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**ORIGINAL ARTICLE The needs of clients coming to counselling following second harm: A Q methodology study**

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Abstract

Second harm is the added psychological distress from an inadequate response by healthcare providers in response to a medical errors or neglect. This inadequate response may require patients to seek counselling. The counselling needs of patients who have experienced second harm have received limited research attention. This Q methodology study addresses this gap in knowledge in order to further inform counselling practice.

Methods

Participants sorted 42 pre-determined statements online followed by interviews to establish the rationale for the sorting pattern choices. Data from the online sort was analysed using factor analysis to establish the viewpoints expressed. The interview data adding to the interpretation of the viewpoints.

Findings

Through a factor analysis two ‘viewpoints’ and 11 counselling needs were identified. Nine of these needs were generic to the counselling relationship and two specific to second harm. This study concluded that people seeking counselling following second harm have needs beyond those expected from a general counselling relationship. These included not being blamed for what happenedand a need for the counsellor to be able to demonstrate that they are able to understand the impact of harm.

Implications for practice

The needs identified in this study as being generic can give counsellors confidence in

working with clients that have experience second harm, knowing that many of the needs identified are not unique. Counsellors can also be confident that those needs that are unique can be understood through extending their knowledge of the topic and listening to those that have been harmed.

**Introduction**

First harm is defined as the harm that happens as a result of an error, mistake, neglect or mismanagement of treatment (Vincent, 2006) and costs the NHS £1bn per year (Frontier Economics, 2014). Globally there is a 1 in 300 chance of an individual being harmed through healthcare related incidents (World Health Organisation 2019).

There is clear evidence that an additional event of harm, referred to as second harm, can be caused by the manner in which a healthcare provider or clinician responds to the patient following an incident of first harm (Ocloo 2010). Second harm may include; non-disclosure, denial of error, lack of empathy or recognition of impact, inability or reluctance to learn from mistakes or implement findings of inquiries, dismissal of symptoms, fears and concerns relating to the incident of first harm and not communicating with the patient and their families (Vincent 2006, Sokol-Hessner, Folcarelli & Sands, 2015). Often these events cause emotional and psychological distress which impact significantly upon successful recovery from the initial event of harm (Ocloo, 2010).

Several high-profile reports in the UK, including the Francis Report (2013), the Kennedy Breast Care Review (2013) and the Keogh Review (2013) state that the culture of organisations and the wider NHS could contribute to poor outcomes, negative experiences and further distress to patients following errors. In 2015 a Report following the Morecambe Bay Investigation (Kirkup, 2015) similarly highlighted the issue of a culture exacerbating distress by dismissing concerns of patients. This report was highly critical and identified a systemic culture of mismanagement and deliberate deception that had the consequence of families being unable to fully access accurate information, leaving them without an understanding of what happened to their relatives. Disappointingly, more recent reports continue to highlight the same inadequate treatment of patients and relatives documenting incidences of second harm experienced by patients who raised concerns or complained about poor care (Ockenden, 2020, Cumberledge, 2020).

Beyond the UK concerns regarding the responses of healthcare providers to incidents of first harm are echoed in the international literature. The work of Berlinger, (2005) documents numerous cases in the USA while in Australia, poor responses from healthcare providers resulted in the development and implementation of the Open Disclosure Framework (Australian Commission on Safety and in Health Care, 2013) that sought to find a more open manner in which to engage with patients following harm. These cases suggest that first harm is a global health issue (Gibson and Janardan, 2001; Berlinger, 2005; Hall, and Hall, 2017).

Additional work has been undertaken by Ottesen *et al*. (2018) in considering the long-term impacts faced by patients and families after harmful healthcare events and by Prentice, *et al*. (2019) in relation to the association of open communication and the emotional and behavioural impact of medical error of patients and families. These studies focus specifically on first harm but don’t identify second harm as an issue.

Similarly, the work of Anderson Wallace and Shale on building trust with patients and families through counselling and coaching adds to the sense that communication, support and enragement with families is important following healthcare harm (Anderson-Wallace and Shale 2014).

The work of Sokol-Hessner Folcarelli and Sands, (2015) on harm by disrespect discusses first harm and the relationship between harm and interactions between patients and healthcare professionals yet fails to recognise that harm outside of the initial harming event exists.

Although these studies are useful in providing some context in relation to healthcare harm generally, these studies and commentaries either focus exclusively on first harm rather than on the specifics of second harm, or merely allude to the nature and devastation of second harm.

