

**An Unusual Guide to Therapy for Extraordinary
People: Creating an illustrated booklet based on
clients' therapy experiences**

A Final Project Submitted in Partial Fulfilment of the Requirements for the Diploma Program
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ABSTRACT

My project *An Unusual Guide to Therapy for Extraordinary People: Creating an Illustrated Booklet based on Clients' Therapy Experiences* is a qualitative research project with an educational product presented in a creative style. That product is a booklet, *An Unusual Guide to Therapy for Extraordinary People*, a guide to therapy based on reported client experiences. Different scenarios were submitted, in response to a survey, as being memorable experiences in therapy. The scenarios have been illustrated and used to highlight how clients should feel when they are with a therapist, advice is provided on what to look for in a therapist. The booklet is unconventional in that it makes use of the client experience and the voices of clients. Much of what is written about therapy, and what works in therapy, is written by researchers and academics for a professional audience. I have taken a different approach. This essay documents the background, my own experience with therapy and concern for how to make the most of what therapy has to offer. The research process is also documented, as well as my findings that informed the booklet and its content.

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INTRODUCTION

The world of therapy and therapists is familiar to those who have studied the field. That world is also known but often retains some mystery, to clients of therapy. I have done both, I have studied to become a therapist and I have partaken in therapy as a client. Therapy is a mysterious practice, a world feelings, and experiences for all parties involved. It can be difficult to know ourselves, as we are encouraged to do in therapy, and to appreciate the qualities that allow us to see ourselves in others, or to appreciate our complexity, fragility and uniqueness. In this project, my final project in the MAPW program, I open the door to the therapist's office in order to demystify therapy, particularly for those unfamiliar with therapy as an experience, and created a booklet, a guide to therapy. The background to the topic, the path that led me here, and the research process that provided therapy scenarios that fill the booklet, are all detailed in this essay.

My personal motivations and passion for this topic are related to, and overlap with, broader social issues. I have my own, ongoing, experiences in therapy and I have worked in the mental health sector and met people who are mystified by therapy, and I mean clients in particular, to them it can appear like a game, one that they don't know the rules to. This project was created for them and for me, the topic is important to me. To colour in the back-story I want to introduce, and explain five things that sit in the background of this work:

- My experience with therapy
- The stigma of therapy
- The voice of the client
- Therapy over other treatments

- Demystifying therapy as a way to empower clients

My experience with therapy

I bumbled through life without therapy, there were the inevitable peaks and troughs but things went well in general until, twelve years ago, my partner of 18 years died by suicide. It was an unexpected and inexplicable tragedy that changed me and left me questioning everything I took for granted, including my sense of self. Like Russell Hoban's fictional character, Riddley Walker, who traverses a post-apocalyptic terrain I was left in a world I struggled to make sense of. I knew I was experiencing grief, and I had no map;

“So sad I fealt then. Sad and empy with a cryin in me. I fealt like that Other Voyce Owl of the Worl musve lissent the woal worl away and every thing gone. Every thing emtyd out of the worl and out of me.” (Hoban, 1980, p. 158).

The grief of loss is an emptying experience, foreign. I was thrown back on myself and left with more questions than answers. That state of questioning everything is not exclusive to people close to a suicide, but it is something shared by them. Again drawing on a work of fiction, this time in Jeffery Eugenides (1993) first novel, *Virgin Suicides*, a group of young men occupy the narrator's role as they try to make sense of suicide. They conclude that:

In the end we had the pieces of a puzzle but no matter how we put them together, gaps remained, oddly shaped emptiness mapped by what surrounded them, like countries we couldn't name. (p. 246).

Suicide defies rational, or ready, explanation. That quote captures how inexplicable suicide remains to me and while I feel I understand a lot, there is also much that remains unknowable. Along with unanswerable questions, an encounter with suicide leaves a special type of scar for those left with gaps and emptiness. I was inconsolable in my grief, I couldn't help but question

my own role. What had I done? What could I have done, that I didn't do? There were no answers and I struggled.

I made an undertaking to use all of the resources available to me and resolved to try therapy, only I knew it then as counselling. Realising that, along with questioning I felt contrary and disagreeable, at odds with the world, I resolved to give therapy five chances. I felt I needed some leeway to find the right person to work with.

Three strikes but not out

I use the term therapy and you could call it counselling, or seeing a psychologist, whatever term is familiar, you will know what I mean. The first therapist I consulted was Smith (real names have not been used throughout this essay). With some trepidation, I turned up for my appointment. Our meeting didn't go well from the outset.

Smith had been counselling people in my partner's workplace, since the death, and Smith was familiar with the case. When we met Smith got my name wrong and couldn't recall my partner's name. He put me off-side in the first two minutes, from there it got steadily worse.

Smith read me a poem, it was one I had chosen to include in my partner's funeral service, I couldn't help but wonder where this is leading. I found myself holding back, defensive, waiting to see what Smith would do next, the ensuing silence made him nervous and he started talking. He explained the conscious and subconscious mind, and for some reason wrote those terms on a white-board. I looked on, distant and all the while starting to wonder if therapy was a good idea.

Smith related the story of a young girl on a family picnic, she chased a ball into some low grass where she saw a snake. He said that the girl picked up the ball and carried it to the car.

After putting the ball into the car her arm was caught in the door, which (as Smith told it) left her scared of snakes. Even today I am unsure of the point of the story because he didn't say. To me, it sounded like a stupid story with no relevance to my situation. I did try to mull over possible links as he rambled on.

Next, in that counselling session, Smith related the story of a man working at a manufacturing plant who lost his arm in an accident involving industrial machinery. On the anniversary of the dismemberment, apparently, the man would experience the sensation of a whole arm. Again, the connection to my own situation was not obvious to discern, and being unsure of what to say I just nodded and stayed silent.

Continuing to talk, Smith hurried on to another story, this time about a man who was mugged at a Melbourne train station car park. The man was so shaken by the experience of being beaten and robbed he was unable to return to the car park. Smith had helped him by slowly bringing the man closer and closer to the site of the crime. First a few blocks away then, the next week, a little closer until they stood together, somehow triumphant, at having returned to the site.

Irreverently, I wondered if therapy was not working, as I wanted to laugh. It wasn't mirth, it would have been an expression of disbelief and despair. If this was professional care, I thought I might never regain the footing I had lost in the world.

Eventually, there was a pause in Smith's storytelling, but not before he informed me that expressing my grief would be important. If only I could get a word in... I had been expressing my grief at home and in the streets, my pillow wet with tears. This might have been the first dry-eyed hour I'd lived through in the couple of weeks since my partner's death.

I had to tell Smith how I was feeling and let him know that I wouldn't be returning. It wasn't easy, I felt ungrateful, I told him that he may have made some assumptions or drawn

some conclusions about how articulate I was, or wasn't, based on the little I had said during our meeting. I informed Smith that I had failed to establish a rapport with him, although that must have been a statement of the obvious. I suggested that it might be better for me to see another counsellor. Strike one.

Smith rang me a week after our session to recommend another counsellor in his practice. I had asked him to recommend an alternative, I was glad he followed through. I followed through myself and made an appointment. On the day I took a deep breath as I entered the office, hoping that this experience would be a better one for me.

It started well when this counsellor, Jones, got my name right, a feat Smith had failed. That feeling didn't last long and Jones asked me if there was anything I would like to know about her. I was surprised by the question, wasn't this supposed to be about me? I felt unprepared for counselling, I was not in the flow and felt edgy. No questions for her came to mind and I knew there should have been questions to ask. I wondered if I was too self-centred.

I didn't have to worry for long as Jones began telling me her background and qualification, detailing her employment history. I was surprised into silence, unsure of what to say but feeling it might be irrelevant to run through my own curriculum vitae.

Jones led the conversation explaining how grief comes in waves and how it could be triggered, almost inexplicably, by unexpected things. I nodded, dumbfounded, I already knew this. It was not new information.

Jones rambled on about grief experiences and I sat there not knowing what else to do. Finally, and thankfully, she wrapped up the session telling me I was numb. Apparently I was too upset for counselling and she suggested that I contact her in a few weeks when I was feeling 'better'. Numb I may have been, but her advice made little sense. Wouldn't upset or numbness be

something a counsellor could help with? I decided on the spot that I wouldn't be contacting Jones again, I thanked her and left. Strike two.

My first two experiences with therapy or counselling were setbacks that served to make me more determined to find a therapist I could work with. Perseverance paid off, and thanks to the recommendation of a friend of a friend, I went to see Williams, a psychologist.

Her dark office offered refuge, and I sheltered there, weathering the storm of emotion and the tide of tears. Talking and listening, being allowed to be normal, whatever shade of normal I chose to wear on any particular day, therapy with Williams allowed me to start to rebuild a relationship with my partner and with myself.

I don't know how often I saw Williams, many times over a period of months, we continued to meet until things felt sort of wrapped up and settled. Well not *done* exactly, but the sessions stopped when we agreed we had travelled as far as it seemed there was to go together a natural close.

Things went better with Williams than with Smith or Jones, listening and supportive, she helped me to normalise my grief experiences although at times the directive nature of her approach left me unsettled; she used to tell me what I should and shouldn't do. Some advice she gave me was useful and some of it went against what I felt was right for me but I tended to comply, bowing to her authority and experience of working with people in distress. I was third time lucky, I felt more whole, even if still incomplete. In retrospect, however, given how unsettled I still felt when we finished, I now count therapy with Williams as strike three. Goldilocks found something just right on her third attempt, the porridge, the chair, the bed. For Goldilocks, and in general, its good practice to try, try again. Three strikes doesn't mean you're out.

There was more for me to do, more to discover, more therapy to come. It wasn't until I found Processwork, or perhaps it was Processwork that found me, that my journey of inner reconciliation really started. Processwork, also known as process oriented psychology, is a framework for finding and aligning to your deepest nature. Processwork is described as an awareness practice and it did enhance my awareness in many ways and particularly about myself, how to be in the world and how to "dream while awake." The concept of lucid dreaming was framed by Arnold Mindell (2000) the founder of Processwork. I like to inhabit a world where dreaming and the fanciful yearnings are valued. The treasure I most value from my studies in Processwork is the personal development I have striven for, and through my work and inner efforts been gifted with.

