On Becomings: Exploration of Reasons Why Qualified Therapists Choose Not to Practice

By

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Abstract

This research aims to better understand the context within which fully qualified psychotherapists, with some experience of client work, made the decision not to continue with their careers after significant effort to complete the requirements of the psychotherapy training. It identifies, groups and analyses those reasons as experienced by a small cohort of qualified psychotherapists using Interpretative Phenomenological Analysis (IPA). The results of this study can provide a better understanding of the support needed for newly graduated therapists that could inform current training programmes and/or entry criteria for the psychotherapy courses available nationally. The interviews and subsequent in-depth analysis of interviews with 3 non-practicing psychotherapists highlighted that qualified psychotherapists who successfully completed a psychotherapy training and client work were influenced by a combination of external and internal unconscious mechanisms when they decided to terminate their practice and those are set within the framework of Object Relations.

Chapter 1. Introduction

The implications of the discoveries of Freud have led to the expansion of the field of psychotherapy and mental health practice in the XX century. There is growing evidence that psychotherapy is effective, reduces overall need for health services, provides long term improvements in health and has less side effects than treatment with medication (Warnecke, 2015).

The profession of psychotherapy is undergoing a modern renaissance with a global focus on destressing, self-care, mindfulness and awareness. This draws the attention to therapists and a variety of therapeutic practices offered in different countries. It is not an average type of job, task or performance-oriented occupation. Therapists, through their work, become uniquely involved with each individual client on a different and unique level. This requires perpetual resources in the form of patience, curiosity, honesty, and emotional availability, a combination of factors that can contribute to potential emotional and physical strains.

There are many psychotherapy courses available in Ireland, offering a variety of levels of qualification. To complete a Masters' training in psychotherapy prospective candidates can choose between 2 and 4 years training and most of them require attendance at weekly personal therapy, clinical practice hours and supervision by both college and an independent clinical supervisor as part of the training[1]. Following a successful completion of the training, an aspiring therapist must complete further supervised clinical practice hours if they wish to become fully accredited by any of the accrediting bodies. Qualified therapists, after significant sacrifice during the training, both personal and financial, engage in an

[1] Overview of online brochures for the following courses: MA in Humanistic and Integrative Psychotherapy, Tivoli Institute (Tivoli Institute, n.d.) , MA Psychotherapy DBS ("Masters In Psychotherapy | Dublin Business School," n.d.), MA in Counselling and Psychotherapy ICHAS ("M.A. in Counselling & Psychotherapy," n.d.), MSc in Psychotherapy DCU ("DCU Courses | MSc in Psychotherapy | DCU," n.d.), MSc Psychoanalytic Psychotherapy UCD ("MSc Psychoanalytic Psychotherapy," n.d.), MSc in Counselling and Psychotherapy DCTC ("MSc Counselling & Psychotherapy," n.d.), MSc Psychoanalytic Psychotherapy TCD ("MSc Psychoanalytic Psychotherapy - School of Medicine - Trinity College Dublin," n.d.)

emotionally tasked anxious process, combined with high levels of ambiguity and doubt (Bager-Charleson, 2010). In addition, the therapeutic outcome is always uncertain, therefore it remains remarkable that anyone would be willing to enter the impossible profession (Malcolm, 1981), in which one can be sure beforehand of "achieving unsatisfying results" (Sussman, 2007, p. 1).

This research looks at another aspect of this dilemma – it aims to explore the reasons, that influence decisions of fully qualified therapists to resign from psychotherapy practice; it aims to better understand the context within which those qualified therapists, with some experience of client work, make decisions not to continue with their careers after significant effort to complete the requirements of the psychotherapy training. It identifies and groups those reasons as experienced by a small cohort of therapists. Mainly, this research attempts to find the underlying root causes for this termination of practice, by asking whether those reasons are linked to the practitioners' unconscious processes, or whether they are caused by external factors. It is also hoped that this study will contribute to a better understanding of the support needed for newly graduated therapists that could inform current training programmes and/or entry criteria for the psychotherapy course.

The concepts presented below are set within the framework of the Object Relations theory. In general terms, this theory suggests that people absorb the experience to use it as material to construct their inner world and they seek to implement that inner world in the outer world, leading to creation of relations with this outer world in a way that will "give realisation to the developing self and to inner relations between internal object and self" (Scharff & Scharff, 1998, p. 220). The concepts of a good enough mother providing a holding environment, secure base, a container and a state of reverie will be highlighted in the background of therapists' journeys into becoming private practitioners – from the conception (of enrolling in the psychotherapy training) through the fragility of therapeutic practice in its

infancy, similar with fragility of the needs of an infant. Those needs, when securely met by the environment (and the mother), contribute to the healthy development, allowing the person to grow to be confident in their environment, to cope accordingly to situations, building resilience and their own competency, even in less favourable circumstances (Bowlby, 1988).

Chapter 2. Literature Review

2.1 Introduction

The literature review presented below is composed of several subsections and aims at highlighting potential reasons to resign from practicing psychotherapy. Firstly, it reviews current regulation and recognition of the profession in Ireland, before moving onto the topic of isolation and need for self-care. It then reviews literature on struggles of the novice therapists in the form of self-doubt and lack of recognition. It continues with looking at the personal experience as a motivating factor to become a therapist, and how it potentially contributes to the initial approaches to work with clients. This literature review concludes with a brief review of a concept of a 'good therapist'.

The researcher aimed to use current information and research to support the literature review, however introduction of certain key concepts in psychotherapy required the use of literature dating back to 1950's. The research was conducted using online and library resources, peer reviewed material only, from national and international sources. The researcher used alternative phrases in search options for all the key words, for example psychotherapy – *helping professions, therapist, counsellor*, with alternative spelling options.

The literature review included in this research was unable to find exact matches or previous data that could provide a direct answer to the research question.

2.2 Regulation and Recognition of Psychotherapy in Ireland

As mentioned previously, qualified therapists that continue with client work are eligible for accreditation with different accrediting bodies, however; there is no legal requirement to become accredited, as psychotherapy as a profession is not regulated in Irish

law at the time of writing. This lack of regulation technically allows anyone, irrespective of their college degree, to call themselves a therapist without any fear of prosecution or scrutiny from any of the professional bodies. There are, however, attempts, on behalf of the Irish Government to regulate the profession under CORU – an umbrella multi-profession health regulator set up under the Health and Social Care Professionals Act 2005 ("Regulation of the professions of counsellor and psychotherapist moves a step closer | Department of Health," n.d.).

CORU's role is to outline a set of professional standards for practicing professionals and educational institutions delivering relevant trainings, to promote and set requirements for continuous professional development, to maintain a register of approved professionals and to review complaints and conduct hearings flagged by the customers ("What is CORU's role? - CORU - Regulating Health and Social Care Professionals," n.d.). Since its formation CORU successfully regulated 7 out of 17 professions listed in the Act, and is preparing for further regulation and registration of the outstanding 10 on a phased basis, over a number of years. Once the registration and regulation of psychotherapy is completed, the professional title of Psychotherapist will become a protected professional title, as outlined in the Act (Book (eISB), n.d.) and practicing without registration will be viewed as a criminal offence (Oireachtas, 2018). The process of registration for psychotherapists did not commence at the time of writing however, the Counsellors and Psychotherapist Registration Board was established in early 2019 (Finn, n.d.).

The need for the mental health support within the Irish society has grown rapidly in recent years, but it is largely supported by self-employed professionals. Employment opportunities are very few within the HSE[2], through the CIPC/NCS and also paid on contractual basis rather than fixed salary. This creates a separate challenge, in addition to the

[2] Glossary of Abbreviations in Appendix 1, page 65.

aforementioned lack of regulation and lack of professional support body. Despite this lack of general regulation of the profession practicing therapists are mandated to adhere to a series of regulatory requirements, such as Child Protection and Health and Safety, which contributes to ambiguity among practicing professionals. There are also several accrediting bodies operating simultaneously in Ireland[3], their codes of ethics and requirements for accreditation are almost identical, which adds to the ambiguity – which one is better, which one is safer, why are there so many?

The establishment of the formal authority could result in an overall perception of a safe and supporting structure, which could be looked up to and relied upon in times of anxiety, uncertainty and distress. A newly qualified therapist and the psychotherapeutic practice in its infancy echoes the principal need of a new-born baby – the requirement of a secure base from its mother. Mary Ainsworth introduced a concept of the use of the mother as a secure base – for exploration of the world and as a secure haven to return to when alarmed (M. D. Ainsworth, 1985, p. 773). This concept indicates a presence of a caregiver who can be trusted in times of distress; it's closely linked with the concept of exploratory activity and it is contradictory to anxiety (Holmes, 2001, p. 12), which inhibits the fun and play that is associated with the feeling of contentment provided by the secure base. Securely attached children are more proactive and confident to inspect their surroundings and learn about the effects they can have on him/her, developing 'a sense of competence' (Ainsworth, 1985, p. 776).

The concept of a secure base has important consequences from a therapeutic point of view as perhaps newly trained therapists who have no access to the 'authority' figure are deprived of this secure base to safely explore and learn, and to have trust in their newly gained

[3] IAHIP, IACP, PSI, APCP, NAPCP, ICP to name a few. Irish graduates can also get accredited with ECP and BACP ("IACP and BACP accreditation," n.d.)

competencies. Similarly, the Object Relations theory evolves around the early stages of life, in which relationships that are satisfying create foundations for optimal health and development, both physically and psychologically (Nolan & Nolan, 2002, p. 10).

The concept of the holding environment refers to the phase in a child's development marked by a total dependence on the carer. It involves the physical aspect of maternal care but also emotional connection in the mother being attuned to the baby's needs and meeting them accordingly (Winnicott, Winnicott, Shepherd, & Davis, 1986). This sensitivity to baby's needs, this attunement is what Winnicott referred to as 'primary maternal preoccupation' and it's what Bion called a state of 'reverie' (Nolan & Nolan, 2002, p. 17). During the academic training the trainee therapists are securely held and supported by their college, peer group, 2 supervisors and their therapists.

Bion's idea of a *container* refers to the mother's role to mentally contain the feelings that are intolerable for her baby, by responding with acknowledgement of those feelings and aiming at modulating them (Fonagy & Target, 2003, p. 272). The mother's role to contain anxieties and fears through the state of reverie can lead to introjection of the good container within the infant: this good container is required to help the baby process the fear and dread, and return them to the baby in modified and digestible form (Symington, 1986, p. 286-291). Lack of robust oversight, that would set the boundaries for professional accountability and conduct, unavailability of the regulatory framework, combined with the fear of potential prosecution in case of malpractice (Sussman, 1995, p. 205), can be a frightening prospect for the new therapists, becoming a hostile environment. For Bion, the desired objects come from deprivation and are seen as bad objects, which the baby needs to remove (Grinberg, Sor, & Bianchedi, 1977, p. 54). In healthy circumstances the bad object can be contained by the good experience, the good object, restore homeostasis for the baby. When the needs aren't met, the baby experiences frustration: if it's able to tolerate levels of frustration, it is then able

to modify the frustrating element, but if unable to tolerate it, the baby will avoid it instead of modifying it. As a result what "should be a thought becomes a bad object indistinguishable from a thing-in-itself and fit only for evacuation" and bad objects that remain unmodified and evacuated "develop the apparatus for projective identification" (Grinberg et al., 1977, p. 58). Unregulated and unsupportive environment can create a space where independent psychotherapy practice can be perceived negatively by novice therapist, who have no one to turn to to satisfy to their needs.

