore clients' experiences of PDT and BPT. It is hoped this information will be used to inform clinical practice.

Method

Design

This qualitative study used semi-structured interviews and IPA was used to guide the data analysis. IPA is an idiographic approach employing detailed analysis of each transcript, before moving to similarly detailed analyses of other cases. It is particularly useful for assessing the meaning people make of process and novel or complex situations (Smith & Osborn, 2003). The flexibility of the interview provides freedom for the participant to tell their story and the interviewer to follow unexpected areas that arise in discussion (Shaw, 2001).

IPA was deemed appropriate for this study because it aims to explore experiences of a novel situation, (in this case, therapy and formulation) and process (interpersonal relationship with the therapist).

Participants

Participant details

Demographic information is provided in Table 1. Therapists were responsible for giving out the information sheets; therefore, it is only possible to estimate how many potential participants were invited into the study. A total of 45 information sheets were sent to the services involved in the study. Six potential participants requested to find out more about the study and six took part. No information was available on reasons for non-participation.

Table 1. Participant demographic information

Sex	Female	5
	Male	1
Age range in years	30-65	
Ethnicity	White British	5
	White Other	1
Number of sessions completed (range)	7 – 120	
Psychodynamic/ Brief Psychodynamic Therapy	PDT	4
	BPT	2
Therapy ongoing/ terminated	Ongoing	3
	Terminated	3
Range of timepoint that interview was conducted relative to therapy completion	7/12 sessions into therapy – therapy completed 10 weeks prior to interview	

Table 1. Participant demographic information

Inclusion & exclusion criteria

Inclusion criteria were as follows: aged 18-65 years old; currently being treated in a UK National Health Service (NHS) community service with PDT/BPT; or: had completed and been discharged from PDT/BPT up to three months before meeting the researcher. The aim was not to compare experiences across models. Clients in ongoing therapy were not informed about the study if their therapists thought that it would have irrevocably affected the transference relationship.

Interviews

A semi-structured interview was developed in line with guidance in Smith and Osborn (2003). Questions and potential prompts were determined through discussion with the research team and consulting research studies in similar areas; however, the interview was non-directive and followed the information presented by the participant. Thus, the interview was co-constructed by the researcher and the participant.

Procedure

The study was conducted in line with the British Psychological Society ethical guidelines (2006). Ethical approval was obtained from Coventry University and the relevant NHS Research Ethics Committees via the National Research Ethics Service. It was further approved by three Research and Development Departments for each NHS trust involved in the study.

Nine therapists, known to offer PDT/BPT in the NHS were asked to facilitate recruitment and seven assented. Their experience ranged from 4-21 years of practice. Therapists informed clients that the study was taking place and gave them a Brief Participant Information Sheet. Contact with the researcher was made directly by the client. All therapists continued to work with their clients as they would irrespective of the research.

Potential participants who had been discharged from therapy were identified by their therapist, who sent out a standard invitation letter with a return slip. In this way the researchers were blind to potential participants' identities, until they had agreed to be contacted and therapists were blind to the clients who chose to participate in the research.

The primary researcher met individually with potential participants, to provide further information and answer questions about the study.

After informed consent had been obtained, the primary researcher conducted all interviews and monitored the effect of the interview through verbal and non-verbal responses. Interviews lasted 60-90 minutes and were audio recorded for later transcription. Participant feedback was incorporated into subsequent interviews. Time was made to debrief participants at the end of the interview and contact details for appropriate support services were available should the participant become distressed after the interview.

All identifying information was kept confidential and once an interview had been transcribed, the recording was deleted. The transcripts were anonymised and given pseudonyms.

Analysis

The transcripts were analysed using IPA, which involved a number of stages as detailed in Table 2. The computer programme QSR NVIVO 7 (2007) was used to manage the data and themes.

Table 2. Stages involved in IPA analysis, adapted from Smith and Osborn (2003).