While I highly recommend therapy, in general, I doubly, quadruply, recommend Processwork practitioners as therapists to work with, to locate solutions for psychological challenges, for understanding your deepest nature, and helping you to appreciate yourself as you are, and for who you are. It wasn't until I started studying at the Process Work Institute in Portland Oregon, six months after my partner's death, that I discovered a therapist and a type of psychotherapy - that gave me a way of exploring my own psyche while allowing for growth and development. I was drawn to Processwork for its sense-making by exploring beyond the rational and every day. Processwork builds awareness, explores polarities, and attempts not marginalise, or smooth over difficult and disturbing experiences. In therapy, I was allowed space to bring myself and my experiences into sessions and I no longer felt the pressure, real or imagined, of going against my natural tendencies. Through therapy with a Processwork therapist, I discovered that what is possible for those left behind in the incomprehensible aftermath of a suicide is empathy for the life lost and forgiveness for ourselves, in whatever role we played in the life of

someone who had to leave. It was mostly because of these profound experiences that I became an advocate for therapy, I wanted everyone to experience the stilled internal state that I was sometimes able to find. The catch was I didn't feel able to share my therapy experiences in most company.

In some ways, my own painful initial experiences in therapy planted the seed for this project. What I had been through with Smith, Jones and to a lesser extent Williams had left me bruised, wanting to right the wrongs done to me – but also fueling a mission to hopefully prevent others from feeling similarly scarred and opening the door to the wonders possible in therapy.

The stigma of therapy

I didn't talk about therapy even while I was experiencing benefits I hadn't considered as possible, shifts in myself and a reassembling of my being. I didn't want to be viewed as less than normal and coping, so silence seemed a better option than sharing. There is something integral to our psyches that can be unrelenting, we get on with things, we get over things, we expect ourselves to buck up and keep on going. Therapy can be regarded as something unusual and for the weak. Our attitudes are slowly changing but an admission to attending therapy is likely to prompt friends to take a step back and change the subject. Therapy is typically associated with mental health issues, something that makes us uncomfortable. We believe that normal people don't attend therapy.

My good friend Robertson rang on a Saturday morning to say our regular coffee at the market would be in the 'new place', rather our usual coffee spot. "Sorry," I said, "I won't make it to coffee today. I have a therapy session at 10:30..."

Phew. I had said it. I had admitted to attending therapy. I was pleased with myself for having mentioned it casually to a friend, an admission I hadn't made to any other friends or family. Even if it was not as easy to 'fess up to as I would have liked, Robertson, to his credit, didn't skip a beat and suggested a catch up over brunch the next day.

When we met he asked how my massage had been. Massage? For a moment, we were both puzzled and muddled. He thought I had gone for a beauty treatment or a therapeutic massage.

The relief I had felt thinking that Robertson, a good friend, had simply accepted my use of therapy, turned to dismay, as I realised I had been misunderstood. Haha.... I nervously laughed it away.

Therapy. I would love talking about *therapy* to be easier, more every day. Therapy is one of the things that helped me through grief, it is one of the ways I have looked after myself. I must have had bats in my belfry for shrugging off, to Robertson, something so important, and something I wanted to talk about and have more known. After all, where is the stigma? Only in my mind? I know I perceive some reproach from the world at large, and there's no specific criticism. It could be just me... I undertook to tell Robertson more over our next coffee.

About therapy

I have been talking personally about therapy and I would like to explore more generally around why therapeutic experiences are rarely disclosed to our friends and family, and even more rarely in wider social circles. There must be all sorts of reasons for our silence. My personal experiences connect with broader issues around therapy and have motivated me to focus my project on clients' experiences of what happens in therapy. I need to speak out loud now. You

need to look no further than the Merriam Webster online dictionary (2016) for a; “Simple Definition of therapy: the treatment of physical or mental illnesses”. There is the stigma simply defined – therapy is for people with illnesses.

The dictionary helpfully, or to my mind, not so helpfully, includes a list of synonyms for therapy “antidote, corrective, curative, rectifier, remedy, therapeutic, cure”, all of which serve to reinforce the widely accepted premise that therapy is for those of us who are ailing and in need of healing. The same dictionary states that first use of the term therapy was circa 1846, and 170 years later the general understanding of therapy still aligns with the quoted definition. I would like it to be understood differently. Yes for healing, and an even bigger yes to personal growth.

Even Professional bodies describe therapy as being a treatment for problems. The Psychotherapy and Counselling Federation of Australia (PACFA) says that:

Therapy is the process of meeting with a counsellor or psychotherapist for the purpose of resolving problematic behaviours, beliefs, feelings and related physical symptoms. (PACFA, “What is therapy,” 2016).

The American Psychological Association (APA), while not going so far as to say that something problematic is a pre-requisite, still frames therapy as a treatment:

Psychotherapy is a collaborative treatment based on the relationship between an individual and a psychologist. (APA, “Therapy,” 2016).

I think it is time our thinking around role or purpose of therapy was expanded.

Still today if you are seeing a therapist it is assumed that there is something the matter with you. You can protest that there is nothing the matter and your listener will probably nod knowingly while wondering about your lack of insight. R.D. Laing, although a psychiatrist, was

better known for his anti-psychiatry views. He took a counter-cultural view to psychiatry and cleverly used his poems, or verbal knots, to make a point:

He does not think there is anything the matter with him because
 one of the things that is
 the matter with him
 is that he does not think that there is anything
 the matter with him (Laing, 1970, p. 5).

Perhaps it highlights a conviction that we all think there is something wrong with us and fear that if we can't see it others do. I, for the most part, don't think there is anything the matter with me. I have my faults and foibles, facets I would like to develop, and attitudes I want to soften.

Psychologically speaking I fail to see anything that is particularly wrong with me per se. I acknowledge that I am not everybody's cup-of-tea and nor do I want to be. Physiologically I enjoy good health, and I'm sure cancer awaits me. These are ordinary states and fears.

I hesitate to call myself normal, I detest the label. As Jung (1935/1985), an influential psychiatrist and the founder of psychoanalytical psychology said:

To be "normal" is the ideal aim for the unsuccessful, for all those who are still below the general level of adaptation. But for people of more than average ability, people who never found it difficult to gain successes and to accomplish their share of the world's work - for them the moral compulsion to be nothing but normal signifies the bed of Procrustes - deadly and insupportable boredom, a hell of sterility and hopelessness. (p.162).

Who, in Jung's world at least, would wish to be nothing but normal? In this project, I am going beyond the "hell" of normal offering options and ideas that, I hope, embrace individuality beyond accepted ideas of normalcy. I want to question the pervasive thinking of the prevalent

medical model which pathologises many states and actions and judges them within a narrow definition of normal. Almost by default we seek to diagnose and treat whatever is judged as unusual; abnormal. Let's not be like everybody else. My own booklet, a platform for my own belief in the value of therapy, is for extraordinary people, all of us.

I do take issue with a pathology-based approach to defining and diagnosing mental health conditions. It not only part of the system we do it to ourselves, "There must be something wrong with me..." The prevailing medical model is one that diagnoses - looks for what is wrong or deemed abnormal – next is treatment and a cure is the goal. I don't agree with pathologising an individual's distress. 'Treatment' seems to be an inadequate approach when there is no physiological illness, and when soothing, normalizing, understanding, valuing, and reconciling would be more in order. As for 'cure', I don't know... psychological issues or distress speak to a need for change, not to go back to where you started, not to go back to where you were, which is my understanding of a cure, but to go beyond that, a recovery, a rebuilding, perhaps even something transformative. I advocate for going beyond whatever sort of normal was enjoyed before upset, before distress.

My own understanding and definition of therapy is; a space to explore the extremes and the norms one's thinking and experiences, within a relationship with a trained therapist, where those thoughts and experiences can be framed in a way that is useful to the client. Embedded in my thoughts about therapy is the importance of the central relationship, often called the therapeutic alliance, between the client and therapist. I know its importance from my own experiences in therapy, and it is that dynamic or relationship that is central to my research.

Going to therapy can, and should be, a rich and rewarding experience that offers the opportunity for personal growth and/or development. I have described the looming shadow side,

and associated stigma, with all sorts of notions about the frailty of needing support, or the shame of not being able to cope using only one's innate resources. I'd like our understanding to focus on the opportunities of therapy.

When writing about why everyone should attend therapy Moore (2011), a professor and psychotherapist, outlines the stigma and the reasons underlying why everybody does not attend therapy:

It appears that the public doesn't always understand what therapy is all about. Still today some people avoid therapy because it could cost them their jobs and reputations. The public seems to think that if you can't maintain the illusion of mental health, then you are not fit to belong to normal society. You become what the Gospel calls a "leper," referring not to a physical disease but to a condition of exclusion. You are ostracized because you are not perceived as conventionally normal. (para 4).

No wonder I have heard apprehension expressed about attending therapy, I have felt it too. Apart from being regarded as a "leper", there's the monetary cost, it can be expensive as it's one on one work typically charged in one-hour blocks at professional rates. Usually, therapy requires a series of sessions to meet a client's goals. There is an upfront commitment to investing in oneself, in multiple ways, that's required before even setting foot in a therapist's office and importantly an implied commitment to someone with whom you hope you can build a sustainable working relationship. I believe the apprehension can also be related to an underlying skepticism about the potential of what can be achieved by therapy. Sometimes it is impossible to imagine ourselves as capable of growing into different versions of who we already are, and sometimes there is no case or compulsion for change.

Like I said, therapy is not spoken about very much and, if you don't know any differently you could conjure up comic images of lying on a couch and talking. I know from anecdotal evidence that there are many questions that an ordinary person might have about therapy: What is the goal of therapy? Who goes to therapy? Why do they go? Should I try therapy? Is there something wrong with me? What happens in therapy? It is that last question I am most interested in, 'What happens in therapy?' - and I am particularly interested in responses from a client's perspective. I want to use real experiences in therapy to inform clients, and potential clients of therapy, about therapy experiences as described by their peers. I'd like them to feel emboldened to try therapy.

The voice of the client

Given our social tendency to eschew therapy, to leave well enough alone, it is not surprising that therapy is mostly spoken and written about by therapists rather than clients. If it is true, and I suggest it is not, that people who attend therapy suffer mental illness or dysfunction, are they an audience who can be relied upon to accurately report on what works in therapy?

Therapy can be regarded as simplistic, compared to other sciences. Psychology and the art of talking are not often thought about as a science, perhaps that's why researchers try so hard to prove its veracity. Professor Romme (2009), who developed the Hearing Voices Approach for working with people commonly diagnosed with schizophrenia, makes a case for listening to the experience of clients:

A lot of research starts from the position of researchers sitting behind desks and – by being philosophical, strategic and objective- working out how to confirm their theory through formulating a researchable question....We think the best research in this field is

to formulate the problem from the from the experience point of view, to observe experiences in a systemic way. (p. 4).

The tendency in psychology and related research, not only when working voice hearers, is to conceptualise the client's experience rather than regard it as a source of information. I believe it is important to look beyond the prevailing medical model, which does not value the client experience as much as the therapist's judgment, and ask clients about their experiences.