In addition, this can be portrayed by Bowlby's conclusion that experiences chronically lacking maternal support may result in lower resiliency, defective control and persistent vulnerable structures (Bowlby, 1997, p. 378). In the event that the supportive environment and containers are not available the infant can internalise a bad sense of themselves (Symington, 1986, p. 291). A state of reverie enables the baby's "true self, the spontaneous experience of being, to develop coherence and continuity" (Gomez, 1997, p. 89) while experiences of a mother "incapable of reverie returns to the infant the intolerable thoughts in a form that is stripped of whatever meaning they had previously held. The infant's projected fears under such circumstances are returned to him as a "nameless dread" (Ogden, 2005, p. 102).

2.3 Isolation of the Profession and Need for Self-Care

There is a growing research in the field of the occupational hazard for mental health professionals and increased emphasis on the necessity of detailed and robust self-care plans.

Practicing psychotherapy is a lonely journey – therapists work in a one to one setting, often out of a private practice, restrained by the confidentiality rule. Therapists are deprived of immediate support and feedback from peers, and debriefing after difficult sessions with

clients is often left until the next supervision. The confidential nature of therapists' work adds to those limitations and a practicing therapist can't share their work struggles with their family at home.

Primarily, the therapists' focus is on the client, the therapist withholds personal information, provides closeness while maintaining distance, limits personal concerns at times of sessions and requires skills to maintain a high level of emotional control. According to Guy (1987) these aspects of a psychotherapists' work and its physical isolation may lead to a psychic isolation of the therapist: secrecy, diminished capacity for intimacy with family and friends, and an emotional distance. Sussman (1995) goes further in summarising that this social isolation of therapists frequently impacts negatively on therapists marriages, parent-child relationships and has a heavy toll on the emotional adjustments of those professionals.

"It takes two for one to be held" (J. Klein, 1987, p. 399) – holding as such involves surviving with the person their expressions of hurt, anger and terror in a way that one feels recognised and understood as a person despite having all those feelings (J. Klein, 1987, p. 401). Isolation of the profession can be understood as a lack of this holding environment, especially in the early days of practice, and can be viewed as a detrimental factor.
Ogden suggested (2005, p. 103) that pathological circumstances may cause the container to become destructive to the contained and this can result in constriction of the range and depth of the thoughts one may think, which can create thoughts of discontinuing practice by therapists.

It is important to consider what can potentially support psychotherapists in their work, to help them sustain their careers in the background of the occupational hazards. As pointed out by Ronnestad & Skovholt (2013, p. 161) not only a therapists' experience within the therapy room is what influences their overall performance and development, but other nonprofessional life events, experiences from supervision and personal therapy that may

contribute to the therapists overall development and professional functioning. Work quality and work-life balance are important factors that contribute to the general experience of job satisfaction, health, and when balanced, can increase the sense of competency in the workplace (Davis, Eshelman, & McKay, 2008, pp. 279–280).

Dryden & Spurling (2014) list self–reflection, personal therapy, supervision, careful and adequate number of clients, support from family and spouses and physical and psychological nourishment as factors contributing to successful professional development and sustainability. This is echoed by Foreman (2018), that career-sustaining behaviours include self-care, wellness and adequate work-life balance.

The current online brochure for Psychotherapy training in DBS outlines the modules, orientation, requirements for personal therapy, client work and individual supervision ("Masters In Psychotherapy | Dublin Business School," n.d.) however, it does not mention the potential impacts of the personal emotional work involved in participation in personal therapy and client work. There appears to be an assumption that potential students have a prior knowledge of the emotional load required to engage in personal therapy, client work and supervision, which is not always the case. The reality of the complexity of the training appears to be expressed more clearly by Tivoli Institute, stating that the candidates should have the "capacity to cope with the emotional and intellectual demands of the course" (Tivoli Institute, n.d.).

2.4 Novice and Inexperienced Therapists

Novice and inexperienced therapists often experience overwhelm and feel highly challenged in sessions with clients, and the therapy training as such can be a threatening experience for them (Ronnestad & Skovholt, 2013, pp. 56–57). It's not only the risk of

traumatisation that may deter the newly qualified therapist from further work: combining the theoretical learning and attempting to apply it in practice by engaging with clients can be a straining experience. Spinelli suggests (2006a, p. 193) that due to the nature of the training the novice therapists are, for the most part, focused on *doing* rather than *being*, which may have profound implications for establishment of the therapeutic relationship.

Overwhelm in the clinical practice and unrelenting stress (due to requirements of the course, full time work and clinical supervision and therapy) can override person's resources. Professional burnout, seen as emotional unavailability to clients can be experienced at any stage of the professional development of the psychotherapist (Ronnestad & Skovholt, 2013, p. 103). It may manifest itself under many themes, such as diminished improvement in therapeutic performance, lower enthusiasm and interest in the work in general, characterised by exhaustion and disengagement (Ronnestad & Skovholt, 2013, p. 164). However, burnout should not only be considered as an inability to practice due to exhaustion. Sussman (2007, p. 181) suggested that burnout can be manifested as loneliness, anger and irritability, evoke feelings of guilt and self-doubt, intolerance, closed-mindedness. This is linked with Spinelli's view (2006a, p. 193) of challenges faced by the novice therapists: they risk being 'indoctrinated' – work strictly *by the book* and thus disregarding their own natural responses arising during the work, which may cause rigidity and fixedness of their own outlook, restricting their ability to 'be' in the relationship.

As with any other profession, new therapists strive to perform well. For occupations where peer feedback and on-site supervision are the norm, a new employee can quickly assess their own performance based on information from those sources. With psychotherapy this feedback is not available or extremely delayed, relying on personal self-assessment, exaggerating the need for the novice therapist to be reassured and praised for the job done well.

Lack of praise and feedback creates conditions of chronic uncertainty. Chronic uncertainty, combined with lack of a secure base to return to in times of potential traumatisation and isolation, lay grounds for the emergence of insecure types of attachment – resistant and avoidant (M. D. S. Ainsworth, 1989; Gerhardt, 2015; Hazan & Shaver, 1994). Furthermore, lack of feedback, combined with difficult clients and countertransference can lead to anger, frustration and general feeling of being *not good enough* – or, in broader terms incompetence (Sussman, 1995, p. 64). The attachment patterns shape adult relationships and become activated by any intimate and close relationship, that creates potential for comfort, security and love, such as friendship or a romantic relationship (Mallinckrodt & Gantt, 1995, p. 308). In the lonely reality of the psychotherapeutic profession, exaggerated by the lack of overall mother authority figure, practitioners may feel compelled to resign.

2.5 Concept of a 'Good Therapist'

This initial need for praise and reassurance of good practice are difficult aspects of the professional psychotherapeutic practice, because how does one measure being a *good therapist*? What constitutes a *good therapist* and *good – for whom?* but the answers to those questions are permanently open to argument. There are several types of practitioners that differ not only in their approach and training, but also in their treatment modalities, their responses to a variety of clients and personal values and characteristics. An attempt to answer these questions is an "arduous pursuit of a moving target" and that a good therapist is a product of "genetic endowment, environmental influence and life experience" (R. H. Klein, Bernard, & Schermer, 2011, p. 29).

Irrespective of the type of training, any therapist trained in the humanistic stream of psychotherapy, begin their journey with Rogerian person-centred concept of Necessary and Sufficient Conditions (Rogers, 1957). Those conditions not only outline what a

psychotherapeutic encounter should look like, they provide clear instructions on the personal qualities a good therapist should possess. This person-centred approach originated from the assessment of the psychodynamic and psychoanalytic approaches as those, which had too many preconceptions about the clients and of what was good for them (Boyne, 2003, p. 208). Those Conditions include congruence and unconditional positive regard – an attitude of acceptance of clients' full humanity and trust in their potential, while prompting the therapists to explore their own prejudices and fears (Boyne, 2003, p. 220).

The practicality of the unconditional positive regard as the totally non-judgemental attitude in the therapeutic setting is difficult and open to criticism. While it does not mean that therapists should like each client and approve each of their worst behaviours but to continue to value the clients as someone with potential to change despite their worst behaviours (Boyne, 2003, p. 221), it can seriously question therapists' "basic rationale for providing therapy" (Spinelli, 2006a, p. 165). This acceptance of the client comes with a personal cost for the therapist: the therapist can never fully express their feelings, but is required to employ those feelings in the service of the client, which requires high levels of control and self-abnegation (Storr, 1990). This can be viewed as another aspect of isolation of the profession – the lack of reciprocated attentiveness and giving, combined with the level of responsibility, which is demanded of the therapeutic relationship, resulting in this self-abnegation, leaves the therapist roaming with a hungry heart (Bager-Charleson, 2010, p. 22).

2.6 Impact of Personal Experience on Training and Practice

It is accepted due to extensive research, that therapists decide to become therapists due to their personal life experience (Dryden & Spurling, 2014; McLeod, 2013; Ronnestad & Skovholt, 2013; Sussman, 1995) and through projection on clients they try to resolve personal distress (Dryden & Spurling, 2014, p. 3; Sussman, 1995). The decision to become a

therapist is the combination of a multitude of factors, many of those deriving from the therapists' dynamics of the family of origin and their developmental past. Each therapist possesses a unique balance of those factors and they may be transformed into therapeutic assets, by becoming aware of those unconscious motivations (Sussman, 2007, p. 197). A personal cost associated with practicing psychotherapy comes from the assumption that if therapists 'professionalise' what they have done in some way all of their lives (their traumas), then their job satisfaction needs to come from the very practice that often left them feeling powerless and defeated as children (Adams, 2014, p. 91). Perhaps, in these cases, the job satisfaction that will provide meaning is expected to come from achieving with clients what they weren't able to achieve in their own childhood.

Those unconscious motivations are often the ones avoided and/or not accepted by the therapists, therefore can pose a threat to the overall therapeutic dynamic. Guggenbuhl-Craig (1971, p. 10) suggests that therapists who refuse to accept that their motives are beyond selfless caring, are more likely to act inappropriately in the therapy room. Therefore, what initially appeared to be altruistic can be narcissistic and therapists with strong narcissistic tendencies may receive narcissistic reinforcements by using clients as mirroring and idealised self-objects, and where admiration and transferential love can supply gratification (Sussman, 2007, p. 178).