Stage 1	Read and re read the first transcript, note interesting and significant points, e.g., summaries of what was said, associations or connections that came to mind whilst reading and comments about the sense of the person that came across or their use of language.
Stage 2	Add emerging theme titles to concisely represent the data. Ensure that the themes are firmly grounded in the text.
Stage 3	List all of these themes and look for connections between them, thus allowing for theoretical connections to be made as superordinate themes emerge. Check these themes are still grounded in the data. Produce a hierarchically organised list of the themes.
Stage 4	Provide a name for the superordinate themes and locate examples of the theme in the transcripts.
Stage 5	Repeat the above stages for all other interview transcripts
Stage 6	Consolidate the list of themes and re-analyse all transcripts in light of them. Consolidate a final list of clusters and superordinate themes representing all participants (Table 3.) and develop narrative account of the participants' experiences.

Table 2 stages involved in IPA analysis, adapted from Smith and Osborn (2003)

Reliability and Validity

All qualitative research can potentially be affected by the researcher's beliefs and views (Richards & Schwartz, 2002). The study employed a number of techniques aimed to reduce the subjective element as recommended by Elliot, Fischer and Rennie, (1999), Hale, Treharne and Kitas (2008), and Richards and Schwartz (2002). The researcher clearly stated their attitudes, biases and theoretical orientation. A reflective journal was used to record decisions about methodology and personal reflections to explore assumptions made about aspects of the data. An independent peer audit was conducted separately by two people on three transcripts. The auditors concluded that the themes were well grounded in the data.

The primary researcher

The primary researcher was a final year Trainee Clinical Psychologist with ambivalent feelings about psychodynamic approaches. The researcher was therefore interested in clients' views of the impact and process of psychodynamic therapy. The primary researcher did not work in any of the services involved in participant recruitment; however, it is possible that their role as a trainee clinical psychologist had an impact on the interview.

Results

Following analysis with IPA, two superordinate themes emerged: Relationship and Journey. The themes have been arranged hierarchically with the subordinate themes and are tabulated by superordinate theme below (Tables 3 & 4). The superordinate themes will be discussed with illustrative quotes alongside their subordinate themes in the following sections. To protect participants' identity, all participants and therapists have been referred to as female and pseudonyms have been used.

Relationship

Themes relating to the therapeutic relationship were mentioned more frequently than anything else by most participants.

Experience of the relationship

Participants talked about the importance of being listened to, not feeling judged and being able to talk without feeling the need to censor what they said. Containment and safety (or lack of containment) featured frequently in the accounts. Geraldine who was in ongoing therapy described the benefits of containment:

It can feel like sort of a weight has been lifted off your shoulders, that someone else has recognised and understood where you are coming from and sort of feeling contained.

The experiences of not being judged and feeling contained seemed to contribute to the therapeutic relationship feeling different from any other relationship in the participants' lives. As Deborah who was in ongoing BPT describes below:

Superordinate theme	Subordinate theme 1	Subordinate theme 2	Number of interviews	Number of times identified
Relationship	Experience of relationship	Being listened to	4	19
		Not being judged	4	28
		Talking without censoring	6	20
		Containment and safety	6	53
		Relationship different	6	24
		Expressing dissatisfaction	3	22
	Client factors	Assertiveness in therapy	6	17
		Motivation/readiness/expectations	6	39
		Previous experience of therapy	4	14
	Relational techniques	Challenges	6	22
		Non directive, no answers given	6	31
		Transference relationship	4	28
	Therapist	Openness or robustness	4	19
		Thoughts and feelings about therapist	6	48

Table 3. Relationship cluster, subordinate themes and frequency

You can't always talk to people at home, so you can have someone to talk with that's not making a judgement either way and just listen...she sort of every week I go, she remembers what I've said and she'll come back with things that I've said weeks ago

Client factors

Readiness and expectations seemed to be important precursors to the experience of the therapeutic relationship. Using self-help material and prior experiences of therapy appeared to increase a sense of readiness, as Caroline, who had completed therapy states:
The experience of the therapy was building on what I'd already learned over the years and I was obviously ready to hear what she said
Previous experiences of therapy, may have made the process of therapy seem less daunting; however, it also seemed to limit expectations of what could be achieved, in a realistic or sometimes quite pessimistic way, as Deborah describes:
I had counselling before but I didn't really find that helpful at all, um, it was just a series of questions and that felt uncomfortable