It is no surprise then that books and articles about therapy are written for a professional audience, including texts and research on what works in therapy. The client's voice is largely missing, and I'd like to address that. My orientation and research approach are influenced by peer-led movements, who are effective in bringing ideas based on life experience to the mental health arena. For a couple of years, I worked in and am now particularly familiar with the peer-led Hearing Voices Movement. Within the mental health system, and broader society, voice-hearers, those most often diagnosed as having schizophrenia, are a marginalized group, often being regarded as untreatable and incurable. Being at odds with the prevailing views of the medical establishment, and offering hope for recovery, the Hearing Voices Movement relies on personal experience and testimony as an important source of evidence, (Longden, Corstens, & Dillon, 2013, p.168). It is that same trusted source of personal experience I wish to draw on and then share with others through this project.

Therapy over other treatments

Another motivation, not that I needed further inspiration, for opening up therapy experiences is that I am hoping to suggest an avenue for treatment that is an alternative to medication for people who suffer psychosis and extreme psychological symptoms, people for

whom the medical model of treatment is largely failing. While talk therapy is recognised as an effective treatment, medication is more often prescribed. Hall (2012) is someone who has published a first-person account of his experiences with psychiatric treatment and found that despite the risks of medication, alternatives are not publicised and rarely offered. There is a case for individuals being better informed about treatment options and how to find something that works for them. I hope my work will inform others about attending therapy as it might otherwise remain mysterious to an audience who could take advantage of therapy.

Though controversial and widely debated, I strongly believe that distress is not an illness. It is not. You probably know that, and sometimes I forget it. Today I am reminding myself, as well as you, that hardship is not an illness. Misery is not an illness. Shame, suffering, sorrow, heartbreak, desolation, misery, anguish and any sort of sadness...disappointment is not an illness. Being inconsolable is not an illness. All of these states can be brought to therapy. I did not receive a mental health diagnosis for my distress, although many suffering distress and trauma do carry a diagnosis. Ordinary people carrying extraordinary experiences can find themselves being treated for a mental health diagnosis. I know this is true for people who hear voices, and who are typically diagnosed with schizophrenia, and then by psychiatry "...are mostly approached only in relation to their symptoms, and not as people with problems and possibilities." (Romme, 2009, p.8).

Medication is often prescribed for long-term use, it addresses symptoms but does not ameliorate emotional issues or heal the wounds of trauma. Emotional pain can sit dormant for many years before manifesting as unusual symptoms. For voice hearers learning to cope with emotions contributes more to recovery than dulling the voices with medication. I find it problematic that, particularly for populations with a diagnosis, our healing resources, and options

for treatment, are limited, there is not a lot on offer. Professor Gail Hornstein, an American psychologist with a particular interest in the lived experience of those diagnosed with mental illness, is quoted by Frisch (2011) as saying:

The great conundrum in psychiatry is that every single method that has been invented works for some people and not for others. That's true for lobotomy, shock treatment, medication, psychotherapy and peer support. If there were a magic bullet it would long ago have been discovered and everyone would be using it. But every psychiatric method has been oversold in a burst of enthusiasm by its inventors. I say this for methods I support as well as methods that I don't. (p.10).

She echoes what I have heard stated informally by friends and acquaintances within the psychiatric profession and beyond. We have a limited toolset of treatments and within those few options we don't really know what works or why, but sometimes something does work and I favour therapy over other options, given how much, or how little, is understood about what works. What I do know that once diagnosed with a mental condition we, friends family and society, are intent on healing that condition. By hook and by crook. With the same determination, I am intent on advocating for therapy even while acknowledging that it will work for some and not others.

Victoria, the Australian state in which I live, has one of the highest rates of community treatment orders (CTO) in the world (Mental Health Legal Centre, 2009). The name of the order is innocuous enough but it describes compulsory and imposed treatments, which include isolation, restraint, electroconvulsive therapy (ECT), and forcibly administered medication. Daya (2013, Seclusion and restraint: sticking out like a sore thumb section, para 2) quotes Professor Hickie to point out that the majority of compulsory psychiatric treatments are in

conflict with the Convention on the Rights of Persons with Disabilities (CRPD). Hickie (2009, p.5) also stated that many forms of psychiatric clinical practice are not only outmoded but unjustifiable. Individuals who most need options are not being offered treatment choices. I believe this in itself is a strong case for sharing more information about treatment alternatives, and in this project. I specifically want to talk about therapy. I want to open the door to therapy, hoping that some will feel informed enough to try it.

One the one hand therapy is, and ought to be, much more than fixing or treating, does there have to be something the matter to gain benefit from therapy? I see it more as an opportunity for personal growth, which I am unsure is apparent to many. The purpose of therapy could be better framed by the profession. On the other hand, if fixing or treating is required therapy is a good treatment over the other options available through mental health services.

I want to recommend therapy for lots of reasons, apart from it being more benign than most other treatment options. I want to recommend therapy as a means for growth, personal development, and reconciliation with one's inner self. Medical diagnosis or no, distressed or not, consider therapy.

Demystifying therapy

I have spoken to the stigma of attending therapy through the points already elaborated. That still leaves therapy as mysterious unknown experience. One way to broaden our understanding of what therapy is - is by stepping into the therapist's office and looking at examples of what happens there.

For some the therapist's office is a daunting unknown domain, for me, it's a setting that offers sanctuary. When I sit with my therapist anything can be aired and explored. I say *sit* as

some may have images of reclining on couches, however, I've never laid down on a couch. I sit. Then there is the non-judgemental acceptance of whatever I feel, whatever I think, and whatever I say. That's unconditional support and acceptance of me. It's potent. That's how I experience therapy. I feel empowered to stand on my own and I feel brave beyond what my innate super-powers would normally allow.

My therapist uses a Processwork orientation. She holds a mirror, figuratively speaking, and reflects back to me, she allows me to appreciate what I see. It's a very special relationship that's all about me and how I am in the world. I know myself better, I am not as afraid of the world that my partner couldn't live in... not as afraid as I used to be. I'm making my own way, maybe not boldly (and maybe bold is coming) but certainly with more awareness of a whole raft of things, every day. I value therapy. I would be a different me without it.

Would you, dear reader, go to therapy if you knew it could be like that? You might need more than my experience as it might not be representative of broader therapy experiences.

I hope, that by exploring real experiences in therapy and, using the voice of therapy clients, to extend a warm invitation to therapy in the form of a guide that provides practical advice on what expect in therapy. My booklet (Murphy 2016), *An Unusual Guide to Therapy for Extraordinary People*, is an informative resource about therapy for those of us who believe there is something the matter with us, and those of us who do not.

I hope that ordinary people, who regard themselves as largely coping with the travails of work and relationships, as well as those as those who struggle with the same, might try therapy - encouraged by reading my booklet. My intent through this project is to inform about therapy experiences from a client perspective.

Intended audience

The audience I am most keen to reach are those already interested in therapy, particularly those who may regard it with caution and may not have tried it as a result. I hope they will be more interested in what peers have to say over that which academics or researchers report.

A broad principle within the Hearing Voices Movement is “*nothing about us without us*”, when relating to those who are marginalised by their experiences and when conducting research with that population (Corstens, McCarthy-Jones, Waddingham, & Thomas, 2014, p. S289). I agree this level of inclusion is a fundamental right of everybody and that belief has guided me in finding an approach to amplify the voices of clients while taking a close look at therapy experiences. The voice of the client’s experience is too rarely heard, let alone used to inform their peers.

The other audience I would like to reach is that of therapists and therapists in training. The voice of the client, as I have shared and illustrated, can also inform therapists about actions that strengthen the therapeutic alliance and actions that may rupture it sufficiently that a client may never return to that therapist. Safran, Muran, and Eubanks-Carter (2011) unequivocally state:

One of the most consistent findings emerging from psychotherapy research is that the quality of the therapeutic alliance is a robust predictor of outcomes....and that conversely, weakened alliances are correlated with unilateral termination by the patient. (p. 224).

Poor client experiences may be noteworthy as “...patients may underreport ruptures due to a lack of awareness of them or discomfort in acknowledging them.” (Safran et al, 2011, p. 225). It might be hard to imagine a client having a lack of awareness about relationship ruptures, and Lott (1999), who sought the stories about therapy from 300 women about therapy, makes an

interesting point that clients generally perceived therapy as risky and unknowable, and that even clients with a professional background did not know how to assess a therapist's competence, "they look to magical signs that the therapist is the 'right one' for an inkling..." (p. 75). Maybe on reading my booklet clients will place more trust in their own feelings and reactions about a therapist. I also hope that therapists will find the booklet a worthwhile resource in alerting them to actions that could result in ruptures. I hope that in addition to being more alert to potential, but I assume, unintentional, ruptures therapists may be more likely to grasp opportunities to address the relationship in the moment, right away the minute it is apparent that an intervention has not landed well with the client. Memorable but uncomfortable occasions for clients have the potential to yield therapeutic gold in that "ruptures provide critical opportunities to identify explore and change patients' self-defeating patterns of thought and behaviour" (Safran et al, 2011, p. 226). It is all too important that therapists take the initiative and facilitate the relationship, again it is Safran and his colleagues who advise that "practitioners should be aware that patients often have negative feelings about the psychotherapy or the therapeutic relationship that they are reluctant to broach for fear of the therapist's reactions". (p. 235).

I hope that the title of my handbook "An Unusual Guide to Therapy for Extraordinary People" invites therapists to read it as well as their clients.

LITERATURE REVIEW

Processwork, the therapeutic framework I have studied, was developed by Jungian author and analyst Arnold Mindell and for the last thirty years or more he has continued to form and expand his ideas:

The premise behind Processwork is that experiencing the world or dealing with a problem is unique to each person and how his or her natural way (“dreaming”) is trying to reveal itself. This dreaming can be experienced through a body symptom, a thought, a feeling or emotion, movement, a role in a group, or through a spiritual experience.

Processwork includes various theories in its teaching to cover a broad spectrum of ways of seeing the world. (<http://www.processwork.org>)

Today Processwork is more than a therapeutic model, it is also used in many other situations that call for facilitation and awareness, notably to work with groups and conflicts.

I have become an advocate of therapy due to the inestimable value Processwork, in particular, offered me. My driving passion, with this project, was to extend a warm invitation to others to try therapy, in the modality of their choice, and open the door to an effective avenue for personal development and/or healing. I want to step right past the stigma often associated with therapy and provide tangible, useful advice.