Personal experience as a motivating factor to become a therapist may not necessarily refer to direct, personal suffering, but also witnessing others' pain, which is traumatic for the witness, evoking emotions of helplessness, shame and being useless. Some research suggests that all therapists suffered some form of loss, are still in touch with their early experience and are not denying their suffering (Barnett, 2007). The therapists self-construct must be relatively flexible if the therapist is truly willing to accept the client's world-view and to '*be with and for*' the client. This flexibility will allow the therapist to enter their client's world-

view *as if it were theirs*, but only if the therapist is prepared to challenge personal biases, viewpoints and assumptions (Spinelli, 2006a, pp. 226–227), which requires high degrees of self-awareness and self-acceptance.

The therapists, the same as their clients, experience infantile wishes, inappropriate coping strategies, defenses against anxiety, traumas, acting out, have phantasies, disturbing memories, love and hate that they try to resolve in the therapeutic situations and very often need to protect themselves in neurotic ways (Sussman, 1995). It appears that the therapists need clients as much as clients need therapists, and that often therapists transform their own distress and traumas into something meaningful, through their work with clients (Adams, 2014). This assumption echoes Casement's view (2013) that what heals the clients often heals the therapist.

2.7 Conclusion

The material presented above suggests that the reasons why qualified therapists decide not to continue in their occupation could be complex and multidimensional, influenced by internal and external processes. The literature review highlighted consistency in the need for reassurance, recognition and praise of practitioners. It also highlighted the need for sources of comfort to build confidence in their own skills and performance, corresponding with the needs of a baby in infancy and early developmental stages to have their needs met and recognised, supported and secured by the mother (the container) in the state of reverie.

The good enough mother provides immediate feedback, reassurance and sets boundaries of what is safe and good, and what needs to be avoided, responding to their baby's needs without a delay. If the delay happens or the recognition of needs is not adequate or doesn't

happen at all, the child sets out on a difficult journey and without a fully developed sense of competence and self-worth. In those conditions of bad internal object relations, the infant protectively identifies with the difficult aspects of themselves it finds in the mother in order to get them outside of self, "in the hope that after their sojourn in the mother, they will come back detoxified" (Scharff & Scharff, 1998, p. 53). Lack of good and solid foundations in early aspects of one's life provides a turbulent start (Gerhardt, 2015) – perhaps too turbulent to continue on the journey of psychotherapeutic practice.

The changes in the level of support for graduated therapists are represented by lack of further support in the form of group supervision, process group, skills class – they are now on their own with the mere support of their individual supervisor. This new reality could create the tension, leading to the exclusion of the object: Guntrip understood psychopathology as "ego's withdrawal from objects altogether" (Greenberg & Mitchell, 1983, p. 152). Similarly, Balint's referred to a basic fault (Balint, 1968, p. 23), which results from significant discrepancies in the early formative phases of development between infant's bio-psychological needs and care. These discrepancies in the level of support could indicate lack of 'fit' between the infant (therapists) and the people who construct his environment. The fundamental striving of a child is not for pleasure but for contact and nurturance (Greenberg & Mitchell, 1983, pp. 171–173).

The popularity of psychotherapy training courses can be measured by the overall growing number of courses available nationally. Some of those who qualify decide not to practice and/or to switch to other professions. The presented literature review was unable to find direct research outlining the reasons behind discontinuation of practice by qualified psychotherapists however, the research generated enough scientific data exposing the difficulties and risks of this profession.

Considering the above, this research aims to review the reasons for which the professional therapeutic practice may be terminated by therapists, who put significant effort into their training and process, and if those reasons are stemming from unconscious internal dynamics of those therapists or are influenced by the environment of practicing psychotherapy, and their ability to build meaningful relationship with this professional environment.

Chapter 3. Methodology

3.1 Methodological Approach

This research aims at exploring and understanding the meaning of therapists' experiences of deciding to terminate their professional practice, therefore the phenomenon in question seems to be particularly suitable for a qualitative approach. Qualitative research allows for an investigative angle and in-depth exploration and subjectivity (Willig, 2013). As summarised by McLeod (McLeod, 2013), the qualitative investigation is fundamental to illuminating what things mean to individuals and how they employ these meanings to guide their behaviours and to make sense of their experience (McLeod, 2013, p. 111). The qualitative research aims to construct theoretical framework around personal meanings of people who experienced the phenomenon under study. This method also allows for identification of the cause and effect links between different factors that will contribute to the building of the explanatory theory to meet the aim of the study.

3.2 Research Strategy

For the purpose of this study an Interpretative Phenomenological Analysis (IPA) was used. It is a qualitative approach, concerned with examination of how people make sense of their life experiences (Smith, Flowers, & Larkin, 2009). The role of the researcher in the IPA type research is twofold: the researcher is attempting to make sense of the participants trying to make sense of what they experienced, relying on participants own account of that experience (Smith et al., 2009, p. 3). The researcher has to rely on the description of the event as provided by the participant, because the researcher cannot directly share the experience. The results are embedded within the researchers' subjective interpretations therefore it is

expected of the researcher to remain flexible and aware of their preconceptions to engage in the hermeneutic circle (Oxley, 2016).

Hermeneutics is understood as the theory of interpretations (Biggerstaff & Thompson, 2008; Oxley, 2016; Smith et al., 2009) and the intention of IPA research is to "understand the whole by looking at the part, but in order to understand the part the researcher also needs to look closely at the whole" (Oxley, 2016). The interpretation and immersion of the researcher into the data can unearth the unspoken part of the participants' experience, which they are unaware of, or unable to explicitly share. The researcher's role is to organise it and write it into a coherent content (Oxley, 2016; Smith et al., 2009).

The depth of the IPA analysis is the pursuit to reveal something of the experience of the participating individuals and to explore similarities and differences allows for the sample to be relatively small. As summarised by Smith and colleagues (2009, p. 55), the IPA researcher requires to adapt an attitude similar to the therapeutic space: the researcher must remain open-minded, patient, flexible, and willing to enter into participants' worlds, fuelled by curiosity and persistence.

3.3 Research Design

3.3.1 Sample eligibility

The qualifying criteria for participation in this study were initially set to include graduates who, after successful completion of the psychotherapy course, decided not to pursue a career in the field of psychotherapy. Graduates had to be qualified to Bachelors or Masters levels (level 8 or 9 on the Irish National Framework of Qualifications) in Integrative/Humanistic psychotherapy or counselling. They must have completed the

number of client work hours that was required by their course and in addition, they were eligible for full accreditation with IACP, IAHIP or any other accrediting body in Ireland.

These criteria were later changed, and the requirement of accreditation was removed. This change was necessary due to the hard to reach population required for this sample – non-practicing therapists are hard to find and in general terms, therapists who weren't pursuing this career would most likely not spend time and resources on going through the accreditation process.

Certificates and diplomas in counselling and/or psychotherapy were not eligible due to the lack of requirement for client work in some of those courses accredited at lower levels. Also, graduates of psychoanalytic training were not eligible to participate in this research due to significant differences in the type and method of clinical practice. The modality of the orientation of the therapist prior to their hiatus was considered irrelevant, as long as it remained within the Humanistic/Integrative stream. The non-practicing qualified therapists, who discontinued their professional practice due to retirement, were also viewed as unsuitable for this research. Also, the researcher decided to exclude people personally known to her from this research to further promote confidentiality and dignity of each participant.

3.3.2 Sample Recruitment

The recruitment of the sample was expected to be difficult, as non-practicing therapists are a hard to reach population. An advertisement was placed by the researcher in the IAHIP weekly e-bulletin, which is emailed to IAHIP members on a weekly basis (see Appendix 1). This advertisement generated one response, and this candidate was deemed eligible for participation.

Following lack of sufficient response from the IAHIP advertisement, the researcher turned to word of mouth to recruit the remaining sample. Twenty-one emails to supervisors, lecturers,

colleagues and work placements were sent, with the same details as advertised through IAHIP. This method generated 4 responses in total. Out of those, one was not eligible for participation due to insufficient qualifications and lack of client hours. The remaining 3 were responded to on a first come first served basis, and 2 of those accepted the invitation to be interviewed, bringing the total number of samples to 3 participants, in line with IPA recommendations for a study at this level.

3.3.3. Demographics

A brief demographic form was completed by each participant prior to the interview (see Appendix 2) asking for their qualifications, number of clients per week, total number of client hours and number of years out of practice. Two of the participants were qualified to a Masters' level in Psychotherapy, one held a qualification of a Bachelor degree in Psychotherapy.

Although it was not included in the initial criteria for eligibility, all the participating ex-therapists shared the following characteristics: they all completed a 4-year part-time course, were in full-time employment at the time of study and they covered the cost of the training therapy and supervision independently.

3.4 Data Collection

The data was collected through the process of in-depth interviews with a sample of 3 participants. This process enabled the researcher to monitor the relevance of the information that was collected and checked for correct understanding of the emerging material (McLeod, 2013, p. 115). Those who responded to the invitation and met the qualifying criteria as outlined above were interviewed by the researcher with the use of semi-structured interviews.

The semi-structured interviews were recorded using a personal recording device of the researcher and transcribed afterwards.

The researcher prepared an interview schedule in advance, which was presented and discussed with the researcher's study group in college. Before the interviews took place with the research sample, the researcher undertook a pilot interview with a colleague who is qualified to a Masters' level in Integrative and Humanistic Psychotherapy. The idea behind the pilot interview was to prepare for potential sensitive issues and to ensure that the questions are open and expansive, encouraging the participant to talk at length (Smith et al., 2009, p. 59). This made the researcher aware of how personal and sensitive the questions were, confirming the importance of the recruitment of the sample out of people who were personally unknown the researcher.

The pilot interview and feedback from researcher's group in college generated further amendments to the interview schedule and the final interview schedule was capped at 14 questions in total (Appendices 3 and 4), with a view for flexible use of the questions and adhering to the principles of the semi-structured interviews (Smith et al., 2009, p. 4), allowing for exploration of unexpected material arsing during interviews.

The interview questions explored the following themes: initial motivations to enrol in the psychotherapy/counselling course, experience from training, experience from initial work placement, decision making process and individual reasons for not practicing, among others.

The in-depth interviews were expected to facilitate rapport building and encourage participants to talk in depth about their experiences. Smith and Osborn (n.d.) further propose that this method of data collection allows the exploration of new areas which might come up, enriching the data. During the interview the schedule was loosely followed, enabling participants to share their story in their own structure. The researcher aimed to be an active

listener and used counselling skills to convey empathy and the participants were debriefed to check for potential adverse effects from the interview.

3.5 Data Analysis

Analysis of the transcripts of the interviews generated rich data covering different aspects of the participants' experiences. Although the life events the participants chose to talk about leading up to their termination of practice were sometimes quite different, an in-depth analysis of the data showed that many of the participants described a similar journey. As IPA is concerned with the content of one's account, the details of exact length of pauses and non-verbal utterances are not required, and was omitted from the transcript (Smith et al., 2009, p. 74). A sample of final transcript with emergent themes is attached in Appendix 5.