Use of the relationship

Specific psychodynamic techniques that can be seen as drawing on the therapeutic relationship were referred to, including challenges, no answers given and use of transference. Participants made several references to the therapist being non-directive or tentative. This was primarily experienced as useful; however, there were times when participants wanted to be given an answer, and felt frustrated when this did not happen. Participants described challenges as primarily helpful, but feeling uncomfortable at times. Jenny was in ongoing therapy and described her physical and emotional response to being challenged:

I think "I'm a bit busted", you know, she's seen what I'm up to. If I'm being a bit manipulative...initially I have a kind of physical reaction, where, physically I feel a bit shaken... then I know I have got to go and think about it and try to work out what I am doing.

All participants described avoiding some of their feelings and pretending or wanting to pretend that things were okay, Deborah described feeling unable to do this during the sessions because of the challenges:
You block a lot of things out and then you're thinking "well there's nothing wrong with me" you know "I'm fine," but then you're obviously asked the questions and then you say things and it becomes apparent

Geraldine found challenges helpful in developing safety in the relationship:
She was saying, you know, it's difficult to trust me ... I am struggling with it and we explored it and talked about it and talked about where it might have come from and things, I trust her more now than I did to begin with

Phoebe described her therapist as robust, and had a positive experience of her therapist discussing transference issues with her as outlined below:
The fact that that happened [a repeat of an interpersonal pattern] within the therapy situation, reinforced what she was telling me but in a way that we could explore what it meant

Despite this, she, as with other participants, struggled to openly discuss her negative feelings towards her therapist. Phoebe had completed therapy within the last two months and believed it was right not to discuss these feelings:
I felt protective towards her… I think overall, the fact that I couldn't turn around and scream and shout at her, probably has had a more positive effect on how we've left things. If I had been able to, I'd really vented at her, and that would have spoiled the experience

Similarly, Barbara described her struggle to openly discuss her feelings about her therapist, but saw this in relation to her confidence:
I wouldn't have the confidence to say "actually you're sitting there telling me how angry I am, but part of this now is because of you" [laughs].

Therapist

Participants valued their therapists being open and robust enough to cope, as Caroline states below:
If I just broke down and started sobbing, people wouldn't be able to deal with it, and she did and she just stayed with me through it, and that was quite phenomenal

Thoughts and feelings about the therapist varied between participants; despite the fact that Jenny and Barbara had the same therapist, their experiences of her differed. Jenny described her feelings towards her therapist:
I liked a lot of characteristics about her, because she was very thorough and intelligent.

Whereas Barbara had a less positive experience of her:
She was very very very, which I know is her job I appreciate that, but she was very very ... aloof I suppose is the word... she was too detached... she couldn't have been more detached if she tried.

The experience of the relationship was central to the experience of therapy. As Caroline described below, therapy for some participants, resembled a journey.

Journey

The only thing I can put the change down to is the journey I went through and the depths. I can't emphasise enough the depth of the journey that I went through. It was a bit like walking through a tunnel and being cleansed.

Participants described a process of change where they initially felt anxious and uncertain about what therapy involved and then developed trust in the therapist to varying degrees.

This first stage is described as moving from uncertainty to making a leap of faith. Geraldine described her initial anxiety in therapy:
I remember the first few times I met her, feeling so anxious and just on the edge of the chair just holding really really tight, like, like you do when you go to the dentist... "Can you tell me a bit about yourself?" that was actually her first question and I remember thinking "What the f*** do I say now? What does that mean?!"

The therapeutic relationship and client factors seemed to contribute to the process of clients feeling able to trust their therapist enough to begin in therapy. Participants described then beginning to talk about "difficult" information in therapy. Participants described therapy as painful/difficult at times and became deeply upset in therapy, as Caroline describes:
I went deeper into my patterns and things and that's when I'd get really upset. It wasn't like an upset. It was a deep internal sob from the centre; it was like the very core of me.