Some recognition of additional second harm comes from the work of Trew, Nettleton and Flemons, (2013). Their work names and describes second harm as being ‘*as a result of what people, healthcare experience or organisations does or does not do to help patients move towards a normal cycle of grief and recovery*’ (p7). Their work recognised that the grief process for patients that have been harmed, whether they had been bereaved or experienced loss as an aspect of the harm, can be hindered by the response of the organisation moving patients from a normal grief process to what they term complicated grief, now termed Prolonged Grief Disorder (American Psychiatric Association 2013). This work focused specifically on the nature of the trajectory and, although offering a definition of second harm, only gives minimal consideration to the discussion of second harm and fails to present an evidence base for their definition. The work is based on a literature review of grief processes and suggests a modified model based on the work of Stroebe and Schut's dual process model that can help individuals move towards recovery following an 'adequate' response, as deemed by the patient, to the harm (2001). The model developed by Trew, Nettleton and Flemons, (2013) is a useful one in the consideration of the linking of loss and grief to harm. However, their model and description of second harm, does not take account of any models of trauma, any other theories that might constitute second harm or the recognition that grief is not the sole constituent of second harm. While their work recognises that second harm may consist of many themes including exclusion, control of information, disrespect and lack of understanding the impact of harm they fail to explicitly take account of the interpersonal nature of second harm. No follow up study has been done leaving their definition incomplete and lacking in clarity.

The academic literature is therefore inadequate in relation to second harm, despite a growing number of studies on first harm which is surprising given that within reports documenting failings within the healthcare sector there is a dominant narrative of continued and exacerbated harm.

This emphasis on sustained harm is also reflected in patient group discourses with healthcare providers suggesting there is a need for formal support for second harm which may include specialist counselling (Walsh, Titcombe and Hughes, 2021). First harm therefore received interest and has generated some research whereas second harm, although acknowledged in the patient safety community has received virtually none.

The nature of additional harm is reported in patient narratives. For example, in 2016 the Learning From Deaths Programme (National Quality Board, 2018), identified a number of areas of concern and aspirational practice in response to work with patients who had lost friends and relatives as a result of errors or poor care. This work focused on the responses, attitudes and actions of healthcare providers following avoidable deaths in the wider NHS and it made shocking reading.

*“The most toxic, damaging, compounding, devastating thing that happens is they drip feed you information, they give you a tiny closed off answer. Letters are sent Friday so they arrive Saturday morning, you’ve nowhere to go, nothing to do with it. Every single time a piece of information came through it raised another question, and another question, and another question.”* (Page 16)

*“They said he wasn’t given pain relief, I know he was, but they never recorded it. As a family it was awful, we didn’t feel anybody took us seriously.”* (Page 17)

*“As soon as we started asking questions it was like we were interfering and that they were the professionals, not us. They became antagonistic”* (Page 18)

(National Quality Board, 2018)

The clinical and often brutal nature of how families were dealt with by organisations after a loss was a feature of this report and there was a clear sense of damaged relationships between patients and clinicians in the descriptions of these dealings. This mirrored the personal experiences of individuals in several high-profile cases including Steane, (2007), Titcombe (2015) and Ryan (2017).

Even where a loss of life is not experienced, patient narratives document a series of interactions that include sustained and damaging incidents such as altered clinical notes, patients not being believed, being ignored, or being made to feel that they are to blame (Cumberledge 2020). In her report ‘*First do no harm’.* Baroness Cumberledge notes that the patients that were part of the inquiry had been significantly impact upon by this behaviour. These left patients feeling abandoned, living with guilt, anger, and a sense of identity loss often due to them having no understanding of what went wrong in their care and why. She notes that this led to family breakdown, financial worries, job losses and reduced quality of life.

The devastating consequences of second harm are mirrored in reports and patient narratives in recent years and with the increasing number of these reports and narratives it is perhaps timely for second harm to be researched.

Additionally, the scope and focus of specialist counselling that might be needed in such circumstances is under researched with no empirical literature on the specific needs of people who experience this specific type of harm (Doctoral thesis to be referenced by lead author). As a consequence, it is also unclear if counselling needs following second harm are the same or different to others who attend for counselling.

Therefore, the objectives of this study were threefold; i) to identify common needs of clients coming to counselling following second harm; (ii) to identify key factors that are both common and novel in relation to counselling that clients believe would be most helpful following second harm, and (iii) to establish clear recommendations for counselling that can be utilised by those working with those that have experienced second harm.