Reflection is the key theme in IPA studies (Oxley, 2016) and the researcher kept a reflection diary. The diary was used to record immediate reflections after the interviews, followed by additional reflective statements during the transcription, followed by further comments when re-reading and re-listening of the transcribed material.

In order to transcribe the interviews, the researcher used Google Docs Voice Typing Tool. As this tool does not pick up recordings from other devices the researcher repeated each word and each sentence from each interview out loud so that the Voice Typing Tool could be activated. This method provided an additional, unexpected layer of analysis and lent an opportunity to experience the content of each interview at a deeper level, to get closer to the participants' experiences by repeating each sentence as if they were the researcher's own. Following the transcription of each interview, the basic emergent themes were compounded into a three columns table, each to represent each participant, under the headings of questions (Appendix 6). Those themes were then physically cut out from the question headings and spread on the table randomly to allow the researcher to reconstruct each emerging theme

from a new, unlabelled angle to search for broader themes. The researcher then grouped similar, repetitive and meaningful themes under newly emerged superordinate themes. This constructed the thematic map of the analysis, which is illustrated in the Appendix 7. The map outlined the specifics of each theme to finally present a selection of extracts to illustrate and support the key themes (Braun & Clarke, 2006).

A total number of 7 superordinate themes were identified during the process of analysis but the following chapter will demonstrate the themes, which were viewed as most relevant to the research question, and therefore will not be an exhaustive account: the researcher aimed at exploring and highlighting the most interesting themes.

3.6 Ethical Considerations

The wellbeing and informed consent of the participants were of paramount importance for this research ("The Counselling and Psychotherapy Research Handbook," 2019) and several ethical issues were taken into consideration by the researcher. As per guidelines (Brinkmann & Kvale, 2018) the information on the purpose of the study was provided to the participants, including the research title, aims and design prior to the interviews. The researcher discussed the risks associated with participation in this research, how the course of the interview may affect them physically and emotionally. The participants were briefed on their rights, which included the right to decide on the depth of their disclosures, their right to withdraw from the study at any point and the voluntary nature of the study (Appendices 8 and 9).

The confidential nature of the interviews and details of data storage, coding and protection were outlined to the participants before the interviews. Fryer (2001) draws attention to the importance of an equal power balance between researcher and participant. In order to promote this, the interviews were conducted in locations proposed by the participants

in safe and confidential settings. Before the interviews begun, a time limit of 75 - 90 minutes was set and 2 copies of the consent forms were signed by the participant and the researcher. Access to the recordings of the interviews was restricted to the researcher and they were stored on the researcher's device, protected with a password. The researcher transcribed the recorded interviews independently, without the use of a third party. To further protect the identity and privacy of the participants, parts of the interviews were edited to remove details of the participants' places of work, their names, previous work placements and colleges, names of supervisors and any other specific details that could compromise their anonymity. The collected data will be stored by the researcher for a duration of 5 years as specified by the college requirements for Master's research and under current GDPR legislation and will be deleted afterwards.

Chapter 4. Results

4.1 Introduction

Three research participants were asked to share their experience of the psychotherapy training, working with clients and the reasons why they decided to stop practicing psychotherapy. The main superordinate themes that emerged from the in-depth analysis were of striking resemblance to the process from conception through birth to infancy:

1. Conception: Experience as novice therapists
2. Birth: Reality of practicing psychotherapy
3. Infancy: Life without psychotherapy

The themes are grouped accordingly as shown in Table 1 below, which also demonstrates subordinate themes that are analysed in detail in the following chapters.

Table 1. Breakdown of Superordinate Themes

Theme One: Conception	**Theme Two: Birth**	**Theme Three: Infancy**
'Experience as Novice Therapists'	'Reality of Practicing Psychotherapy'	'Life Without Psychotherapy'
Expectations of self as therapists First experience of client work Perceptions of self as therapists Initial frustrations with undervaluing of the profession of psychotherapy Lack of immediate feedback and reassurance	Sacrifices Isolation Lack of employment opportunities Lack of regulation Letting go of clients	Personal gains New relationship with psychotherapy Potential return to practice

It is of crucial importance to notice that all participants agreed that the psychotherapy training was the "best thing they've ever done and the hardest thing they've ever done". All participants recalled having a great experience while in training and in supervision. They demonstrated solid respect, care and empathy for their clients and have no regrets of enrolling in the psychotherapy training in general. They all agreed that while first experiences with clients may have been difficult at times, they don't think that having different clients would change their decision regarding continuity of practice, which is explained in detail in the chapter below.

The names of participants were removed and they are represented by a letter P (for Participant) and a number (P1, P2 and P3). The researcher adopted this system to avoid unnecessary gender stereotyping on behalf of the reader, as it is believed that the gender of participants has no influence on their analysed experiences. The extracts from interviews are presented in the form of vignettes best reflecting the discussed themes.

4.2 Theme One – Conception: Experience as Novice Therapists

This theme describes the participants journey from their initial motivations and hopes of becoming qualified psychotherapists to their early work encounters with people seeking therapy and with clinical supervision. During this time their phantasies of psychotherapy as practice and themselves as therapists were confronted with the first hands-on experiences of the actual work. The mechanisms of the psychotherapists' day to day reality was revealed and their initial phantasies required adequate adjustments.

All participants had prior experience of working with people with emotional and mental health difficulties, primarily in the social care sector. They were familiar with the complexity of human problems, its impact on individuals and families and overall, they loved working with clients. Despite this prior experience and familiarity, all participants expressed that they

were “unsure how to be a therapist at the start” and found the initial experience difficult. The difficulties can be grouped into further subsections:

4.2.1 Expectations, Experience and Frustration of the Initial Work

This subtheme describes three aspects of participants’ experience in their early client work. They shared their views of themselves as therapists in their early sessions with clients and their own expectations of themselves as practitioners. The high expectations and desires to perform at a high standard were not met in their own self assessments as therapists. This created a sense of uncertainty and insecurity for participants, with added sense of alienation and frustration: they felt that the position of psychotherapy as a profession is undervalued and misunderstood by the general public and their own close circle of friends and family.

The early client work generated difficult feelings in participants:

> *P1: Oh! it was nerve wracking at the beginning […] it was like “what the hell! what am I supposed to do with these people?”*

Similarly:

> *P3: It was terrifying…terrifying. It was tough going, yeah. […] especially starting off you’re just unsure, sometimes you’re so focused on what to say next you forget what the person is saying, not listening properly…*

The participants expected themselves to be composed and able to accept and tolerate any type of human emotions appearing in the room without being affected by it. The desire to be a good listener and to have correct answers for the clients added extra pressure. There appears to be a strong self-critic in the below statement from P2, a strong expectation that therapists, including the participant, should be on a certain level of self-process, self-awareness:

P2: [….]I question can I not sit in the psychotherapist chair because I have not done enough process myself? is that why I can't sit there with the clients?

The expectations of themselves as therapists contributed to the general feeling of *slog and struggle* of the initial work as a psychotherapist, of not being good enough – they aimed at some standard of performance, a form of perfection:

P2: so…I just thought I'll be amazing (laughing). I thought I'll be that therapist that your clients will come in and go "oh my God I love you!", you know, I'll be that…just…poster person for being a psychotherapist.

P1: […] That last person in the evening…it's like really trying to gather yourself to have some kind of presence for them. And there were times where I felt really bad about that. Really, really felt that I could be doing so much better here...

All participants disclosed that their original motivations to enrol in a psychotherapy course were to help people, that they had a general interest in people and understanding of emotional and mental health difficulties, or that they were keen to learn more about themselves. Perhaps their original motivations are linked with their initial approaches in their role as therapists: they explained ambitions to fix clients, or make it (their struggles) better for them:

P3: …especially at the start it was a big factor…trying to fix stuff you know, especially at the start.

P1: I think I went into in the psychotherapy Masters' thinking that the job is to fix people or help people be fixed […] and yes, the feeling at the start of my job was to make this better for them

P1 quickly became aware that

P1: that job isn't to help create, or be part of creating […] this beautiful, shiny, perfectly adjusted person at the end, but just to help people who aren't perfectly adjusted to still manage to cope and have good quality of life or to reach whatever they want to be at themselves

This realisation appeared to have a bitter-sweet effect for this participant and contributed to further uncertainty around what's required of a good therapist. Participants strived to

implement the learned theory to their best ability and were finding it hard, which led them to the assumption that they are not good at what they are doing, rather than seeing this difficulty as a part of the learning process:

> *P2: But the piece I found the hardest was being a psychotherapist to […] my clients. I found that really, really hard and I can…[…] I think I'm only realising now, that actually the piece I found most difficult with clients was the non-judgmental piece and I'm only realising that now and I'm only accepting that now. Because it's a really hard thing to say for a psychotherapist that actually, you know, one of the core values that you need is to be non-judgmental and I found that really difficult*

Of their initial clients*:*

> *P2: […] "I can't, I am judging you, I am! I want to tell you to cop on, I want to tell you to pull up your socks"*
>
> *I know I can do that in therapeutic way I know I can, but I know also what I'm feeling here, you know, and yeah I found that really, really difficult.*

It was evident for the researcher that P2 had put a lot of thought in this interview from their own perception as a subject. This participant showed great restraint in pointing at the system or others, and made great effort to bring each answer back to their own process. This created a space in which the researcher felt a refreshing sense of honesty and self-awareness in the participant, and this made this experience extremely valuable to the researcher to be a part of. This participant verbalised that the realisation and acceptance of certain processes that influenced their decision not to practice happened during this interview. It was interesting to witness this participant to be authentic during the interview however, the researcher felt a strong need to provide reassurance to this participant, that their psychotherapeutic skills were of good enough level, that they did a good job and should consider returning to practice.

The participants mentioned a "heavy sense of responsibility" around provision of one to one therapy and this appeared to be inflated by a general lack of understanding of the profession, of how difficult it is to become a trained psychotherapist, how many personal

commitments it requires, resulting in psychotherapy as a profession and psychotherapists not being valued. They felt that people who never experienced structured work on themselves such as process group or personal therapy, were unable to understand the emotional costs associated with this training. The sense of responsibility stemmed not only from the responsibility for the provision of a therapeutic environment but from the additional obligations of practitioners, such as child protection, health and safety in addition to knowing the theoretical background of their work:

> *P1: well, I certainly don't think there is enough credit given to anyone who does psychotherapy courses. I think that, had I known what I was getting into, I probably wouldn't have thought I'll be able to do it (laughing). I mean like, people like doctors they do huge amount of work but nobody gives psychotherapists credit for the amount of sacrifice that they have to put in…. I certainly never felt nervous about sitting in front of somebody. It was the more the weight of responsibility for being a therapist […] and at the start I certainly felt very inclined towards really thinking about what the service is going to be, you know, really thinking about what the psychotherapy is going to be and trying to be my best and that's why that kind of weight came from.*

> *P3: I don't think people really understand the pressures (of the training & practice), especially in those close relationships with friends and family, so you have to look for the support somewhere else […] that was the big one for me…not the lack of empathy but the lack of understanding I suppose of those pressures on you…pressures you put on yourself, even regarding the accountability…child protection and welfare and all those kind of things…pressures of missing something.*

4.2.2 Lack of Immediate Feedback and Reassurance

Lack of immediate feedback and assessment of their work, which is closely linked with the feeling of isolation, appeared to be a shared contributing factor in their initial difficulty. There appears to be a sense of disappointment in how they perceived themselves as therapists in their initial work with clients. They were dedicated and focused, applying their learned skills of active listening and core conditions, "saying all the right things" but yet struggling to see their own success in it, struggling to acknowledge that they are good *enough*. Their need for structured praise, reassurance and recognition of their hard work impacted on their confidence in themselves as practitioners.