Client Voice

There is a gaping hole in the discussions about therapy and therapeutic experiences, almost invariably the audience to whom any discussion is directed is therapists. This is a hole I would like to fill by providing a resource based on client experiences. Typically when the audience of any publication is clients themselves the discussion is framed as self-help. The self-

help genre is targeted at those working on themselves rather than advice for those working with therapists.

I am determined to draw on the experiences of peers in therapy to inform those thinking about starting or returning to therapy. The primary question I want to answer is ‘What are memorable therapy experiences from a client perspective?’ I think those experiences will inform others about what happens in therapy. I have used the responses to the first question to support a broader idea of sharing client’s actual experiences of therapy to help to demystify the process and address the stigma of attending therapy for prospective clients.

I guess a preceding question is why take this approach of seeking client experiences? I could have chosen to champion my own views and experiences, or penned a missive exhorting the benefits of therapy as I understand them, but I have been impressed by the effectiveness of peer approaches. Sherry Mead is the founder of the Intentional Peer Support (IPS) approach says:

In general, peer support has been defined by the fact that people who have like experiences can better relate and can consequently offer more authentic empathy and validation. It is also not uncommon for people with similar lived experiences to offer each other practical advice and suggestions for strategies that professionals may not offer or even know about. (Mead & Macneil, 2004, p.394).

I have witnessed the value of peers sharing stories Romme et al (2009) created a book of 50 stories of recovery for the Hearing Voices movement. That work is also founded on the belief that people with similar experiences can relate to each other with authenticity and empathy. While I have things worth saying about therapy, I am interested in the experiences of others will be different from my own.

What's important in therapy

In 1936, Samuel Rozenzweig wrote a paper suggesting that therapeutic outcomes were not a guide to the veracity of any given type of therapy, that all therapies were equal. Just under the heading of his paper he included a quote from Alice in Wonderland, “At last the Dodo said, ‘everybody has won, and all must have prizes’.” Rozenzweig’s research and observations led him to the conclusion that:

...it may be said that given a therapist who has an effective personality and who consistently adheres in his treatment to a system of concepts which he has mastered and which is in one significant way or another adapted to the problems of a sick personality, then it is comparatively little consequence what particular mode that therapist uses. (1936, p. 414).

Many do trust the Dodo argument that all therapies are equal and that it is the therapeutic relationship and other relational factors that are responsible for better or worse outcomes. Although empirical data is wielded by both sides this topic represents more of an ideological argument than a scientific one. Those like Bentall (2009) who see mental illness through the lens of the medical model see the Dodo bird verdict as implicitly untrue regardless of the evidence, believing some methods or paradigms superior to others as a treatment. On the other side of the debate, and according to Wampold (2013), those who see therapy as context-based and relying on a shared frame of reference between client and therapist for the best outcomes, welcome the Dodo bird verdict. Norcross and Lambert (2011, p.3) go as far as stating that the “culture wars in psychotherapy dramatically pit the treatment method against the therapy relationship” they go on to detail why the argument and the growing body of research is misleading and unproductive. They call for greater collaboration among the various communities of psychotherapeutic

practice, without going so far as to suggest including the experience and opinions of clients. Even the research paper with the most promising title I located, about empowering clients didn't go further in that empowerment than allowing clients to elect their preferred therapeutic approach from a list (Vollmer, Grote, Lange, Walker, 2009). While choices were appreciated by clients, the choice itself seems a superficial way of allowing the client to have input to the therapeutic process particularly if the dodo bird argument is true.

Rozenzweig's research led to our understanding of what are now called the common factors. Common factors are those factors common to effective therapeutic outcomes, those aspects of therapy that are common across technique and theories. While there is no comprehensive list of individual factors, Hubble et al (2011) describe four groupings of common factors:

- Therapeutic relationship or alliance, perhaps the biggest contributor to outcome success
- Client and extra-therapeutic factors, anything outside of the therapy sessions. The client's internal and external resources.
- Models and techniques that bring about positive expectations by clients
- Therapist factors, recognizing that some therapists are more effective than others and better at building effective alliances

It has been interesting to explore the survey data and what was reported as being memorable experiences. In the Findings section I review what sort of factors stood out and, by their absence, what factors did not.

The therapeutic alliance

Babette Rothschild (2011) is the author of several books about trauma-informed approaches to therapy and understands the importance of building an empathetic relationship with clients. She is a voice of reason in the 'what works' discussion, her approach begs therapists to simply remember the human being sitting in their consulting room. I believe the person she identifies as a human being is all too often seen as a patient, labelled as someone with less capacity than the therapist. A shared humanness can be overlooked and then I know anecdotally, from my own and my colleagues' experiences as therapy clients, that when interventions don't appear to work it can be the client who is accused of 'lacking insight', being 'treatment resistant', or having a condition from which recovery is not possible. Problems all tend to sit with the client.

It is Rothschild (2011, p.16) who reminds us that "At times for every client, and all the time for a few clients, it will be the best strategy and the best therapy to be together talking or just sitting quietly." For a couple of my survey respondents their memorable experiences, did involve sitting quietly together with their therapist.

Bohart and Tallman (2011, p. 98) call for greater client involvement in therapy and for training of therapists in the art of listening and to value their clients. If as they suggest "...the client is an active self-healer" (p. 103) then the door should be open for more listening and sitting quietly together. It's possible that therapists do that already, it is gentle advice, perhaps deceptively simple.

Power in the therapeutic relationship

Diamond (2016) has a specific interest in power and goes further, than those quoted above, she addresses therapists, in the role of a trusted advisor, and looks closely at the inherent positional power of the therapeutic relationship and the challenges of that relationship:

Therapist and client, coach and trainee, advisor and advisee, student and teacher – all engage in a powerful partnership of personal transformation which involves more than the simple transmission of information and skills. (p. 186- 187).

Her statement suggests more than simple listening too, although that must be a good start.

Diamond outlines multiple levels of dependency implicit in the therapeutic alliance and notes the potential for abuse of power. She provides four specific solutions for therapists (p. 189 – 193):

- Be honest with yourself, even if you can't fully
- Cultivate role conflict
- Develop reflexive knowledge
- Keep your eyes on the noble goal of the role

While qualifying her advice saying that the challenges she explores are “just the fundamental ones”, advocating for therapists “to become vigilant and self-aware” (p.193), I am struck by her recognition that the more powerful role, that of the therapist, as having inherent tendency to have a lopsided outlook. Diamond's advice stands out in that she directs attention to the need for introspection and self-awareness by the therapist where it can be more usual to project relationship issues on to the client role. In my own experience, as an example, I have needed to move away from a therapist who has felt sorry for me, a disempowering experience, I couldn't wear the pity. Maybe the pity was mine, but whose ever it was I didn't like it being put onto me.

Real or implied the therapist holds the balance of power, by default, in the therapeutic relationship. The therapist is a trained professional and clients are typically seeking to make changes in their lives, they may be looking for reassurance, support, comfort, advice, understanding – they are turning to the therapist for those sorts of things all of which endow power on the therapist, someone assumed to have special healing abilities. A therapist through their responses and reactions can change the way a person sees themselves in both positive and negative ways.

Lott (1999) who studied the relationship between women and their therapists, devotes a chapter of her book to the therapist's power and explains how clients give up their power;

When a woman enters the hermetically sealed environment of psychotherapy, her hope and her anxiety are often at a very high pitch. In this state of high anxiety, with her understanding of the therapist's power so unclear, clients tend to give away their own power. Like tranquilised patients being wheeled into the operating room for surgery, clients entering the therapist's domain feel they have no choice but to submit totally. (p. 72).

She paints a graphic picture, and I wonder about how rationally the relationship can be viewed, by clients, as we give over power to the professional. Many of us could feel unable to judge a therapist's competence while knowing little about therapeutic practice. We are likely to grant therapist power and might tend to blame ourselves when things go awry. Lott does have a suggestion to assist clients "What may empower...clients the most may be sharing their therapy stories with each other" (p. 85). In that sentence is a validation for my approach with this project.

Conceptualisation of therapy

After exploring power a little I have no doubt that the therapeutic relationship is complex. I have needed to have my own coping and resilience recognized, even as I was disheveled with grief and despair and a lack of direction. I have wanted my agency, however limited it was, to be recognized and respected. An argument that complements my thinking about therapy and healing is paced out by Amy Mindell (2006) in the introduction to her book proposing using Processwork, in a therapeutic way, as an alternative to therapy. She does not like the assumption that there is something amiss in respect to clients and she admits to not knowing what might be right or wrong for an individual she is working with. That level of transparency, unfortunately, is not espoused by many of those I have encountered in the mental health profession.

Siver (2002), says that Processwork is a way of working for therapists that does not seek to change people. He describes a Processwork approach as seeking to uncover "...deeper meaning in a broad range of human experience by following experiences in the moment through tracking signals, synchronicities, and somatic experience." (p. 2). What he doesn't point out, but something that is implicit in his statement is that any meaning uncovered is discovered by the client themselves, the therapist facilitates rather than fixes or directs. Processwork, as described by both Mindell and Siver, is not diagnostic in nature, nor is it goal oriented, it is also not against goals or change.

Where Longden (2013), a therapist with a lived experience of psychosis, says "that an important question in psychiatry shouldn't be what's wrong with you but rather what's happened to you", Amy Mindell (1995 p. xii) goes further with an approach that asks "What is happening? What is unfolding in the moment?" working in the here and now she suggests the possibility for a different client experience. This is significant step towards destigmatising therapy, with the

therapist's approach not assuming the client is ailing or failing. With this approach, the therapist is relieved of any expectation to treat or cure.

Arnold Mindell (1985), was for many years identified as a therapist, says that "I don't believe in therapy because I don't know any more what is right for other people". (p.9).

Processwork also serves to remind me that my project is not about winning, putting one style or approach ahead of another but about listening to the client and whatever can be discovered from their memorable experiences. That said I need to be open about a bias, in that I do believe in therapy and I think it is right for many people, whatever does or doesn't trouble us, and I know more about Processwork than other approaches. Still the idea of a capable client who can describe what happened rather than what is wrong, a client who can be facilitated and followed is not so common when reading about therapy.

People seeking therapy are likely to turn to Google to find out more. Reading through on-line postings about therapy after asking Google the question "what is therapy?" I see that therapy is touted as being for people seeking to fix something. There is a long list of disorders and frailties, distress, anxiety, suffering, addictions, conflicts, negative effects, problems, grief, and other so called dysfunctions that suggest an individual is not coping in some way. If you're unsure if you need to see a therapist, there is an idea mooted by Grohol (2013) that attending therapy won't hurt. That's an interesting thought but it is not much of an invitation...