**Ethics**

This study was reviewed by the West Midlands-Solihull Health Research Committee number 18/WM/0103 in May 2018 and the Ethics committee and the College of Health and Social Care research ethics committee at the University of Derby and a favorable opinion was given by both. All participants were provided with details of the study, able to ask questions and gave written informed consent.

## Methods

This study took a Q methodology approach. Q methodology, developed by [William Stephenson](https://en.wikipedia.org/wiki/William_Stephenson_(psychologist)) (1902-1989), is a method of researching opinions on a topic (Brown, 1993). Q methodology looks for correlations between participants across a sample of variables known as ‘Q sorts’ whereby participants prioritise statements pertinent to the topic.

Q methodology was chosen for this study because the approach can articulate and make explicit the voices of the those who so often feel marginalized. In the context of this study patients and families often feel marginalized and their voices ignored (Ocloo 2010). Therefore, methodologically it was important to choose an approach that would ensure that their voice was heard. Q methodology is a systematic, valid and robust means of allowing implicit opinions to be identified, extracted and interpreted (Brown, 2006). This methodology was sympathetic to the needs of this population.

A Q methodology study consists of four stages: 1 generating the Q-sort pack; 2 administering the Q-sort; 3 collecting data and 4 factor analysis and interpretation. These methods completed during each of these stages are discussed below.

## *Stage 1 Generating the Q-sort pack (known as the Q set)*

To generate the Q sort pack, also known as the Q set (Watts and Stenner, 2012), a review of the concourse is required. The concourse comprises of the body of knowledge and experience that represents the range of common opinions and views about the topic of interest (Exel & Graaf, 2005). However, second harm is poorly identified, and an accepted definition was lacking which presented a challenge to the identification of material relevant to the concourse. Therefore, the concourse was constructed through the collection of materials that reported patients views and experience of the interpersonal responses of healthcare providers to their concerns raised about care. As a consequence, the concourse comprised material in the public domain and was inclusive of newspapers, reports, books, patient narratives and social media.

This detailed and in-depth analysis of patient narratives gave rise to an opportunity to identify a working definition of second harm that was used to frame the study and provide context to the inquiry. For this study second harm was defined as*: ‘the impact on individuals of the contemptuous response from healthcare professionals towards patients that hold professionals to account for errors, failings and mismanagement of care’.*

To ensure a focused, thorough and systematic development of the concourse two strategies were applied. First, a clear framework from where sources of material might be extracted which was developed by the researcher and secondly, inclusion criteria that material should meet to be retrieved for this study. Sources were included where 1. the source evidenced the opinion or range of opinions about the patient experience of second harm, 2. where the source gathered contributed as a whole to a wide range of media and categories of sources in which the opinions of individuals about second harm are expressed and 3. where a source had the potential to add to the development of statements that were aggregated and were indicative of a theme that contributed to potential opinion statements.

The review of the concourse was carried out over a period of 14 months. Sources were reviewed from the following:

• Newspapers -weekly internet search and search for stories

• Books search using popular internet search engines

• Reports from high profile cases on neglect, error or failings in care

• Review of websites of patient organisations.

• Discussion with colleagues, Action against Medical Accidents (AvMA), staff, and patient safety/counselling colleagues as to previous sources of which they were aware.

• The AvMA weekly news bulletin which collates all sources of information about patient harm using a computer programme that scans the internet. This enabled cross checking to ensure that nothing was missed and included all news sources, updates on previous reports, comment in newspapers, reports, news items, TV and radio programmes and activities that contribute to the understanding and documenting of patient harm from a wide variety of sources.

A total of 80 written sources were accessed that specifically were from patient comments, or from observations within inquiry reports which reflected patient experience of second harm.

In this study 41 statements were subsequently identified from this concourse (see Figure 1 and Figure 2). A small group of participant experts review statements to ensure adequate coverage of the concourse. As a result, one additional statement was added totaling 42 and a some small adjustments were made in wording.

## *Stage 2: Administrating the Q sort.*

Administering the Q sort involved recruiting participants who had experienced second harm within healthcare. Sampling followed a purposive approach and participants were recruited through a three-pronged approach: social media; professional contacts and word of mouth. Twenty people responded to the initial call for recruitment and ten went on to participate. Those who did not participate cited concerns regarding the requirement to inform their GP that they were involved in the study which was a condition of ethical approval. Inclusion criteria were that the person had an experience of second harm themselves or to a close family member and they had access to a computer. If these criteria were met there were no further exclusion criteria.