Most participants described finding the content of therapy painful or difficult, either through the information they spoke about or through the process of developing an understanding of their difficulties.

Formulation/developing understanding

Participants developed their understanding gradually through discussions with their therapist; however, all participants described a process of fitting things into place. Deborah used the analogy of a jigsaw to describe this process:

Putting the jigsaw together, all the pieces coming together and you're starting understanding who you actually are... it's like making a model of somebody and "oh that's me!"

Super ordinate theme	Subordinate theme 1	Subordinate theme 2	Number of interviews	Number of times identified
Journey	Uncertainty	Anxiety at start of therapy	5	35
	Painful	Difficult emotionally	5	11
	Formulation/ Developing understanding	Process	6	21
		Unconscious to conscious	5	30
		Responsibility and choice	5	19
		Finding out where I've "gone wrong"	5	17
		Impact	5	22
	Changing habits of a lifetime	Frustration/difficulty	6	22
	Ending	Feelings re: ending	6	39
		Time limit on therapy	5	15
		Readiness	5	29
		Change after ending	3	12
		Booster sessions	4	13
		Internal therapist	6	15
	Still work to do, reality		6	36

Table 4. Journey cluster, subordinate themes and frequency

Sometimes this happened straight away and was described as being like a switch or a light bulb going on, other times, a lot of thought and discussion was needed before information went from an unconscious to conscious awareness. Clients experiencing BPT and PDT described light bulb moments as well as slow dawning realisations. Caroline described how the content of her therapy began to make sense at an emotional, as well as intellectual level:

A lot of what we talked about, I knew it up here [pointing to head] but that's the change that I made in therapy, it was about the information going from here [head] to here [pointing to chest] and that's why it's had such a big impact.

This new understanding of finding out where I've gone wrong opened up possibilities of change. Jenny discussed the impact how understanding increased reflection and influenced future decisions:

...if you can just take a step back and look at why you're making ridiculous choices then you don't tend to make them any more

Participants experienced the development of understanding their difficulties as both positive and negative, because, whilst highlighting opportunity for change, it placed responsibility for this change upon the client, ambivalence about having choice and responsibility is described by Barbara:

... because you've actually learned that you are responsible for yourself basically, sometimes that can be very annoying because you just think "I just want to feel sorry for myself today, I don't want to take responsibility",... so that's a double edged sword in some respects

As participants developed their understanding of their difficulties, they began trying to make changes. This was described as difficult

and at times frustrating, as participants recognised how pervasive some of their difficulties were. Geraldine described recognising her repeating relationship pattern after an interaction, and feeling frustrated with the difficulty of changing habits of a lifetime:
You just think "oh for f***'s sake, why did I do that again? It's so obvious!"... I feel annoyed with myself because the conversation or my reaction to them is based in the past rather than the relationship I am having with them there and then.

As discussed above, participants experienced a range of powerful emotions throughout therapy; the anticipation of the end of therapy was no exception to this.

Ending
Ending was associated with a range of feelings, some participants described frustration that not enough had changed, others described feeling of abandonment, but all participants described strong feelings of fear. Barbara, who had completed therapy two weeks prior to the interview outlined her reasons for feeling frustrated with the time limit put on therapy:
Part of my frustration is that you are limited in terms of finances, you get x number of sessions and that's it, and it doesn't matter where you are at and so you get left in limbo.

Despite the difference in the amount of time participants had in therapy, the feelings and readiness to end that participants described were similar. Geraldine did not feel ready to end therapy, which was due to occur in a few months time:
At the moment it feels like it's going to get swept away, the carpet or the rug whatever it's called will be pulled from under my feet.