One site, goodtherapy.org (2016), lists a comprehensive A-Z of issues treated by therapists of noting that those who go to therapy are "ordinary people struggling with common, everyday issues." That is it, in a proverbial nutshell, ordinary people struggling with issues go to therapy. Troubling, to my mind at least, is the implication is that ordinary people who are coping with issues, do not go to therapy. I sense the underlying accusation of normality, maybe others do

too. I might not be alone in thinking that it is commonly accepted that ‘normal’ people do not see a therapist. I mean why would they? Popular belief is that therapists are there to help, support, address, fix and while that is true I think there is a bigger picture too. The website for the Californian Association of Marriage and Family Therapists (CAMFT) notes that according to a 2004 study, more than one in four adults seeks treatment for mental health problems. Even with that prevalence of therapy experiences the emphasis is on ‘problems’. I would laugh if I didn’t find the overt put-down of those who seek therapy so annoying. There is a paradox in CAMFT’s statement. If one in four of us ‘seeks treatment’, that sounds like a normal, ordinary or usual, experience to me. If twenty-five percent of us have mental health problems then I think that to have a mental health problem is somewhat normal.

I am largely talking to the stigma of therapy and the thinking that something is wrong with the client that pervades the research of what works, or happens, or should happen in therapy. It is a little insidious, the practitioners listen to practitioners and they address problems for clients.

Client experiences

There is a body of work that explores client experiences in therapy, I don’t mean to imply that none exists. One researcher Sherwood (2001) looked closely at what heals and what harms in therapy using interviews. She did assume a healing relationship, while noting the centrality of the quality of the client/therapist relationship in determining therapeutic outcomes. Relevant to my own work, Sherwood also said that “There is a need for more research in counselling and psychotherapy which pays greater attention to the experience, language and understanding of the clients.” (2001, p. 1). Even so her own efforts are directed at therapists and presented in order that

therapists can achieve better outcomes for themselves and their clients, while I am looking foremostly to inform the client population.

In the same year as Sherwood's work was published, Lambert and Barley (2001) declared that "Decades of research indicate that the provision of therapy is an interpersonal process in which a main curative component is the nature of the therapeutic relationship." Having garnered more than enough support for looking at the therapeutic relationship, and noting the gap in the literature for being directed to clients, I intend talking to clients through my booklet, rather than the audience usually addressed – therapists. Like I have said, I hope therapists will read it too.

APPROACH

This is a qualitative research project with an educational product presented in a creative style. I have created a guide for clients about therapy, based on reported client experiences, that shows different scenarios that have been experienced in therapy. My stated aim was to extend a friendly invitation to try or continue, therapy by highlighting a diversity of memorable experiences and offering a glimpse of what happens behind the door of a therapist's office. The booklet expresses and describes what happens in therapy in pictures and words. By illustrating and contrasting both positive and negative therapy experiences I am trying to give a comprehensive picture of what can happen and have clients feel prepared for different styles and responses from therapists. By reading about what did or didn't go well for others, a person could feel more prepared, for therapy, empowered with some agency, certainly better equipped for whatever unfolds. I produced the booklet hoping to promote broader awareness, of what to look for in a therapist. I hope that on reading it people will feel more informed about therapy and ready to try it, or to start a conversation with their therapist about their working relationship, which given the power imbalance between a therapist and their client may not be easy to do.

The survey

The foundation of this project is client's reported experiences in therapy. To gather these stories I created a simple survey, using Survey Monkey an online questionnaire tool. The survey was comprised of six sections:

1. Welcome. This section contained information about me and why I was sending the survey. Benefits and risks of participation were outlined, as was the confidentiality I applied.

2. The memorable experience itself.
3. The feelings associated with the experience.
4. The motivation for therapy and the focus of it.
5. General information about the therapist.
6. Demographic information.

Within each section most of the questions allowed for open-ended responses so respondents could write as much as they felt was necessary. Some questions were more structured where respondents could choose from a list, as many choices as applied.

The exception to the free format responses was that to describe feelings associated with the experience I asked respondents to rate their feelings using the Abraham-Hicks Emotional scale. The scale describes a range of emotions from most positive to most negative. It can be used as a measure of how empowered a client feels.

The survey is reproduced in full, in the Appendix.

Inviting participation

The survey and an invitation to participate was shared across social media. Apart from having a therapy experience that stood out as memorable, there were no particular participation criteria, all responses were welcomed.

The survey was shared with friends and colleagues on email and I made use of the reach of Facebook on social media. The survey was distributed through my social networks and through groups I am active in like Living with Suicidal Feelings, and the Hearing Voices movement. I also used professional contacts including therapists, social workers, and community mental health organisations to reach people with memorable therapy experiences. There was

interest from peer-led mental health groups who have a political agenda of being interested in the voice of consumers of mental health services. I called on fellow students, those I know through the Process Work Institute, where I studied in Portland Oregon, to share the survey with their contacts. I shared the survey through online forums like the Processwork community's on-line forum, and the on-line email forum provided by International Association of Process Oriented Psychology (IAPOP). Banking on the goodwill of these friends and forums I hoped to garner 50 respondents. The survey was distributed in English.

There were 86 respondents in all; that is 86 people gave an affirmative answer to the first question and agreed to proceed:

Do you agree to proceed knowing the terms as described above? By clicking Yes, you consent that you are willing to answer the questions in this survey.

Of those 86, 49 completed the survey in its entirety and I added one of my own experiences, an event that had sparked my interest in this topic. 37 respondents had none of their data recorded due to the design feature of the Survey Monkey tool, whereby anyone who does not complete a survey to the final question has no responses saved. Any respondents who did not go through to the last screen were not included in the survey.

I asked respondents, who would otherwise be anonymous if they wished to provide contact data for a further interview. I had hoped that an in-depth follow-up would possible for a sample of up to 6 respondents. None provided contact information.

Ethical Considerations

In preparing the survey there were some ethical considerations. I was clear that the responses submitted about the therapeutic experiences could be published, that my intention in

asking for experiences was so that I could share them in order to promote a broader awareness of what happens in therapy. I outlined the risks and benefits of participation and offered to communicate personally about any feelings the survey might bring up:

You will be contributing to a resource that informs others about experiences that can happen in therapy by highlighting a diversity of those experiences. You may or may not directly benefit from this study. It is possible that sharing your experience will help to reconnect with something important, it could bring clarity or new insights to your work in therapy. It is also possible that participation in the survey may bring up difficult feelings. You're welcome to contact me directly via email for a referral for counselling or if you'd like to talk about anything that comes up for you.

I hope that others will benefit from what has been shared and reported by their peers by reading the handbook and feeling empowered by any knowledge gained.

Your interest and involvement is respected and very much appreciated.

Anonymity was also considered, I did not record any names or data that would be a means of identifying the respondents inadvertently or intentionally.

Having provided a little information about me, this project, outlining the risks and benefits of participation, as well as ensuring anonymity respondents were asked to agree or decline to continue. This was all on the first screen of the survey.

Open-ended responses were accepted for the questions about therapeutic experiences, allowing participants to record answers in their own words. Those words were not altered but consistently used as reported.

Demographics

I wondered about how representative of broader society the survey respondents would be. There was a skew to women and a good range of ages were represented. The survey respondents were mostly female, that is 84% of them reported being female. That's interesting and I am unable to draw any valid conclusions, based only on this information, about who responds to surveys, who attends therapy or even the gender balance of my friends and contacts – the most likely people to have participated.

There was a good distribution of ages, with few very young or elderly respondents.

Age	Respondents	Gender identity
25- 34	8	8 female
35 – 44	15	11 female, 2 male, 1 gender queer, 1 female transgender
45 – 54	16	13 female, 1 transgender, 1 gender-fluid, 1 no response
55-64	10	9 female, 1 male
65 – 74	0	
75 – open	1	1 female
Total	50	42 female, 3 male, 2 transgender, 1 gender queer, 1 gender-fluid, 1 no response

“How do you describe your race or ethnicity” was the question and the answers are tabled below:

Respondents	Race or Ethnicity
1	American, Indian and Latino
1	Anglo
1	Anglo-aboriginal
1	Anglo-Saxon
2	Asian
1	Asian Australian
3	Australian
1	Australian English background
12	Caucasian
1	Caucasian born in the Netherlands
1	Caucasian Australian
1	European
1	Greek

1	Half Jewish half Anglo
1	Human
1	Indian
2	Mixed
1	Mixed Anglo/Maori
1	New Zealand European
1	Non-indigenous Australian of Anglo-Celtic-Germanic ancestry
5	White
1	White and German
1	White Australian
1	White British
1	White Caucasian
1	White European
5	No answer provided
50	Total respondents

It is apparent there is a lot of diversity around race identity. I regret not using a simpler question about nationality, which may have given more meaningful answers.

Questions about sexual orientation and relationship status also drew varied responses, It would be difficult to sensibly table the responses to this question as I allowed a free format response and there were many different responses. While some responses sound similar I want to respect the differences and not change the answers provided by interpreting them. For my purposes, I am happy that respondents, although mostly female and over 45 years old, represented ethnic diversity in their ranks.

Limitations

There are some limitations with this project, I will outline them briefly here. I hope that none are significant enough to dilute the impact of the booklet produced.

Small data set

With 50 respondents I am assuming I elicited a representative sample of respondents, I can only hope that working with a larger population of therapy clients, and asking the same questions would reveal a similar pattern of responses. While the population sample of 50 respondents was small, and I had plenty of data to draw on for a small booklet. There were sufficient scenarios to identify some patterns and repetition in them. Respondents self-selected by completing the survey giving credibility to the results.

Context

There is scope for looking beyond a single experience to the overall therapeutic process. Some who reported negative experiences stayed with the same therapist, some context around the memorable experience could have explained why. Within therapy, I would expect there to be both positive and negative experiences. Some context, perhaps a measure of the relationship – how robust the relationship is, or should or could be - might have answered questions about what happened or why.

Client perspective

Another limitation and one almost necessary with my goal of hearing client voices is that the therapist's voice, opinion, and perspective have been reduced to all but silent in the scenarios. Therapists are not defended, or justified, for how the client reported their experience. It might have been interesting to hear the therapist's side of the scenarios.

Transference and counter transference

I haven't yet mentioned projection and transference so I am unsure of the role of those in this work, or how to identify them in the data collected. This again relates to not having context around the scenarios. Weighing how the effort, and time, to complete the survey might have impacted the number of respondents was a consideration. I did not seek more contextual information giving preference to simplicity and manageability for respondents.

Selecting scenarios for the booklet

One challenge I faced in creating a booklet that would invite people to try therapy was presenting less positive experiences in a way that I hoped would not dissuade prospective therapy clients from trying therapy for themselves.