P2: […] Of course I don't know what my clients thought of me and in that, you know, when I did my closing with them, you know, they thanked me and everything but you know, they weren't saying "oh my God you were amazing" or anything like that, you know.

Furthermore, P2 appears to be unconsciously looking for admiration and love from their clients, which could potentially provide the gratification required from providing therapy.

There was a striking resemblance in their summary of the support in college and in supervision as adequate, well structured, professional and they "loved it". However, there was a sense of void between their perception of themselves as therapist and the reassurance they felt they received from the outside world:

P2: because there was such a support and we were like in the bubble, the psychotherapy bubble, where we are all training to be psychotherapist and we all are supporting each other in our own processes, and we are amazing.

P1: So, I think it's a really lonely place to work even though you're with people all day.

P3: if you're accredited and you're a practicing psychotherapist one thing is it's a lonely, lonely existence […] Social work, project work, even teachers, you know, you have visible supports…it's the isolation, you can't bounce off ideas...that's for me, that's what I'll be thinking of […] I hadn't a clue (how isolated this profession was), I hadn't had a notion, no.

The participants have tried hard to become the best at what they were doing, best therapists for their clients but have not received enough recognition and validation for their work from the general population, family and friends. This void constitutes the feeling of isolation not only of the actual day to day work but of the profession – no immediate peer support, no direct feedback from clients and confidentiality that restricted them from sharing difficult sessions with partners and friends.

It appears that it's not the complexities of clients' realities that were difficult for the participants, but their own lack of ability to remain confident in their learning and progress, in their skills, their inability to trust the process and that they were safely held within their supervisions and skills classes. They longed for more continuous flow of reassurance and

recognition, which failed to materialise from the outside world, and which they had not had enough of in themselves.

4.3 Theme Two – Birth: Reality of Practicing Psychotherapy

This theme looks at participants perceptions of their experiences after some time in practice and it corresponds with the process of birth: the initial learning was completed, the participants had nearly 2 years of client work behind them, they were preparing their dissertations/thesis and getting ready to finish college, to sign off on required client, personal therapy and supervision hours. The concepts of becoming qualified, independent therapists were now materialising and the participants were unconsciously entering a phase of decision-making process regarding their future practice. Within this theme further subthemes emerged: they are linked with the level of commitment and dedication to complete the training versus the lack of expected improvements in professional quality of life after graduation, and lack of career prospects in the field of psychotherapy.

4.3.1 Sacrifices

The participants were in agreement that the psychotherapy training and practice they completed were extremely challenging and required enormous sacrifices in personal, financial and physical aspects of their lives. They shared that while they were aware of the need for self-care at the time, there simply was no extra time to fit in any more activities into their days. All the participants worked full time and studied part time and attended personal therapy, work placements and personal supervision on a separate evening each week, leaving them with no free time during the week.

> *P1: oh yeah, it was really, really intense. There wasn't a spare minute […] so I was working and studying and doing client hours. I found it just exhausting. By the time you finish work and go to session you know you have session from 6 to 7 and 7:15 to 8:15 and then 8:30 to 9:30… You've been up since 6:30.*

P3: I remember it to this day…lot of stress, lot of stress, running around the place. My counselling and my supervision and my personal counselling were all on different days so you're always on the road…Jesus, I'll never forget it. There was…I've done pretty much 2 Masters since but that was the most stressful for me….to fit it all and pay the bills and mortgage at the end of the day, yeah. […]

There appears to be a general sense of loss and sadness around the impact of the training on the personal relationships as experienced by the participants. The aforementioned feeling of not being understood in terms of what this type of training entails, contributed further to the sense of isolation:

P1: Definitely affected my...my social life and my ability to…particularly doing the Masters' and doing the work life balance was just out the window. My health really suffered. Physically my health suffered […] time to invest in other things is just really, really limited...so in a relationship time was really limited.
[…] Friday I did not want to hear or see or talk to or share or experience anything with another human being. So that's really hard then when you're in a relationship with somebody and they want to tell you about their day. I don't care. Because you've, you've used up all your caring somewhere else, you need a bit of space for yourself. So, I think that was something really challenging to negotiate I think as well.

P2: so I probably needed this more of self-care and then…I felt when I was doing self-care in terms of not drinking you get the abuse from your friends […] so terrible when you think about it

4.3.2 Isolation and Lack of Employment Opportunities

The general sense of participants' statements points in the direction of extreme sacrifices that are not matched with professional gains. The frustration and anger is are evident in their statements, mixed with a sense of loss and uneven balance of inputs vs outputs.

The participants completed the requirements of their professional trainings in terms of their clients, supervision and personal therapy hours. Following their completion of the course they started work towards their accreditation. This is the time when realisation of the loneliness of the profession became more profound and where the assumed lack of equal employment opportunities, in addition to the general lack of recognition of the profession.

Those unexpected aspects of practice created foundations for a shift in the perception of psychotherapy as a career choice for the participants. They realised that the struggle they

initially associated with the requirements of the training will continue into their private practice post-graduation, that the exhaustion and sacrifices need to continue to establish a meaningful practice. Combined with lack of reassurance and feedback that would stimulate feelings of being good enough in their new role, this frustration was projected towards the system, creating a sense of entrapment and unfairness in the form of perceived lack of employment opportunities:

> *P1: psychotherapists are not valued […] The HSE won't hire me as a psychotherapist, doesn't matter how experienced I am, how good I am at it. So the way, particularly in Ireland, the psychotherapists are viewed is so dismal in comparison…the profession is not supported in any way […] And because of that then to actually get work in it, that actually maintains the standards of living, is extremely difficult. So to get private practice you're talking about quite a significant amount of outgoings to actually set that up, then you're looking at good 3-4 years of slogging, trying to build a practice, you're still not guaranteed clients, you're still not guaranteed hours, you are still paying rent at an office - it's really hard to get bedded in somewhere. If you can find work in an actual service most of the psychotherapists are part-time and sessional so you're getting maximum of 15 to 18 session hours a week, which is enough really, but you're not paid full-time that's a full-time work but for a psychotherapist, but you're not paid full time salary.*

This participant provided elaborate description of their views of the flaws of the system and lack of regulation of psychotherapy. This participant repeated most of the questions out loud several times before providing an answer however, the researcher observed that the answers were rarely direct and almost always pointed at circumstantial and environmental situations and outside of, not within the participant's power. There was an excessive repetition of a word *certainly* throughout the interview: most of the sentences were opened with *certainly*, as if the participant was self-reassuring in rationalising their answers, trying to make themselves believe in what they were saying.

The researcher felt a strong sense of victimhood in this participant's portrayal of the reasons why their practice come to an end. To the researcher, some aspects of those reasons, such as money and lack of regulation, felt like an expression of some deeper, unnamed frustration. There was an element of something unresolved for this participant in this, despite the 6 years

since they saw their last client – anger combined with pressure and a sense of obligation that they should be practicing.

This participant tried to warn the researcher in a caring manner that psychotherapy is not a good career choice, and stated that they have discouraged people from studying psychotherapy in the past. The researcher noted that this participant viewed themselves as treated unjustly, which contributed to the sense of bitterness and hurt:

> *P1: I'm earning more in my current position. I'm actually better with my current job so I've done this training and now actually be promotable in the job that I'm already in, that gives me much better prospects, pension, sick days, […] I've all that stuff. How am I going to get this if I go in to being a psychotherapist […] So, the working hours are really, really tough, you are working when everybody else is off. So again, as I said earlier on the work balancing actually doesn't shift back properly […] and that's for people who are really good therapists they just can't keep it up. So yeah, I need it yeah, it wasn't worth it.*

Similarly, for P2 the financial struggles associated with setting up a practice were of importance, however this participant appeared to accept this reality from their own lifestyle perspective, rather than as a consequence of being mistreated by the system:

> *P2: money […] you never going to be a rich therapist, right, but I suppose that I was kind of thinking…I'm not going to be able to sustain my life […] I always knew in terms of my life and my lifestyle that I would always have to have two jobs. I'd have to be a psychotherapist and also […] so that probably fed into it a little bit...and therefore not being able to juggle the two*

The perceived lack of employment opportunities was contrasted with the sudden loss of the support network that was provided by the college – the participants found themselves lonely and unsupported, not recognised and not gaining much from the practice, both financially and personally.

This loss of a caring and supportive environment seemed to have a big impact on the participants and contributed to further exposure of the isolation of the profession. This lack of continuity of love/care was difficult:

P2: […] But it's actually since coming out of the bubble […] since coming out of the supportive network that we have in the training actually, I have experienced loneliness of my process because I'm not talking to people as much about it, I'm not sharing so therefore and doing a lot of work by myself

P1: being a therapist is also extremely lonely as a profession. And there isn't a huge amount of camaraderie in the field, and I think that's another big block, it's very hard to build up a rapport and a work spirit.

The reality of the post-graduate psychotherapist life was different than the phantasy and revealed the need for further sacrifices, additional commitments and on-going hard work. The objects that were needed were not possessed – the needs for reassurance, feedback, praise and comfort were projected into an empty space. They were not coming back detoxified and modified, but were instead amplified – the anticipated break, better work-life balance or proper earnings were not on the horizon and were therefore unconsciously functioning as bad objects, which needed to be rid of. They strived to get accredited to gain a sense of completion but found it extremely hard to continue into the future:

P2: I think it was very much early on I was thinking "I'm not sure" but I was always kind of thinking of the end call: just get to the end of the Masters, then after that get your accreditation because when you have your accreditation you can always go back to it.

So the hardest decision for me was to stop before I got accreditation and kind of leave it unfinished, you know, because that's not what I do, I finish everything.

P1: […] So, I really loved it but I couldn't see the light at the end of the tunnel. So then, when I'm accredited I started to question 'then what'? so I get accredited that doesn't make any difference I'm not going to suddenly be able to open an office and be a therapists to do my job, and not suddenly be able to be guaranteed client hours, no one suddenly is going to employ me. I'm not going to be able to get a job where I have a pension […]and I've done the training but the slog didn't seem to be worth it.