Participants who had finished therapy described a process of grief, loss, "aloneness" and fear. When she was asked how she felt about the next few weeks after the end of therapy, Barbara replied:
Frightened to death, I can honestly say frightened to death [begins to cry]

Caroline had completed therapy ten weeks prior to the interview, she described a process of change after ending, involving the development of independence and reliance upon oneself to continue making progress:
I went through a bit of a grieving process and then I went through a stage where I felt in a void, not knowing what to do really, and then I suppose I can't put it down to a significant event, but something must have happened ... I started to feel passionate about things, almost like a generator inside beginning to whirl and move me forward.

This process of change after the ending appeared to be facilitated by a continuing bond with the therapist, for example, booster sessions were viewed as a "safety net" and time to consolidate learning from therapy. Booster sessions also appeared to facilitate the client to think that the therapist cared about what happened to them after therapy ended.
Phoebe described feeling "special" as a result of booster sessions being offered:
Therapists have other patients, which demand their time and energy so you never know if you are special to them or not... [therapist] did feel that I was, you know special in a way because she wants know to what happens to me afterwards, at least initially.

All participants described the need to work on making changes. Most described having an internal therapist, imagining what their therapist would say, or reminding themselves of their goals and how to make changes. Caroline explained how her internal therapist helped with the recognition that there was still work to do after therapy ended
The fact that I don't see her doesn't mean that I don't have those processes and those tools. She's given me a survival kit and it's up to me to use it.

Relationship factors were central to the experience of the journey of therapy and these two clusters were closely linked in participants' narratives.

Discussion

This study aimed to explore: clients' experiences of PDT and BPT within the NHS and the way clients described their process of change. The themes that emerged: Relationship and Journey will be dicussed and linked with the aims in the following sections. Methodological considerations, clinical implications and future research will then be discussed.

Interpretation of findings

Relationship
Both client and therapist factors contributed to the variation in experiences described. Non-specific factors relating to the therapeutic relationship such as containment and not being judged, were frequently mentioned in participants' narratives and these are commonly cited as important by clients within all therapy models, supporting findings in previous literature, (Bury et al., 2007; Elliot & James, 1989; Glass & Arnkoff, 2000; Llewelyn, 1988). This study further endorsed the importance of these. In many ways these themes appeared to have links with Rogerian ideas such as Unconditional Positive Regard (Rogers, 1967), rather than dimensions associated with psychodynamic models of therapy.

Client factors such as assertiveness, readiness and expectations seemed to impact on the client's experience of containment and use of the transference relationship. Where disagreement and conflict were not discussed, participants did not think that their therapist

was aware of their underlying anger or dissatisfaction. Participants described this in the context of their own traits being repeated in therapy, rather than something specific to the therapeutic relationship. Frustration at the distant or aloof nature of the therapy was reported by some participants as in Bury et al (2007) and Nilsson et al (2007). This study found that due to protectiveness, confidence or not wanting to "spoil" therapy, some participants did not openly share their negative thoughts and feelings about their therapist. Discussion of therapists picking up on clients feelings to encourage open discussion was notably absent from the transcripts. This highlights the need for research of this kind.

Participants' experience of change in therapy was described as a journey relating to a transformation, followed by a period of grief and increasing self-reliance. Bury et al. (2007) described the process of therapy feeling "like a roller coaster ride" (p. 87) and the emotional experiences described in this study concur. The results detail stages experienced during this process or journey and the accompanying emotions experienced in the context of the stage of therapy, the transference and the relationship in which therapy takes place.

Participants' experiences of developing an understanding of their formulation involved a mixture of the "penny dropping" and needing a long time for some things to make sense to them at an intellectual and emotional level. Their experience of working within this formulation at times brought a feeling of freedom and possibility of change, but other times it was experienced as difficult because of the level of responsibility for change that rested with participants. Understanding is seen as a central part of the change process, (Leiper & Maltby, 2004); however, there is "virtually no research at all on clients' views of formulations" (Johnstone, 2006, p. 212). The results presented here provide the beginnings of a framework for understanding how clients may experience this within a psychodynamic model.