I had a total of 50 respondents, including me, all responses were reviewed and synthesised to try and develop broader principles about what could be learned and shared. In looking at both positive and negative experiences I found the data compelling in that it comprehensively addressed my primary research question "What are memorable therapy experiences from a client perspective?" There were sufficient depth and diversity in the experiences to colour an informative booklet about therapy.

As I sorted through the memorable experiences to put together the booklet there were some challenges. I wanted to inform clients about therapy based on the experiences of their peers. Of the experiences 46% were more negative, and given the propensity of negative experiences it was difficult to see how I could use this negative orientation to extend, as I wished to, a warm invitation to try therapy. Some of the reported experiences lacked sufficient context to

really understand them, and some were similar. I wanted to choose scenarios that represented a diversity of experiences.

Seventeen or 34% of the reported experiences were selected for inclusion in the booklet and illustrated. Ten of those selected represented the less positive experiences along with six positive ones. There were a couple of experiences reported where the therapist's behavior could have been interpreted as surprising, if not ethically questionable, but the client had felt positive about the session. I left those out for having insufficient context through which to understand what had happened or the thinking that led to a positive experience being reported from an odd sounding situation.

There was some repetition of experiences. Two respondents experienced a therapist falling asleep during their session, for example, another two experienced being sent away because their emotional state was deemed too intense, and two were told that their friends didn't like them but rather put up with them because they felt sorry for them. Even as I write about those examples I have to pause. Each of those events was disappointing, even distressing, and none of them very inviting to others to try therapy. Wanting to honour a range of experiences and fairly represent what was reported, I decided to include one of each of the similar experiences.

It took some months for the booklet to emerge. I started by illustrating some of the most striking scenarios. By striking scenarios I mean the ones that struck me as worth sharing, I leaned towards the most challenging and provocative experiences in the data. At the same time, I wanted to promote my belief that therapy is valuable for everyone and not pathologise those who attend therapy. I tried to achieve a balance.

While not changing the event, itself humour can soften our responses and attitudes to what looks quite distressing. A touch of humour was introduced through my illustrations, fortunately accessing humour is something I can readily do. I was also conscious of using a Processwork oriented approach and including scenarios I did not like as well as those I liked, trying to show all perspectives and not only paint a rosy picture of therapy. I intentionally used a Processwork approach which does not marginalise unwanted, or less positive, experiences, but rather believes all perspectives are valuable. With that in mind, I was truly able to embrace the inclusion of negative experiences. The booklet expresses and describes what happens in therapy in more than words. I hope it will promote broader awareness of what can happen in therapy.

I spent a lot of time fretting about how to present the data and related stories to potential readers of the booklet. Important to me was faithfully representing the memorable experiences, which typically extended to a sentence or two. This brevity meant there was little context to work with. I started by illustrating, or trying to illustrate one scenario. With my unfamiliarity with art materials I unintentionally set out on a four month journey of trial and error learning about water colours, art paper quality, and finding a drawing style that accommodated my lack of drawing experience. I made many trips to my local art supply store and spent hours perusing the shelves and reading directions on the packaging of pens and paints. The first successful drawing, after a lot of experimenting, was created using coloured marker pens in a graceless but simple style. One page to show after four months of effort. Thankfully in a further three days, I had three drawings completed.

I developed two characters, a client and a therapist, it felt a bit like they developed themselves in the end and I used the same two figures in each illustrated therapy scenario.

The title I selected for the booklet informed its further development and the sort of information to include beyond the client scenarios; “An Unusual Guide to Therapy for Extraordinary People”. ‘Unusual’ in that I was using real client experiences to form the bulk of the text and ‘extraordinary’ in that I wanted to avoid being judgmental about who should attend therapy – no use of normal vs struggling – but every-extraordinary-body.

I recognized that the client as the hero of the story. This text was certainly about clients for clients. My breakthrough moment was when I noticed patterns in the client experiences that could be related to the therapists involved. Interestingly these patterns could be framed to inform clients about how they could feel in the presence of the therapist or within the therapeutic relationship. I have mentioned how the reported experiences converged and overlapped, and they also aligned with common factors research, there were five points evident in the experiences of therapy that stood out as advice, on a feeling level, for clients.

The feeling attitudes identified provide a sense-making frame for the experiences. They are outlined here in the Findings section. Although scenarios shared some commonality and could have been used to highlight more than one of the points, I sorted them so that each highlighted a particular point. For each feeling attitude, I illustrated one positive experience and two more negative ones. These experiences serve to make strong points about finding a therapist with whom you can share a rapport, and build an effective therapeutic alliance.

Other sections in the booklet

To fill out the booklet I created some content to wrap around the experiences, so it became a guide. In addition to giving some background to the source of the memorable experiences, and introducing the client as the hero of the story. I saw that much of what is

published is therapist-centered and while the therapist plays an indisputably important role, I feel it is a mistake to cast the therapist as the hero in therapy.

I wrote a paragraph on what works in therapy, my own take on the dodo bird debate. I also talked about when to use therapy adopting a non-judgmental view. I think this part is the essence of the warm invitation I have, all along, wanted to extend:

You may know your strengths, or you may want to use therapy to discover them. Some things in life cannot be changed – therapy can help you carry those. Whether you find your head hanging low or being held high, therapy can be a place for reflection and exploration. (Murphy, 2016, p. 7).

I included a comprehensive list of reasons for attending therapy. I outlined the feeling relationship factors that emerged from the data and illustrated them.

Under the heading “Everything clients need to know about therapy” I encourage talking to your therapist if the fit and feel of the relationship is not quite right. I know this could be difficult to do and I hope some will try. I suggest that sometimes the best thing to do is to consider working with a different therapist. I hope readers will see that sometimes when things don’t quite work that it might not be you (the client) who is to blame.

I outlined ten alternatives to therapy, things to consider and try, before closing the book with a piece of advice for therapists who may have left their clients feeling hopeless, discouraged, guilty, confused or despairing, these feelings were all reactions reported by clients in the survey.

FINDINGS

With 50 responses I ended up with a lot of data, a diversity of experiences in therapy was reported. I did discover a couple of interesting things which I will explain more fully;

- Bad is indeed stronger than good
- Type of therapy is not so important
- No mental health diagnosis required
- Patterns in therapist's behavior
- A case for more feedback between therapist and client

Bad is indeed stronger than good

When I asked about memorable experiences that stood out in people's minds I also asked them to recall how they felt at the time. The emotions reported are tabled below. Respondents were able to report more than one emotion. At one stage I considered including emoticons (smiley faces) on the scenarios to illustrate how the clients felt but looking at the drawings their feelings seemed self-evident.

The total who reported positive experiences in therapy were 27, and more negative experiences counted 23. So 46% of respondents to a survey about experiences in therapy, described a less than positive experience. That was surprising when enquiring about an experience that ought to be empowering or healing.

Feeling about experience	# reported
Joy/freedom	12
Empowerment	18
Love/appreciation	13
Enthusiasm/eagerness/happiness	6
Optimism	6

Hopefulness	16
Contentment	5
Boredom	2
Pessimism	1
Frustration/irritation	10
Overwhelmed	6
Disappointment	8
Doubt	4
Worry	1
Discouragement	4
Anger	13
Vengeful	0
Rage	2
Jealousy	1
Guilt/insecurity/unworthiness	5
Fear/grief/despair	9
Other emotions, in your own words:	27

In looking at what appears to be a negative bias in the data, it is good to remember the academic work of Baumeister et al (2001) who listed many ways in which we have a negativity bias. It seems we are neurologically wired that way, in that we continually look for negative information, and over-react to it. The researchers noted that even our memories, which they expected to be subject to a positivity bias were not. They note that we learn faster from pain than from pleasure, and negative interactions have more impact on a relationship than positive ones. Their research both supports the weighting of experiences reported and, I believe, justifies using many negative ones in the booklet as advice. I have to admit that in asking respondents to share a memorable experience I inadvertently tipped the scales, so as to say, toward negative experiences; bad being stronger than good.

Type of therapy is not so important

In the survey, I asked respondents about the type of therapy they attended. Question 11 of the survey asked “What was their particular approach, if you know that. Were they practiced in

ACT, CBT, EMDR, Gestalt, Processwork or another therapeutic modality? Please answer 'don't know' if you don't know this information.”

These were the responses documenting the type of therapy attended:

Anthroposophic (Steiner)	1
Art therapy	1
CBT	3
DBT, existential psychology	1
EMDR	1
Gestalt	5
Grief counsellor	3
Humanistic/ACT	1
Narrative therapy	1
Person centred	1
Positive psychology	1
Pranic healing	1
Processwork	13
Psychoanalysis	4
Sensorimotor psychotherapist	1
Social worker	1
Systemic therapist	1
Don't know	10

It's interesting that 20% of respondents didn't know the type of therapy they attended. While the dodo bird debate values relationship over type of therapy, the relationship is a professional one. The work will, almost inevitably, be deeply personal but given that one party is in service to the other I am surprised that not more importance is placed on the qualification or background of the service providers by their clients.

There is a noticeable bias to Processwork therapists as 26% respondents worked with someone using that modality. This is explained by my own involvement in Processwork, I have been studying Processwork across the last 10 years in America. I have many peers, friends, and colleagues in the Processwork learning community, some of whom responded to the survey.

The other 54% of respondents consulted people with specialties across 16 different modalities. There is a diversity of therapeutic approaches, even with the skew towards one of

them I am not interested in fueling in the dodo bird debate and pitting one style of therapy against another. I refer to Hubble et al (2010) who stated that “No ‘right’ treatment exists anyway. The data are unequivocal: All treatment approaches have won, all deserve prizes.” (p. 33).

For my purposes of providing advice to clients, I did not focus on any particular therapeutic model in the booklet produced but said that there are many to choose from.

No mental health diagnosis required

Most respondents did not have a mental health diagnosis or did not record one in the survey. A diagnosis was noted by 32 percent or sixteen people, and of those, four (25%) described more than one diagnosis. Fourteen of the survey respondents provided a definitive ‘no’, ‘nil’ or ‘n/a’ to the question of diagnosis. Twenty did not provide a response to the question.

The numbers above informed me that many, the majority, who attend therapy did not do so with a diagnosed mental health condition. I can conclude that attending therapy, at least among my sample population, is something people do for reasons beyond a medical imperative.