4.3.3 Letting Go of Clients

As a result, for most of the participants the work with clients was allowed to come to a natural end and they were not searching for new clients. In their recollection, it was a combination of the circumstantial events combined with exhaustion, disappointment and lack of perspectives – *no light at the end of the tunnel*. They did not appear aware of the internal, unconscious processes that contributed to this decision at the time. For P1 the exhaustion and

physical toll was too profound, and this participant realised the break was needed, which initiated preparatory work to end client work in a safe manner for the clients. For the other two participants the client work just faded away, they claimed that it ended naturally, and they did not look for new clients.

> *P1: […] there is a huge amount of personal sacrifice that goes into being a therapist without the kind of level of reward that's needed.*
> *I had come out of the Masters, and I was really just exhausted and frail. I kept working away for a year and just kept trying, I needed to stop, I needed a break, I couldn't keep up…the level of sacrifice was just too much.*

> *P2: it's not what they thought it was going to be […] well this is actually too hard, or I'm not sure if I like it […] It's a really, really difficult job*

The interview with P3 was appreciated for its concise and direct answers, gentleness and general curiosity of this participant's own process. It was evident that this participant was putting a lot of effort into answering honestly and for themselves – there was a surprise with some of their own answers and discoveries during the interview and this was also invaluable to witness for the researcher, how this participant made sense of their own journey during the interview, 10 years after finishing work with clients. The researcher felt great sense of sadness for this participant as if they were let down by the system and "them". Similarly, the researcher felt the need to encourage this participant to return to practice and continue their hard work with clients.

> *P3: I don't think it was a conscious decision (back then), I think it just happened to be honest. I think it was more circumstantial…*

4.3.4 Lack of Regulation and Authority in the Profession

The participants verbalised high dissatisfaction with the lack of authority body and lack of recognition of the profession throughout the interviews, which appeared to serve as an

additional insult when contrasted with the level of sacrifice they put into getting qualified and get their client practice hours:

> *P1: […] I just don't understand...anyway... that's just the way these things are run….It's part of the undervaluing of the psychotherapy, that you can do all that, you can be an accountant and decide to go back to training in psychotherapy but you can't do that, you can't be an accountant and decide to do a 2-year course and be a doctor, but for some reason they think that's ok to do it for psychotherapy.*

From the researcher's perspective there was a general sense of disappointment, frustration and bitterness that the dedication and sacrifices demonstrated by the participants were not reciprocated, not recognised and not profitable at the end of their journey. There was a sense of resentment and general 'hard done by' atmosphere, a sense of unjust and unfair treatment. The prospects of a solo career without the support of college and peer groups were contributing factors in their decisions to stop or not to look for more clients. The projection of those frustrations and disappointments is evident for P3, combined with idolised vision of CORU: seen as a much needed and desired container, that will hear and respond to their complaints and needs for reassurance, but also as a phantasy, that will set and maintain boundaries of each individual practitioner, that will guard them from the potential bad aspects of practicing psychotherapy.

> *P3: accountability wise…when we were going to college (2004) they were talking about getting CORU, accreditation. Once it's regulated…yeah. Until it's regulated not something I want to be involved in, accountability wise […] If it is regulated it will cause counsellors and psychotherapists to take more ownership or a ….not respect from other professions but I think it will be acknowledged once it's regulated….the accountability piece.*
> *There are people practicing with very basic qualifications and they might be best in the world but at least if you have a piece of paper saying I've met all these conditions or criteria, same as psychologists or social workers…I think it would be a really, really good thing for the profession in general. […] I think it was more of a pressure I put on myself, the accountability piece, but I think when CORU are involved there's no grey areas as such…it's going to be a good thing.*

There appears to be a frustration on behalf of this participant suggesting that perhaps in their view not everyone in this profession displayed equal levels of commitment to good practice, which P3 believed a regulatory body can resolve and maintain.

4.4 Theme Three – Infancy: Life without Psychotherapy

The participants agreed that they would reconsider returning to practice in the future if certain conditions were met. Two of the participants mentioned financial and professional recognition factors, while one participant recognised difficulty with their own process and inability to provide non-judgemental attitude, disqualifying themselves from practice by setting standards for their own practice very high.

It was of significance for the researcher to witness that while they all loved the training and listed several personal and professional gains from the training and work with clients, overall they had no further relationship with psychotherapy on a consistent basis in their lives after ceasing practice. There seemed to be a sense of exclusion of psychotherapy in their post-practicing lives, a sudden change from all-about-psychotherapy for 4-5 years to none.

4.4.1 Personal Gains

All the participants recalled a sense of relief after finishing work with the clients. They had more time and were more flexible to engage in other aspects of their lives, that were left unattended during the training/practicing years.

> *P1: I was certainly less grumpy, was a lot healthier. I was a bit happier (laughing), yeah so I was probably just nicer to be around.*
>
> *[…]So now I do other things, which is amazing, I wouldn't give any of that up just to go back and do psychotherapy. As much as I enjoyed that, I can scratch that itch when I come in to work. I wouldn't give up my work life balance now at all, no way.*

On the other hand the sudden availability of free time opened up a loneliness aspect for P2, which was camouflaged during the training:

> *P2: so the first stage was the honeymoon period. Loved all my free time and then I realised "oh my God this has taken up so much of my life"[…] but since finishing my training in college and all of that it's actually opened up this kind of loneliness piece.*

Each participant discussed their personal gains and development as a result of becoming a psychotherapist. From the personal gains' perspective, the most commonly mentioned was the development of self-awareness and self-confidence. Those new qualities also resulted in better relationships with others:

> *P3: it's given me an awful lot of confidence I think, lot more self-awareness […] Massive confidence professionally and personally, yeah. I'm very proud of it […] I wasn't very confident in groups at the time so that has changed for me, yeah.*
>
> *P1: so do I see myself differently? I'm pretty sure I can, yeah I can handle any kind of work load anyway certainly. I'm pretty sure I can bounce back from stuff much better. And one thing I do think I get from psychotherapy is just a realisation that, you know, even psychotherapist have their own stuff as well (laughing). Like nobody is better than anybody else (laughing).*
>
> *P2: actually I don't think everybody needs to go to therapy. I think everybody needs to become a psychotherapist. Because they become so self-aware […]So just in terms with my relationship with myself […] I would have gone in to the training not really liking myself and loving myself…and I suppose I have now developed a love for myself, which is really foreign feeling for me and you know […] I developed a really good relationship with myself.*
>
> *[…] And, and I definitely see it with my family, I have a much better relationship with them, much better relationship with some of my friends…*

Another important gain for each participant was the transferrable skills. Each of them highlighted the importance of learning certain therapeutic skills that they are able to use in their day to day work, outside of strict psychotherapy practice:

> *P1: I'm able to apply those skills to here (work) and it does make me a really good worker here, in what I do here. […] I'm glad that I did it because I have the skills and approach and understanding that I wouldn't have otherwise […] I'm actually better with my current job so I've done this training and now actually be promotable in the job that I'm already in, that gives me much better prospects*

P2: I use it every day, in terms from mindfulness perspective, from the self-critic perspective from... just understanding my feelings you know[…]and then in supporting others, it's really, really helped me as well…

P3: it changed how I work with people, definitely, more in a person-centred way […]I was using an awful lot of my skills in my work so it would have informed a lot of the roads I went on after if you know what I mean, especially having the transferable skills from counselling and psychotherapy…I still am using the skills.

They continue to work with a variety of people in multidisciplinary teams, not only care related. The skills learned can be applied in management and community settings, to enhance work with clients or customers but also with other staff and colleagues.

4.4.2 New Relationship with Psychotherapy and Potential Return to Practice

As mentioned previously, realising that each participant has very little or no relationship with psychotherapy in their current lives apart from transferrable skills was significant for the researcher. During the interviews each participant took a long pause before answering this question and there was a noticeable amount of either laughter or deflection when they realised how distant psychotherapy is for them now.

P3: [long pause]actual therapy…very little at the moment, yeah, (laughing) I'm so busy…the awareness piece is still there, the relationship building, trying to remain non- judgemental but yeah, the actual therapy…no, in personal life (voice changed)

In contrast, P2 uses the therapy at times of need, however, this participant was the last one to finish college and client work out of the interviewed sample, and is relatively new to not practicing:

P2: I am I'm kind of…I'm a psychotherapist, so I don't need to go to therapy anymore…and then I was going: well, actually I do and…actually I've tried couple of psychotherapists and that hasn't worked and then during the summer I got a really good one that really helped me so yeah, it's still very much part of my life (pause) yes particularly at the moment

Another participant appeared to have been disillusioned with the actual effectiveness of psychotherapy as such:

P1: (hesitating, long pause) None really. The therapy, as a formal setting, where there is a therapist and the client (hesitating) none, really. […] I often think that formalised process doesn't work very well anyway. So, for me personally it doesn't really have a place, for my work it doesn't really have a place. I suppose what I gained from it was set of skills and knowledge base that I can apply in a host of different situations and host of different settings and I can speak in informed way about things.

In terms of discussing potential return to practice in the future all participants agreed that they would consider it. They listed certain conditions and changes that would need to happen before they would reconsider:

P3: If it was regulated I think definitely, I'd love to do part time if I was confident in my personal circumstances, definitely, I'd love to do it part time, 5-6 hours a week.

[…] you've got to get it right, you've got to get your family circumstances right and you've got to have supervisors that's good for you. Support wise – I think that's where CORU could come in as well, you'll be listed and you'll have to do all kind of things, I think it'll be an excellent thing…

P1: So, I think if the system was changed and something opened up I have to look into it what the offer was again, what the structure was. I wouldn't necessarily….I double think about it (laughing)

The participants are seen here to rely on the improvements to the phantasised system, that could improve things and make the psychotherapeutic practice a less hostile place for them. The frequency and passion with which they made reference to CORU or the system suggested strong longing, a wish, a desire that remained unfound, a self-soothing vision of unachievable perfection.

When analysing the ways in which they have made a decision not to practice they all agreed that it was not a definite end and that they go through phases, when the thought of returning to practice is considered from time to time:

P2: I initially was saying I'm taking a break, then I've heard myself saying I've given up, I was like 'that's interesting' and only now I'm doing that whole thing, you know, I've moved on to "well maybe I might".

the other piece I'm really interested in is organisational psychology, organisational culture so I'm thinking that actually if I don't go back to client work I would definitely probably bring up all my learning into, into corporate, organisational environment.

P1: […] I still feel like I have this this thing that I've done that I should use and I've had to think I'm actually still processing that sometimes […] I don't think I made a definitive decision I'm not doing that anymore. What I did was I made an on-going decision not to restart.[…]

It felt to the researcher that with more reassurance and additional supports in place, all participants would feel more secure and would not hesitate to try again. It felt as if they needed a holding hand for little bit longer to find their feet and their balance before letting go of their fears and anxieties of their own performance as therapists, in an unstructured system of private psychotherapy practice.