The theme changing habits of a lifetime, again relates to the experience of working within an informed formulation. Particiants in Nilsson et al (2007) reported finding connections and patters over and over again to get to the root of things. In this study, participants reported becoming consciously aware of their repetition compulsion and being driven to behave in familiar ways, whilst simultaneously feeling ambivalent about taking responsibility to change or feeling frustrated by difficulties in making change. The choice and responsibility theme as well as the changing the habits of a lifetime theme seems to link with a hypothesised stage discussed by Leiper and Maltby (2004), the Differentiation Stage involves relinquishing familiar ways in order to make space for new ways of being. This study described the ambivalence and frustration participants experienced whilst attempting to distance themselves from old ways of being and repeatedly recognising their defences and repeating relationship patterns.

Participants described not feeling ready for the ending, regardless of the length of time they had therapy for or whether they were in BPT or PDT. Participants feared they would not manage without the support of therapy. Although participants in Bury et al (2007) described panicky feelings (p. 91) the accounts were retrospective. The fear described in the present study appeared to be more intense, possibly because either the endings had not yet happened, or had happened more recently than for participants in similar studies. One possible reason for the intense fear about ending has been put forward by Mann (1973) who suggested that the intense fears experienced at the end of therapy relate to the client's fear of another unresolved ending. Ending well in therapy is an essential part of the process to healing.

The experiences participants reported seemed to support some of the theorised processes and the experiential research. Participants reported a range of strong emotions throughout their journey in therapy; however, the level of containment experienced by the participant seemed to mediate this to some extent.

Methodological considerations

Much of the research on clients' experiences has been done retrospectively over the whole of therapy. This study was initially conceptualised to explore clients experiences of BPT, which has not been reported in published qualitative studies; however, due to recruitment difficulties, it was extended to include the experiences of PDT and asked clients at points in therapy from half way through BPT, to ten weeks after ending PDT. It therefore provides perspectives on psychodynamic therapy at different points in time. The study would have further benefited from a longitudinal design.

In terms of the methodology used, reflexivity is a limited safeguard against the researcher's unconscious needs and drives (Forshaw, 2007). An audit of the analysis was conducted by an independent researcher and another member of the research team, therefore this represents the agreed interpretation of three people, but does not demonstrate objectivity (Brocki & Wearden, 2006). Thus, the results represent an interpretation of the information obtained, providing a viewpoint rather than an objective and scientific truth.

Clinical Implications

Further knowledge of the processes clients experience may help therapists to become more sensitised to them. Therapists cannot assume to know fully what their client is experiencing. Participants believed that where they did not discuss their dissatisfaction, the therapist did not raise it either, given that the model encourages open discussion of such feelings, it may be that therapists were not fully aware of these feelings, or for whatever reason, chose not to discuss these feelings with the client. Further study may bring further clarity to this.

Therapists may not acquire further information on their clients after therapy has terminated, some therapists in the study offered booster sessions.. Mann (1973) argues that endings are difficult for therapists because they raise doubt in their minds about how

effective they can be and exposes them to unconscious conflicts of the same nature that clients experience. If therapists are expected to contain clients' anxieties about ending, a thorough knowledge of the processes clients go through prior to and shortly after therapy ends is needed. This may also facilitate wise choices about when and if a booster session(s) may be most beneficial to the client. Opinion is divided as to whether booster sessions facilitate the process of ending or undermine the achievements made. All participants reported strong feelings of fear about the ending, and some experienced abandonment feelings that were not discussed with the therapist. Perhaps if clients had an idea of what they may expect to experience, and negative feelings towards the therapist was normalised, it might enable navigation of the ending.

As can be seen, the relationship, once again emerged as central to therapy. Where dissatisfaction was not addressed, it appeared to have a negative impact upon the therapy process; whereas open discussion that was initiated by the therapist seemed to increase the sense of safety and containment. This highlights the need to address relationship issues in therapy, which may be seen as more or less important depending on the model used. When clients struggle with assertiveness in their relationships outside of therapy, have an external locus of control, or are protective towards their care giver, there may be a heightened need to address such beliefs that it would "spoil" the experience.