Diagnosis	Number of times reported
Anxiety	2
Bipolar Disorder	2
Borderline Personality Disorder	3
Cyclothymia	1
Depression/clinical depression	8
Dissociative Identity Disorder	4
Drug Addiction	1
Obsessive Compulsive Disorder	1
Post-Traumatic Stress Disorder	1
Schizophrenia	1

In the booklet I included a list of reasons that one might seek therapy for, based largely on my own experience and anecdotal evidence I have heard from friends, colleagues, and

acquaintances. My list of reasons are intentionally broad and will apply regardless of having a diagnosis or not. The reasons are intended to highlight the potential benefits of therapy across differing goals or situations;

- Find meaning in experiences
- Taking steps toward change
- Connect differently with self and others
- Overcome challenges
- Harmonise with your inner-being
- Hold or tolerate uncertainty
- Pay attention to things usually ignored
- Explore aspects of self and our worlds
- Clarification and understanding
- Build strengths
- Connect with personal powers
- Reach for available resources
- Navigate relationships
- A crisis
- Come to terms with individual limitations
- Fix, heal, or correct something
- Tame addictions
- Ameliorate grief
- A treatment, a cure, and remedy

Mine is a positive framing of what can be attended to in therapy. While it is a broad list, it is not all-inclusive, there may be other reasons for seeking therapy. In fact, I am certain there will be other reasons.

Patterns in therapist's behavior

As already outlined, I selected client experiences for a range of reasons. Some experiences as reported were too interesting to ignore, some lent themselves being illustrated for the booklet, and some were selected as they perfectly balanced other experiences and could be used to highlight a polarity. I selected scenarios that captured the range of experiences among the survey participants. Negative and positive experiences were selected. There were a couple of positive ones that let me breathe out and smile while others were notably more negative and left me speechless with disbelief, I used both.

I wanted the scenarios to provide pictures of what therapy – positive or negative – looks like. A range of experiences. Perhaps that will empower, or encourage, people to take a more active role in their own therapy. I wasn't very scientific in my method of selection and as I sat back to take a view of the scenarios I wished to use, I noticed they related and overlapped when considering the therapist's behavior and attitude. I tend to eschew giving advice or being too directive, and I did not want to provide too much advice in the booklet. With a little encouragement from a trusted advisor, it was possible to identify five feeling factors supported by the data that clients could look for in a therapist. My advice is that a client should feel that they are:

1. Listened to and heard

2. Not just seen as a symptom or a problem to be solved, but that the therapist is interested in you as a person
3. Believed, that the therapist is open to considering your experience
4. Working with a genuinely nice person, someone with whom you can build a working alliance
5. Respected rather than put down by a judgmental attitude or someone who thinks they know best

I collated the experiences to highlight each of the feeling factors and I doubled up, using two scenarios, to show what might happen if the therapist did not have that feeling factor. I called them ‘feeling factors’ above, and they are also relationship factors, in that they contribute to the quality of the therapeutic alliance. It is one of the responsibilities of the therapist to ensure a positive therapeutic relationship. Making a conscious and deliberate effort to build a trusting relationship must be done by the therapist, and some will do it more naturally and more readily without having to deliberate about how. In my work clients are encouraged to notice how they are made to feel by the therapist.

A case for more feedback between therapist and client

Based on the survey data, feedback, a chance to talk about the relationship between client and therapist could be important for clients. Many of the respondents discontinued seeing the therapist with whom they were working after the memorable experience they reported. Of the respondents 56% continued working with the same therapist, their comments range from positive “I hold them in my heart” to more marginal “Yes I continued to see him but I felt that he had no idea with what he said to me as being a problem.”

The question posed in the survey was “How did the experience impact future work with the person? Did you continue to see them?” Four respondents did not provide an answer and 36% discontinued seeing the therapist involved. Of those who discontinued most stopped immediately. A couple of respondents continued with the therapist described in their memorable scenario and ultimately stopped and giving reasons that are distressing and make a strong case in themselves for open feedback during therapy sessions. I see it as a matter of ethical practice:

- “I saw him for a further 8 months or so, but I didn't learn to control my rage with him, and often I would self-harm instead of getting angry with him. Our relationship ended after I overdosed in his office, to punish him for perceived abandonment.”
- “Saw him one more time when he was in town the next year. That session was also very confusing and frustrating. He insisted I had a crush on him and wanted an affair with him, which I did not feel at all. Again I felt he wasn't owning his own energies.”
- “We went for 3 frustrating sessions, this was not the type of work I felt I needed.”

My findings support the value and the need for, more continuous feedback between therapists and their clients.

DISCUSSION

Central to my research was the open question “What are client’s memorable experiences in therapy?” I had my own experiences and I have gained a lot from therapy and I feel therapy is undersold to potential clients. By undersold I mean that there is a stigma attached to seeking and attending therapy, it is less accessible than it ought to be as it is not talked about very much. I think there is also a pressure in the public health system to deliver effective low-cost treatments to people in distress and while therapy is an effective option, it is expensive to deliver. My research showed that therapy can have bumps and surprises, the unexpected happens and many of the reported memorable experiences were negative. The power imbalance in the therapist/client relationship makes it all the more important that clients are better informed about therapy. A couple of issues that bear more discussion are:

- Feeling attitudes of clients about the therapist/therapy
- Feedback

These are both discussed below and finally, in this section, I have included my contributions to the field.

Feeling attitudes

Wampold (2012) recently published a paper in which he drew the conclusion that “The therapist.....needs to appreciate that psychotherapy is a deeply humanistic experience- two humans in a room in an intense interpersonal interaction.” (p. 447). My own advice to clients on what to look for in a therapist is complementary to Wampold’s thinking particularly when I suggest that a client should feel that they are not just seen as a symptom or problem to be solved. In many of the memorable experiences that clients reported, therapists appeared to lack a

humanistic approach, at least, that is from the point of view of their clients. A small step in the right direction is, one I have adopted here, referring to people in a therapy setting as ‘clients’ rather than ‘patients’.

I have mentioned the Common Factors as an approach to therapy that focuses on delivering what works in therapy, and looks beyond, but does include, the model and techniques a therapist employs. The work of Duncan et al (2010) is an exploration of research relating to the common factors. In the book referenced, the second edition of their collaboration together, they add Therapist Factors, to their previous work of ten years earlier, and note:

That the therapist was previously overlooked turns out to be a particularly egregious omission. Available evidence documents that the therapist is the most robust predictor of outcome of any factor ever studied. (p. 38).

Therapist factors are included in the Processwork model and framed as metaskills (Amy Mindell 1995). Metaskills are defined as the feelings, beliefs, and attitudes of the therapist not distinct from the therapist’s skills but rather merging with them. While the use of metaskills is often implied in a therapists work Amy Mindell’s position is unequivocal:

Explicit or not, the attitudes we have towards people cannot be disguised or hidden; they create strong atmosphere. Our attitudes and the way we talk, greet our clients, move, sit in out chairs, the way we use our techniques.

In fact, even if we have good skills or ideas, using them with the wrong feeling will produce the wrong psychology or adverse effects. (p. 32).

Amy Mindell takes therapist factors to what she call a “spiritual art” (p. 36) and connects the concept of metaskills (or therapist factors) to “Taoistic attitudes – which values the ongoing flow

of nature”. She recognises that a therapist will have a range of feelings and attitudes that will ebb and flow as she works and recommends that the therapist brings them into her work “consciously and usefully”.

Some therapists relate better to clients than others, the relationship between clients and therapists is key to achieving positive outcomes. Norcross (2010 p. 116- 119) examines the therapeutic relationship and provides practice implications; advice for therapists based on what clients have reported works for them. Some of his advice to therapists is mirrored in my own advice to clients:

Norcross to therapists	Me to clients
Listen to clients	Be listened to and heard
Privilege the clients experience	Believed
Avoid critical or pejorative comments	Work with a genuinely nice person

The parallels are not surprising as Norcross and I are both reviewing what works according to clients, although I did not ask that question directly. Therapy is intensely personal, clients perhaps know that better than some therapists.

Feedback

I made a call for more feedback in this paper in the Findings section. Sparks and Duncan (2010) talk about the value of making space for feedback within therapy:

Soliciting systemic feedback is a living ongoing process that that engages clients in the collaborative monitoring of outcome, heightens hope for improvement, fits client’s preferences, maximises therapist-client fit, and is itself a core feature of therapeutic change. (p.378).

I find it interesting that feedback is described as an event, albeit a systemic one. Within the Processwork model feedback is a “cornerstone” of the work (Amy Mindell, 2006, p.137). Rather than relying on feedback as a discrete event and asking for feedback. The Processwork therapist uses her awareness to constantly inform her about the client and the direction of the work. Feedback comes as signals in different communication channels, not only verbally, and that feedback can be positive, negative, or mixed; edge feedback, where a client may say yes and no at the same time.

Diamond and Spark Jones (2004) devote some pages to issues related to following feedback including a discussion of ethics and consensus, stating that “obtaining consensus about how to proceed is an ethical consideration” (p.79). They don’t preclude explicit feedback but do note that “In a situation where there is power differential, non-verbal signals are especially important.” (p. 79). I particularly agree with their observation that “feedback is an ever present compass” (p. 77) from which the therapist takes direction. They recommend curiosity and a non-judgemental attitude, not construing positive or negative feedback as necessarily good or bad. They say that “Each step forward is determined by the feedback, and signal by signal the feedback leads deeper into the unknown process” (p. 77). I have little more add to their advice that “Feedback signals also communicate a client’s relationship...to the therapeutic process in general.” (p.77). I can only nod in assent (a feedback signal), supported by the comments submitted in the survey. Sparks and Duncan (2010) agree with the sentiment, “...feedback assumes a role alongside the more widely researched client, therapist, and alliance variables, emerging as a common factor.” (p. 378).

Contributions

The most obvious contribution I have made is the booklet itself. While it is, as intended, an unusual guide to therapy, I believe it is a useful guide. It is already useful in that it starts to fill the hole in the field of therapy research by seeking and illustrating therapy experiences from a client perspective. The primary audience is clients of therapy, and I acknowledge that I am addressing a much larger audience. I can already see the booklet as a resource for therapists to share with their clients. I hope that some therapists will do that. I plan to make the booklet available on my new, but as yet still being developed, website; blahblabblacksheep.com.au

I am grateful to Arnold Mindell, the founder of Processwork, who believes that all parts in a system need to be identified and allowed to speak. My own work was emboldened by this tenet of Processwork and I allowed clients to speak of their experiences, which is my kind of democracy. In my work I have ensured that clients of therapy are visible and present and, I hope, they feel supported by my attempts to faithfully portray a representation of their experiences.

My unusual approach also supports Amy Mindell's work on metaskills. Amy focused the importance of those skills for the therapist so that the therapists work was an authentic expression of herself. My approach has amplified the need for the therapist's genuine feeling attitudes in service to the client, especially by highlighting scenarios when those skills looked to be absent. I make the value of our feeling attitudes accessible to an audience beyond process workers.