Chapter 5. Discussion

5.1 Introduction

This research aimed to explore the reasons, that influenced decisions of fully qualified therapists to move away from psychotherapy practice. It hoped to better understand the context within which those qualified therapists, with some experience of client work, made decisions not to continue with their careers after significant effort to complete the training, by asking whether those reasons are linked to the practitioners' unconscious processes, or whether they are caused by external factors. It hoped to contribute to a better understanding of the support needed for newly graduated therapists that could inform current training programmes and/or entry criteria for the psychotherapy course.

The researcher discovered that the reasons why qualified therapists decide not to continue their practice stem from their internal unconscious processes and their views of, and their relationships with the external mechanisms of rules of private psychotherapy practice.

The research observed that the participating therapists were unable to construct a view of themselves as good enough practitioners in, in their view, a pathological and non-facilitating environment of psychotherapy practice: unregulated, isolated, financially not profitable with no career opportunities.

Finally, the Object Relations theory mentioned in Chapter 1 instructs that internal objects are formalised following interaction between a person and their external objects. This relationship between the self and the other – in participants' case the psychotherapeutic practice, was internalised as a bad object and was characterised by fear, disappointment, anxiety and anger (Scharff & Scharff, 1998, 224).

5.2 Theme One – Experience as Novice Therapists

This theme looked at expectations that the therapists had of themselves as psychotherapists, their initial experience as psychotherapists and the frustrations associated with those initial experiences. The results outlined in the previous chapter suggested that the participants wished for their personal psychotherapy practice to be profitable, they had visions of themselves as therapists fixing people and bringing measurable outcomes, being able to apply their skills by the book without allowing themselves room for error or learning, straight after college. The literature supports this view that novice therapists can be restricted in their practice by the pursuit of perfectionism: Bion stated that "phantasies of omnipotence, and this tendency to cling to theoretical a priori knowledge are the analyst's chief reactions in the face of the something new and unknown that appears in every analytic session" (Grinberg et al., 1977, p. 116). In addition, this finding corresponds with Spinelli's view (2006b) that rigidity and the need to perform strictly by the book may prevent novice therapists from constructing proper relationships with clients**.**

The participants described similar experiences in their rejection of the flaws that are the integral mechanisms of private practice, and they appeared angry towards the system that failed to recognise and apply robust boundaries to the profession to date. Their anger and frustration with the system, with the lack of actual authority revealed itself in its exclusion – there was evident black or white thinking, inability to accept the profession with its imperfections and positives as one.

Nolan and Nolan (2002) pointed out that the baby (in this case the therapist) externalises intolerable feelings and projects them into the mother (professional practice); by accepting those stimuli the mother unconsciously engages in projective identification, by identifying with the baby and attempting to understand what might have caused those feelings. This inner work is referred to as reverie (Nolan & Nolan, 2002). For the participants that participated in

this research there was no container – their needs, fears and anxieties were not responded to and remained unmet.

This theme also unveiled participants' initial motivations to enrol in psychotherapy practice and how it potentially impacted on their initial desire to fix and resolve clients' issues. A link can be made between their own unresolved problems that were unconsciously awaiting fixing in their initial work with clients. This supports the theory in Chapter 1. that becoming a therapist is often triggered by unconscious methods of self-medicating, the need to fix in others' lives what went wrong in our own, and the desire to save ourselves (Adams, 2014, pp. 8–9).

5.3 Theme Two – Reality of Practicing Psychotherapy

This theme reviewed participants' experiences of isolation, sacrifices, perceived lack of employment opportunities and regulation, and that their client work was allowed to come to a natural end. The participants described that the process of becoming a qualified therapist is difficult and full of sacrifices, leading to the development of a new identity – that of a psychotherapist. This development of new identity as a therapist can be viewed as experiences of those early relationships with the mother (profession of psychotherapy), where the child (new therapist) needs to feel loved and related (Nolan & Nolan, 2002, p. 10). The mother's role is to provide the facilitating environment and to be available as a usable object, a secure base – enabling the child to grow and progress. In the event of environmental failures, which can be viewed as the participants dissatisfaction with the reality of psychotherapeutic practice, and lack of mother figure in the profession (lack of regulation) "the child's progress towards maturity will be interrupted or frozen and he or she will defend himself or herself in different ways" (Nolan & Nolan, 2002, p. 12).

Balint proposed (1968, p. 66) that "the aim of all human striving is to establish – or, probably, re–establish, an all–embracing harmony with one's environment, to be able to love in peace". Balint explained (1968, p. 67) that prior to its birth into intense state of relatedness (participation in training, commitment and sacrifices) to his environment, the self and the environment are in the state of objectless *harmonious interpenetrating mix-up*. This corresponds with participants' views of their training and the support received while still in college. This homeostasis is disturbed during birth – seen as a trauma (ending college and embarking on a solo journey of private practitioners) and requires new adaptations, marking a separation of the individual from the environment. From this separation objects emerge – some will provide gratification and some frustrations. Those primary objects can be seen as beginning one's journey into independent psychotherapy practice, which in the case of the participants were marked with frustration with perceived lack of employment opportunities, lack of regulation, isolation, leading to not seeking new clients. In the event that the supportive environment and containers are not available, as it was demonstrated by this research, the infant (the participants) can internalise a bad sense of themselves (Symington, 1986, p. 291). This is providing further link with Bowlby's view (1997, p. 378) presented in Chapter 1 that chronic deprivation and lack of supportive environment results in lower resiliency, defective control and persistent vulnerable structure.

5.4 Theme Three – Life without Psychotherapy

This theme looked at participants' current relationship with psychotherapy and their personal gains from the psychotherapy training after their client work ended. The participants disclosed that psychotherapy does not have a place in their lives now. In Object Relations theory the excluded bad object is mourned and eliminated from the internal space (Scharff &

Scharff, 1998) and it loses its significance and no longer matters, as it is demonstrated in case of the participants.

The participants viewed themselves as enriched by the experience in many ways, on both professional and personal levels but yet this was not satisfying enough. The internalisation of the negative experiences from their environment outweighed the positive experiences. There was a strong focus on the lack and shortfalls, exacerbating the feeling of injustice, hurt and lack of care. This can be seen as the 'entirely good' or 'entirely bad' categorising, which resembles what Klein referred to as splitting.

The mother's role is to detoxify and contain the anxieties and phantasies (Nolan & Nolan, 2002, p. 12): the acceptance of the profession is not unconditional for the participants – they have their phantasies of it and appear to be rigidly holding on to those, which is restricting. Also, their potential return to practice was found to be portrayed in a conditional manner. This echoes Gerhard's view (2015, pp. 140–142) that people whose needs were not meet in infancy and childhood will demand certain needs to be satisfied when they are adults: they appear demanding, they turn to others to have their initial, unmet needs satisfied.

The process of object relating is not only restricted to the infancy. Relation building with objects is evident throughout the lifecycle and includes relating, sorting, construction and exclusion of objects in the "continual remodelling of the self" (Scharff & Scharff, 1998, p. 235) – this process can be seen in the journey experienced by the participants of this research. However, this relating goes beyond their decision to discontinue practice – they embarked on another journey with new selves, the non-practicing ones, and this was further modified by the participation in this study.

Chapter 6. Conclusion

The research highlighted that qualified psychotherapists who successfully completed a psychotherapy training and client work were influenced by a combination of external and internal unconscious mechanisms when they decided to terminate their practice. Those mechanisms relate to their inability to view themselves as good enough therapists in a not good enough holding environment, demonstrated in their perception of the profession of psychotherapy as unsupportive and isolating. Their needs for on-going support, feedback and reassurance were not met by the current, unstructured system of psychotherapy practice in Ireland, which contrasted with the securely held, supportive and protective nature of their training.

As mentioned in the literature review in Chapter 1 the mother that holds effectively transforms hunger into satisfaction, pain into pleasure and loneliness into company, which is what Bion calls the capacity for reverie (Grinberg et al., 1977, p. 56). In case of the interviewed practitioners this state of reverie did not occur, there was no sense of relief, the unpleasant desires were not modified. The participants found themselves in a situation where suitable containers were not available and they were left with overwhelming levels of anxiety and unmet needs. There was no modulation of unmanageable feelings and experiences, there was no reflection and mirroring. Lack of the mother figure for the participants resulted that they had no opportunity to cope with and re-internalise what was projected, to build their capacity to regulate own negative affective states (Fonagy & Target, 2003, pp. 122–123).

The research concluded that the system in its current form does not appear to be holding of the qualified therapists and is perceived as the bad object. From a protection of the womb to cold, hostile and unfamiliar environment, which does not resemble the comfort and containment of the training, the process of becoming an independent psychotherapist was

found to be difficult and unsuccessful for the participants of this study. Discontinuation of practice (exclusion) and avoidance of further sacrifices and hard work was considered a better option for those participants, despite the feelings of loss and disappointment from unused skills.

The positive and negative experiences of life have the power to transform the meanings of one's outer and inner life experience for better and for worse. From the perspective of Object Relations theory the psychotherapy practice lost its meaning for the participants due to lack of reciprocated love, understanding, care and regard: "throughout life we are looking to introject objects that will contain us through their regard for us. In this way we feel held […] and to the extent that we create objects from experiences of being misunderstood, rejected or persecuted, we feel hurt and diminished" (Scharff & Scharff, 1998, p. 224).

6.1 Strengths

The choice of IPA as a method for this research corresponded well with the very personal and subjective nature of participants' journeys resulting in termination of practice. The evidence gathered throughout this process addressed the gap in the existing research of why many of qualified therapists decide not to practice. The homogeneity of the sample adds value to this research, where all participants were graduates of a 4 year training, personal therapy, client work and external supervision.

Also, despite participation from both genders it felt important to the researcher to not include the participants sexes in the results and discussion chapter, to avoid unnecessary gender stereotyping on behalf of the reader. The researcher assumed that gender was not a contributing factor in participants' experiences of current psychotherapy system in Ireland and their reasons to discontinue their professional practice.

6.2 Limitations

The small sample size can be viewed as a limitation if attempts to generalise the outcomes are to be made. Also, there was a difference in the length of time that the participants were out of practice. P3 had been out of practice for significantly shorter time than the other participants, which may suggest influence on the on-going link and relationship with psychotherapy. More homogeny in the time since ending practice could produce better clarity in the current relationship with psychotherapy.

The participants were all graduates of Dublin colleges and their psychotherapeutic practice was conducted in Dublin. This provides further limitations as there are many more practicing therapists in Dublin than in other regions of the country, which could potentially contribute to the fear that new therapists may not have enough client work to sustain a living wage.

6.3 Suggestions for Further Research

The researcher felt that further investigation is needed of how strongly the motivating factors to become psychotherapists influenced the initial approaches to clients and their expectations of themselves as therapists. Was the need to fix people in their initial client work stemming from the original motivations and personal unresolved traumas, which in turn led them to expect sudden changes and improvements in clients' lives thanks to their input as therapists?