Future research

Potential areas for future research include: comparing experiences in PDT with BPT; closer scrutiny of the process clients go through during the first few months after therapy ends and comparing the ending experience of clients who have "booster sessions" with those who have a clear cut ending.

As clients seem to continue making changes after therapy ends (Mitchell & Brownescombe Heller, 1999; Barth et al., 1988) it would be important for their internal therapist to be relatively "accurate". There is potential to assess this, for example, either client-generated or standardised scenarios, could be given simultaneously to clients and therapists and then compared to ascertain how closely the "internal therapists'" comments match what the therapist would actually say to the client.

Longitudinal study of clients' experiences of PDT and BPT would give further, valuable information. Experiences of these models could be compared with a larger sample of participants than was used in this study, using a similar method to Nilsson et al. (2007) who compared clients' experiences of PDT and CBT.

Jenny and Barbara had the same therapist, but experienced her differently, therefore another possibility for future research, would be to study clients' experiences of the same therapist in terms of for example, projective identification and how much client's perceive the therapist in a particular way, and how much the therapist feels invited into a particular relational position. Bergin (1997) and Carroll (2001) have argued for the importance of considering the influence of the therapist on therapy. Additionally, the therapists' understanding of how the client sees them could be studied to explore the parallel process. Høglend (2003) suggests that interpersonal patterns are not as pervasive as has been previously argued. Studying clients' feelings about the therapist and the therapists' perception of this may shed further light on this debate.

Conclusion

As psychodynamic theories argue that increased client understanding may lead to change, it follows that increased therapist understanding of clients' experiences may lead to therapy assisting changes. Continued focus on transference and counter-transference is clearly extremely important for monitoring therapeutic process; however, it is hoped that this paper will highlight how much some of the usual social rules enter the therapy room, such as not wanting to upset the therapist, to be rude, or to spoil the ending will attune therapists to this potential and facilitate further discussion of the transference and counter-transference. Having a sense of commonly experienced emotions during the process of therapy, such as intense anxiety at the beginning and end of therapy and the frustration and anger experienced during the process, may increase therapist sensitivity and promote effective containment at these points.

Acknowledgements

The authors would like to thank the participants and therapists who made the study possible, Pat Horwell, Dr. Helen Tracey, Dr. Sarah Kent and Dr. Eve Knight.

References

Barth, K., Nielsen, G., Haver, B., Havik, O. E., Mølstad, E., et al. (1988). Comprehensive assessment of change in patients treated with short-term dynamic psychotherapy: an overview. A 2-year follow-up study of 34 cases. Psychotherapy and Psychosomatics, 50 (3), 141-150.

Berg, C., Raminani, S., Greer, J., Harwood, M. & Safren, S. (2008). Participants' perspectives on cognitive-behavioural therapy for adherence and depression in HIV. Psychotherapy Research, 18 (3), 271-280.

Bergin, A. E. (1997). Neglect of the therapist and the human dimensions of change: A commentary. Clinical Psychology: Science and Practice, 4, 83-89.

British Psychological Society (2006). Code of ethics and conduct. The British Psychological Society.

Brocki, J. M. & Wearden, A. J. (2006). A critical evaluation of the use of interpretative phenomenological analysis (IPA) in health psychology. Psychology and Health, 21 (1), 87-108.

Bury, C., Raval, H. & Lyon, L. (2007). Young people's experiences of individual psychoanalytic psychotherapy. Psychology and Psychotherapy: Theory, Research and Practice, 80, 79-96.

Carroll, K. M. (2001). Constrained, confounded and confused: why we really know so little about therapists in treatment outcome research. Addiction, 96, 203-206.

Clarke, H., Rees, A. & Hardy, G. (2004). The big idea: Clients' perspectives of change processes in cognitive therapy. Psychology and Psychotherapy: Theory, Research and Practice, 77, 67-89.

Elliot, R., Fischer, C. T. & Rennie, D. L. (1999). Evolving guidelines for publication of qualitative research studies in psychology and related fields. British Journal of Clinical Psychology, 38, 215-229.