I also hope that my description of therapy as being useful for all of us, wherever we identify on, a range of normal, stands upon a Processwork foundation. I want us all to feel normal despite whatever is regarded as normal by society. I see normal as a process or

continuum that has been broadened with an awareness of the changing nature of our temperaments, that we don't occupy only one position on an imagined scale but have the fluidity to occupy all sorts of normal. According to Mindell (1985a, p. 11) "The very idea of process contrasts with the idea of a fixed state, which is a static picture...". Being normal should include what might be unwanted and discover meaning in that, accepting that how we are on any given day, or moment is somehow intended for us:

This is a spiritual attitude that is interested in discovering how our innermost being attunes itself to whatever arises in everyday life and how this prevents us from being victimized by our experiences" (Diamond and Spark Jones, 2004, p. 19).

What better place is there to explore our nature and understand our deep diversity than in therapy? The personal development that can be gained is a way to change ourselves and subsequently the societies and worlds we inhabit.

Further research

My next steps on this topic will be guided by feedback from readers of the booklet when it is shared. I am confident exciting opportunities await.

Given that my research question was an open one "What are client's memorable experiences in therapy?" and that an underlying passion of mine is to expand our sense of normal, I would like to do more research on our sense and perceptions of normal. I want to embrace the curious, odd and exceptional. I am interested in research that explores something unknown and there is a lot more scope for hearing from clients about therapy, what is therapeutic and what is not.

It would be interesting to open up to a larger scale study along the same lines as the one I have just completed to see if the themes identified play out across a bigger population of clients. I am particularly interested in discovering if the poor experiences are as prevalent. Is there really a case for therapists using better feedback skills? I wonder if there is a way to explore that topic without making therapists look bad for a lack of feedback awareness. I am already certain there is a case for therapist training to include metaskills training, improving a therapists feeling attitudes and skills.

Emotional responses of clients is a further area for more research. Respondents reported how they felt after their memorable experience, rating their feelings using the Abraham-Hicks Emotional scale. I didn't use that data except to determine if an experience was a positive or negative one and that judgment was really evident in the scenarios described. The emotions were an all but unnecessary confirmation of the effect of a scenario. I have not analysed that data beyond it beyond tabulating it in the Findings section. There is scope for further analysis of the emotional responses in particular and perhaps seeking links with empowerment and emotions experienced by clients. It might be interesting to see if emotional responses relate to staying with a particular therapist over time. It might also be interesting to look at the feelings of Processwork clients compared to others. I talked about the value of metaskills and continuous feedback within Processwork and I wonder if client experiences are measurably different as a result. An initial idea I had for naming this project was "How do you feel about that?" a classic line used by therapists in the movies or on TV shows. I became more interested in 'what happened' over 'how did you feel' and both stand as good open questions that could lead more research and bring clients more to the fore when we talk about therapy.

The opportunity to create more booklets excites me too. I have a couple of ideas; one is around what clients want from therapy. Client resources are identified as a common factor of what works in therapy, it would be interesting to explore the personal resources that can be directed towards change. I'd like to question if change is wanted by all. This interest comes from my involvement with groups of people who live with suicidal feelings, where there is a tension between hoping for change and hopelessness.

Another booklet might centre on expanding normal and what is thought of as normal. Like I talked about in the Contributions section, I would like normal to be regarded as a process rather than a state and to build an understanding of normal that goes beyond the everyday, perhaps that we can be something better than normal.

Many interesting opportunities for future research exist within the fields of Processwork and the therapeutic relationship in general. I believe the client's experience is paramount I would love to do more research with that in mind.

The Introduction to this essay extended to 22 pages as I drew on personal reflections and issues that are important to me, like stigma, have all perspectives represented, my own belief in the power of therapy and wanting to demystify therapy. As well as therapy being useful to people in distress or carrying difficult experiences, I felt called to make therapy more accessible to the everyday normal person. I was able to weave many disparate but in some ways related threads into this one project. This project and paper have provided me with a foundation for further work in this area, something I am passionate about. I am starting my own business to further my ideas and work. So far my business has a name Blah Blah Black Sheep, there is a lot to do to bring it to the world and my intention is to work more with individuality, beyond the labels that are used to assign us to groups. I value difference, our curious and unconventional traits and

thoughts and our black sheep parts that can feel unwelcome in society and within ourselves. Maybe we are all black sheep diverse and individual and looking for acceptance. As I nurture and develop my own audacious authenticity, I will bring it into the world through delivering training, facilitating groups and discussions, working as a therapist and constantly seeking a way of being that is better than normal.

There is a need, maybe even a craving, in the world to be ourselves, Mindell (1985a) tells us that:

....regardless of what sort of psychotherapy they use. The happiest of them are not the ones who have made birch trees out of maple trees, who have solved their problems or changed themselves but the ones got birch sapling to grow respectfully into birch trees. (p. 121).

The same goes for black sheep, happiest will be those of who live as black sheep, or birch trees.

APPENDICES

The Survey

The survey used is replicated on the following pages. There are some anomalies in the character spacing and formatting that resulted in the conversion from the on-line survey tool, Survey Monkey, to a format that could be pasted into this document.

How did you feel about that?

Welcome to My Survey

About me

I am Anne Murphy, a student in the Masters of Process Work offered by the [ProcessWork Institute](#) in Portland Oregon.

For more about me visit my [website](#)

I can be contacted via email, should you wish for more information; anne.j.murphy@gmail.com

About this research project

The purpose of this survey is to collect client experiences in therapy and use these as the basis of a handbook. The majority of resources about therapy are written from the professional perspective of the therapist. Through this project I want to create a resource that provides information drawn from a client or experiential point to view. The voice of the client is not often heard when experiences in therapy are explored.

The handbook is intended to express/describe what happens in therapy in pictures and words using the voice of the client. It will be published as an on-line resource to promote broader awareness of what happens in therapy for both clients and therapists.

The survey will take 15 - 20 minutes to complete. You will be asked to recall and briefly describe one particularly memorable experience you had in in therapy or counselling. There are some general questions about the therapist, without identifying them. You will also be asked for some demographic information, without identifying yourself. Your participation is anonymous and voluntary. You are free not to answer questions and to withdraw from the survey at any time by quitting the screen and not submitting a response.

Responses will be collated and sorted into similar themes. Each identified pattern or theme will illustrated and a handbook created. The handbook will be made available via an electronic download and is intended to inform others about what happens in therapy, a situation that is rarely talked about or shared. I will include a link to the finished workbook on my website under the [Useful links](#) tab, I expect this be towards the end of 2015.

Benefits and risks of participation

You will be contributing to a resource that informs others about experiences that can happen in therapy by highlighting a diversity of those experiences. You may or may not directly benefit from from this study. It is possible that sharing your experience will help to reconnect with something important, it could bring clarity or new insights to your work in therapy. It is also possible that participation in the survey may bring up difficult feelings. You're welcome to contact me directly via email for a referral for counselling or if you'd like to talk about anything that comes up for you.

I hope that others will benefit from what has been shared and reported by their peers by reading the handbook and feeling empowered by any knowledge gained.

Your interest and involvement is respected and very much appreciated.

Confidentiality

Responses are anonymous and confidential I will not have any information via this survey tool with which to identify you.

1. Do you agree to proceed knowing the terms as described above? By clicking Yes, you consent that you are willing to answer the questions in this survey.

Only the first question requires a response, all other questions are optional.

Response data is only saved if the survey is completed by pressing 'done' on the last page.

- Yes
- No

How did you feel about that?**A memorable experience in therapy**

Take a few moments to identify one experience, a conversation or an exchange, with someone in a therapeutic role. Think of one incident that is particularly memorable.

* 2. Describe the experience in therapy or counseling that you just recalled. Something that went well or not so well. What happened?

3. What was it about this experience that made it memorable?

How did you feel about that?

Describe the feeling you recall from the particular experience you just described.

4. Select the emotions that best describe how you felt afterwards. The *emotions listed are based on the Abraham-Hicks emotional guidance scale*. You are also welcome to use your own description of your feelings.

- Joy/freedom
- Empowerment
- Love/appreciation
- Enthusiasm/eagerness/happiness
- Optimism
- Hopefulness
- Contentment
- Boredom
- Pessimism
- Frustration/imitation
- Overwhelmed
- Disappointment
- Doubt
- Worry
- Discouragement
- Anger
- Vengeful
- Rage
- Jealousy
- Guilt/insecurity/unworthiness
- Fear/grief/despair
- Other emotions, in your own words:

How did you feel about that?

Motivation and focus

Some optional information about why you sought therapy whether that was for personal growth, support, guidance, healing, or another motivation.

5. Describe your motivation for seeking therapy leading up to the memorable experience you described

6. How long have you been in therapy over a ll ?

7. How long you were in therapy with the practitioner described your memorable experience?

8. To what extent was your original motivation fulfilled or not, or has your focus/motivation changed?

How did you feel about that?

Information about the practitioner

9. Describe the role of the person involved in the experience you noted. For example coach, counselor, mentor, psychiatrist, psychologist, therapist. What role best describes them?

10. How did the experience impact future work with the person? Did you continue to see them?

11. What was their particular approach, if you know that. Were they practiced in ACT, CBT, EMDR, Gestalt, Processwork or another therapeutic modality? Please answer 'don't know' if you don't know this information.

How did you feel about that?

Demographics

This section is optional, it asks for a little more about you. Demographic data supports the research aspects of this project and provides a little context for the survey results. In any case if you do, or do not wish to provide this data please press done at the bottom of the page to save all earlier responses.

12. What is your age?

- 18 to 24
- 25 to 34
- 35 to 44
- 45 to 54
- 55 to 64
- 65 to 74
- 75 or older

13. How do you describe your race or ethnicity

14. What is your gender identification?

15. How do you define your sexual orientation?

16. What is your current relationship status?

- Married
- Widowed
- Divorced
- Separated
- In a domestic partnership or civil union
- Single, but cohabiting with a significant other
- Single, never married

17. What is your approximate average household income?

- \$0-\$24,999
- \$25,000-\$49,999
- \$50,000-\$74,999
- \$75,000-\$99,999
- \$100,000-\$124,999
- \$125,000-\$149,999
- \$150,000-\$174,999
- \$175,000-\$199,999
- \$200,000 and up

18. What is the highest level of education you have completed?

19. Are you currently employed?

- Yes
- No

20. What is your profession or role at work currently or when you last worked?

21. If you have ever studied in a field relating to therapy and mental health please describe

22. If you have a diagnosed mental health condition please note it here. Please also say if you do not agree with the diagnosis

Thank you for your time and energy in completing this survey.

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