Interview with P3 highlighted an important aspect of trainee therapists' learning – their learning from observations of their own supervisors and therapists. Therefore, another interesting avenue for future research could be an exploration of novice therapists' experiences of their own personal therapy and how it impacted on their initial approaches to

clients, what type of therapists they would like to become and what expectations they had of themselves in their roles as therapists.

6.4 Implications for Psychotherapy Training

As demonstrated in Chapter 1, there are detailed information on DBS website outlining requirements of the course however, it felt to the researcher that the information on the website assumes that potential students have prior experience and understanding of the emotional load and requirements associated with personal therapy and client work. This may not always be the case: the participants of this research appeared unaware and shocked with the hard emotional and physical load required to finish this type of training. Out of the concern for welfare of students during training the emphasis should be on assessment of their ability to self-care and structure their time during the training, especially if they are in full time employment and/or have busy and demanding family life.

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Appendices

Appendix 1. Glossary of Abbreviations

1.	APCP	Association of Professional Counsellors and Psychotherapist
2.	BACP	British Association for Counselling and Psychotherapy
3.	CIPC	Counselling in Primary Care
4.	DBS	Dublin Business School
5.	ECP	European Certificate in Psychotherapy
6.	HSE	Health Service Executive
7.	IACP	Irish Association for Counselling and Psychotherapy
8.	IAHIP	Irish Association of Humanistic and Integrative Psychotherapy
9.	ICP	Irish Council for Psychotherapy
10.	NAPCP	The National Association for Professional Counselling & Psychotherapy
11.	NCS	National Counselling Service
12.	PSI	Psychological Society of Ireland

Appendix 2. IAHIP Advertisement

Invitation to Participate in Research - Call for Inactive/Non-Practicing Psychotherapists

Participants required for a research thesis aimed at understanding **why fully qualified therapists decide not to work in their occupation**. The participants need to be:

- Psychotherapists/Counsellors qualified to Bachelors/Masters level
- With minimum required number of client hours completed
- Not currently practicing (but not due to retirement)

This research aims to explore the reasons and to better understand the context within which qualified therapists, with some experience of client work, make decisions not to continue with their careers.

Contact details:

Ph:
Email:

Appendix 3. Research Thesis Demographic Sheet

Kaśka Kopczyńska
December 2018

1.	Type of Qualification	
2.	Number of client hours completed	
3.	Number of clients per week	
4.	Number of years/months out of practice	

Appendix 4. Original Interview Schedule

1. Can you tell me what motivated you to become a psychotherapist?
2. What were your original post-graduation plans?
3. How would you describe yourself as a psychotherapist?
4. Can you tell me about the way you see yourself now in comparison to before you completed the psychotherapy studies?
5. Can you tell me about your experience of working with clients?
    - Prompts (if needed):
        - *What aspects did you find most rewarding/fulfilling and what most challenging?*
6. What was your experience of clinical supervision?
7. Can you tell me about your self-care practice when you were actively working with clients?
8. Can you tell me about how you first became aware of your plans to cease working as a therapist?
    - Prompts (if needed):
        - *What do you think brought this about?*
        - *Was it personal or professional?*
        - *Can you describe how you felt at the time?*
9. What was your experience of the decision-making process?
10. What was the time lapse between your decision not to practice and ceasing the client work? What were you experiencing during this time?
11. Can you tell me about your last sessions with clients?
    - Prompts (if needed):
        - *How was it for you?*
12. Can you tell me about how you have been since you stopped seeing clients?
13. How do you see yourself in the future? (return to practice?)

Appendix 5. Amended Interview Schedule

1. What initially drew you into the field of psychotherapy?
2. Can you tell me about your experiences of psychotherapy training?
• *Do you keep in touch with people from your course?*
3. In what way has completing a psychotherapy course changed you?
• *Do you see yourself differently now? Do you see others differently now?*
4. Can you tell me about your initial experience of working with clients?
• *What aspects did you find most rewarding/fulfilling and what most challenging? Was supervision helpful?*
5. Can you tell me how your work as a therapist has impacted on your personal life?
6. Why do you think people who have trained to become a psychotherapist don't work in this occupation?
7. Can you tell me what you think brought this about for you? What happened in your case?
• *Was it personal or professional? Can you describe how you felt at the time?*
8. Can you describe how you came to make the decision?
9. What was the impact of your decision not to practice on people close to you?
10. Can you tell me about your last sessions with clients?
• *How was it for you?*
11. It's been _____ years/months since you've stopped seeing clients – how have you been since?
12. What place does therapy have in your life now?
13. What would you do differently if you were starting over?
• *Any regrets in retrospect?*
14. Can you tell me anything else important that we haven't discussed?

Appendix 6. Transcript Sample

Q4	**K: so in line with that in what way do you think psychotherapy has changed you?** I: has changed me? K: Yeah I: it's changed me in (mumbling) way. K: ok I: So just in terms with my relationship with myself and in turn that has led to me having better relationships with others. I do feel I'm hmmm at times I'm reverting back to my old ways, you know, so then I know I need to work on myself again or continue on that road, but I suppose I would have gone in to the training not really liking myself and loving myself and I suppose I'm have now developed a love for myself, which is really foreign feeling for me and you know I really, really…yeah developed a really good relationship with myself. And, and I definitely see it with my family, I have a much better relationship with them, much better relationship with some of my friends, and again the non-self-aware ones where difficult, but so yeah…. I also, I changed jobs… I know it's a lot of money to invest in to get this and as so I changed jobs at the time I was I was working in (name of the company) came here in 2012 and it just helped me so much to settle in here to build really good relationships, to know….not to get stressed or that. I use it every day, in terms from mindfulness perspective, from the self-critic perspective from... just understanding my feelings you know, sometimes you sitting there going something's going on here and I can't quite put my finger on it and then you realise, actually, that's pure jealousy, or that's. Do you know and so yeah it's a... you know and then in supporting others, it's really really helped me as well, and I suppose, you know, family members that are going through or friends they're going through a really difficult time I feel I can be very much real to them, and be, be there in a different way, not just a giving advice way more just a holding way. K: ok thank you for sharing this that's very honest I: yeah	speaking slowly voice changing hesitating laughing thinking while speaking Change in voice banging with the pen on the table banging continued Laughing

Appendix 7. Table of Combined Emergent Themes

Most challenging aspect of client work		
P1	**P2**	**P3**
Exhaustion Tiredness Felt bad about being so exhausted: felt could have done so much better – tried to be present for clients despite exhaustion – not good enough? Not enough credit for therapists – hard to do the training & placements	Only realising now that most difficult piece was to be non-judgemental as a core value, found it difficult Expected self to be totally non – judgemental Only accepting this now Struggled to be non-judgmental towards clients with poor self-awareness Aware of own process and feelings Doesn't feel different type of clients would make a difference Would prefer solution focused goal-oriented therapy, quicker fixes, outcome oriented Only figuring it now variety of clients – challenging to work with traumatised clients with childhood issues Struggled with very self-unaware people	People don't understand pressures (of training?) & what's going on in your own head – especially those close to you don't understand those pressures Lack of understanding among people of the pressures in this work & training Fear of missing something (in clients) Pressures with accountability re child protection etc Fear of what's coming next
Impact on personal life		
So consumed by college & client work Social life affected Poor work – life balance Health suffered - Exhaustion No time to invest in other things Unable to listen and talk anymore at home after clients – used up all caring somewhere else so couldn't have any more at the end of the week at home Negative impact on relationship	Personal life not too impacted Poor work life balance Supported in supervision Didn't feel was carrying stuff from client work Stories of others during training (cried a lot of tears for others) Found the environment very supportive during training Didn't feel impacted by client work	Needed support elsewhere because family and friends didn't really get it (how hard and challenging the process is)
Self – care		
Poor work – life balance Health suffered No time to invest in other things Exhaustion	Not enough self – care Exhaustion Constantly go go go go Doing masters very lonely experience	Lot of stress Time restrains Pay it all & fit it all No time to fit in self-care

Appendix 8. Thematic Map

Appendix 9. Consent Form

CONSENT FORM

Protocol Title:

An exploration of the reasons why qualified psychotherapists decide not to work in their occupation

Please tick the appropriate answer.

I confirm that I have read and understood the Information Leaflet attached, and that I have had ample opportunity to ask questions all of which have been satisfactorily answered.

☐**Yes**
☐**No**

I understand that my participation in this study is entirely **voluntary** and that I may withdraw at any time, without giving reason.

☐**Yes**
☐**No**

I understand that my identity will remain confidential at all times. ☐**Yes**
☐**No**

I am aware of the potential risks of this research study. ☐**Yes** ☐**No**

I am aware that audio recordings will be made of sessions ☐**Yes** ☐**No**

I have been given a copy of the Information Leaflet and this Consent form for my records.

☐**Yes**
☐**No**

Participant _____ _____
Signature and date Name in block capitals

To be completed by the Principal Investigator or his nominee.

I the undersigned, have taken the time to fully explained to the above participant the nature and purpose of this study in a manner that he/she could understand. We have discussed the risks involved, and have invited him/here to ask questions on any aspect of the study that concerned them.

_____ _____ _____
Signature **Name in Block Capitals** **Date**

Appendix 10. Information Sheet for Participants

INFORMATION FORM

My name is Kaśka Kopczyńska and I am currently undertaking an MA in Psychotherapy at Dublin Business School. I am inviting you to take part in my research project which aims to explore the reasons and to better understand the context within which qualified therapists, with some experience of client work, make decisions not to continue with their careers.

What is Involved?

You are invited to participate in this research along with a number of other people because you have been identified as being suitable, being a qualified psychotherapist. If you agree to participate in this research, you will be invited to attend an interview with myself in a setting of your convenience, which should take no longer than an hour to complete. During this I will ask you a series of questions relating to the research question and your own work. After completion of the interview, I may request to contact you by telephone or email if I have any follow-up questions.

Confidentiality

All information obtained from you during the research will be kept confidential. Notes about the research and any form you may fill in will be coded and stored in a locked file. The key to the code numbers will be kept in a separate locked file. This means that all data kept on you will be de-identified. All data that has been collected will be kept in this confidential manner and in the event that it is used for future research, will be handled in the same way. Audio recordings and transcripts will be made of the interview but again these will be coded by number and kept in a secure location. Your participation in this research is voluntary. You are free to withdraw at any point of the study without any disadvantage.

DECLARATION

I have read this consent form and have had time to consider whether to take part in this study. I understand that my participation is voluntary (it is my choice) and that I am free to withdraw from the research at any time without disadvantage. I agree to take part in this research.

I understand that, as part of this research project, notes and audio recordings of my participation in the research will be made. I understand that my name will not be identified in any use of these records. I am voluntarily agreeing that any notes and audio recordings may be studied by the researcher for use in the research project and used in scientific publications.

Name of Participant (in block letters) _____

Signature_____

Date / /