Elliot, R. & James, E. (1989). Varieties of client experience in psychotherapy: An analysis of the literature. Clinical Psychology Review, 9, 443-467.

Forshaw, M. J. (2007). Free qualitative research from the shackles of method. The Psychologist, 20 (8), 478-479.

Glass, C. R. & Arnkoff, D. B. (2000). Consumer perspectives on helpful and hindering factors in mental health treatment. Journal of Clinical Psychology, 56 (11), 1467-1480.

Hale, E. D., Treharne, G. J. & Kitas, G. D. (2008). Qualitative methodologies II: A brief guide to applying interpretative phenomenological analysis in musculoskeletal care. Musculoskeletal Care, 6 (2) 86-96.

Høglend, P. (2003). Long-term effects of brief dynamic psychotherapy. Psychotherapy Research, 13 (3), 271-292.

Høglend, P., Amlo, S., Marble, A., Bogwald, K. P., Sorbye, O., Sjaastad, M. C., et al. (2006). Analysis of the patient-therapist relationships in dynamic psychotherapy: an experiential study of transference interpretations. American Journal of Psychiatry, 163 (10), 1739-1746.

Johnstone, L. (2006). Controversies and debates about formulation in: L. Johnstone & R. Dallos, (eds), Formulation in Psychology and Psychotherapy, (pp. 208-235). London: Routledge.

Leiper, R. & Maltby, M. (2004). The psychodynamic approach to therapeutic change. London: Sage.

Llewelyn, S. P. (1988). Psychological therapy as viewed by clients and therapists. British Journal of Clinical Psychology, 27, 223-237.

Luborsky, L. & Crits-Christoph, P. (1990). Understanding transference: the core conflictual relationship theme method. New York: Basic Books.

Macran, S., Ross, H., Hardy, G. E. & Shapiro, D. A. (1999). The importance of considering clients' perspectives in psychotherapy research. Journal of Mental Health, 8 (4), 325-337.

Mann, J. (1973). Time-limited psychotherapy. London: Harvard University Press.

McLeod, J. (1990). The clients experience of counselling and psychotherapy: A review of the literature. In W. Dryden & D. Mearns (Eds.), Experiences of counselling in action, (pp. 66-79). London: Sage Publications.

Messari, S. & Hallam, R. (2003). CBT for psychosis: A qualitative analysis of clients' experiences. British Journal of Clinical Psychology, 42, 171-188.

Metcalf, L. & Thomas, F. (1994). Client and therapist perceptions of solution focused brief therapy: A qualitative analysis. Journal of Family Psychotherapy, 5 (4), 29-66.

Mitchell, S. & Brownescombe Heller, M. (1999). Why purchase psychoanalytic psychotherapy on the NHS? A set of guidelines. Clinical Psychology Forum, 134, 36-40.

Nilsson, T., Svensson, M., Sandell, R. & Clinton, D. (2007). Patients' experiences of change in cognitive-behavioral therapy and psychodynamic therapy: a qualitative comparative study. Psychotherapy Research, 17 (5), 553-566.

Poulsen, S., Lunn, S. and Sandros, C. (2010) Client experience of psychodynamic psychotherapy for bulimia nervosa: An interview study. Psychotherapy, Theory, Research, Practice, Training. 47(4), 469-483.

Richards, H. M. & Schwartz, L. J. (2002). Ethics of qualitative research: are there special issues for health services research? Family Practice, 19 (2), 135-139.

Rogers, C. R. (1951) Client-centred therapy. London: Constable.

Rogers, C. R. (1967). On becoming a person: A therapist's view of psychotherapy. London: Constable.

Shaw, R. L. (2001). Why use interpretative phenomenological analysis in health psychology? Health Psychology Update, 10, 48-52.

Smith, J. & Osborn, M. (2003). Interpretative phenomenological analysis. In: J. A. Smith, (Ed.), Qualitative psychology: a practical guide to research methods, (pp.51-80). London: Sage.