In this study of ten participants, two were male and eight female. Geographically, participants were from Scotland n=2, Wales n=1 and England n=7. Five had experienced second harm themselves and five has experienced second harm in the care of a close family member. The initial harm had happened between 20-5 years ago. All participants had also experienced second harm arising from the poor response to raising concerns about the care with the provider organisation.

## *Stage 3: Data collection phase*

The data collection phase involved participants completing a ‘Q sort’ activity followed by an interview. Both of these were conducted by the lead author, a doctoral candidate who is an accredited and registered counsellor and senior nursing academic. The lead author completed training in Q Methodology and qualitative interviewing. The Q sort was conducted remotely using computer software called ‘Q sort ware’ where the statements were available for sorting. Participants were asked to complete the sort in response to a question called a ‘condition of instruction’. In this study the condition of instruction was ‘*Following the experience of second harm, what would be important to you in the relationship with your counsellor*?’

Post sort interviews are a recognised step within Q methodology (Gallagher and Porock, 2010). These short interviews serve the purpose of enabling the data gathered via the Q sort to be better understood by providing more insight into the decision making behind statement sorting (Stickl *et al.*, 2019). Post sort interviews ask purely about the sorting process and the rationale for decisions. In this regard, post sort interviews are crucial to the correct interpretation of the sort data (Watts and Stenner, 2012). These interviews were conducted by telephone and were recorded using a digital recorder. Each lasted between 8-12 minutes.

Data generated from the Q sort was suitable for factor analysis at which point the study moved to Stage 4.

***Stage 4: Factor Analysis and Interpretation***

The final stage of Q methodology is a factor analysis and interpretation. The analysis is facilitated using a statistical package called the PQMethod which analyses the individual sort data through a uses a centroid factor analysis. Factor analysis identifies any correlation between the sorts using an Eigen Value (EV) and reduces the many individual viewpoints expressed through the sorting pattern down to a few factors. These factors represent shared ways of thinking between the participants (Herrington & Coogan, 2011). These factors are then interpreted as viewpoints (Corr, 2001). In Q methodology ‘viewpoints’ are defined as a common set of preferences profiles from participants that form a cluster of correlations (Exel and Graaf, 2005).

However, before the extraction takes place, there are key decisions required by the researcher. First, the decision on how many factors requested for extraction via the software. Watts and Stenner (2012) give some guidance in relation to the number of factors that can be extracted from any set of data as well as the decision about the number of factors to retain as being significant. As the decision about the number of factors to extract is taken when the request to extract is made to PQMethod programme, three criteria were used in the decision-making process utilising specific criteria described by Watts & Stenner (2012) as shown in Box 1.

Watts and Stenner suggest that should there be a point in the data where the cumulative explained variance for each factor levels off. This would normally be undertaken by constructing a graph of cumulative explained variance. However, completing a test run of the programme with a request to extract three factors rather than two, the third factor only explained 2% of the variance and had an insignificant EV so there would be no value in conducting such an analysis. In addition, PQMethod offers a choice in considering the number of factors by either using Horst’s criteria to allow the programme to choose how many factors are extracted, asking the programme to either extract maximum factors, or stipulating how many the researcher chooses to extract. The latter was recommended by Brown (1980) and therefore was chosen for this study. With only one factor having an EV of 1, it would have been appropriate not to extract Factor 2. There is much discussion in the Q methodology literature about looking at the patterns and the whole of the results rather than merely being led by the ‘mathematics’ (Watts and Stenner 2012) and this second factor, being close to the level of significance did add to the holistic view of the perspectives of participants. Watts and Stenner emphasise a need for flexibility in the exploration of factors solely based on an EV and prefer consideration of a factor based on what might be revealed about the opinions of those who conducted the sort. Therefore, we took a pragmatic decision to explore EV of one and those approaching one.

At this point the programme generated what is called an unrotated factor matrix where factor loadings showed the extent to which each individual Q sort was associated with each of the factors following extraction. Factor 1 accounted for 21% of the study variance and Factor 2 for 10% of the study variance. This left 69% of the study variance that was not accounted for by either factor, usually termed the ‘residuals’, after which no further factors of any significance can be extracted. The large amount of residual data might at first have appeared to be concerning, perhaps expecting that the needs of individuals that have undergone a specific common event might be similar. However, this was more likely to express the complexity of human need and the thoroughness of the diversity of the concourse. A lack of a diverse concourse is known to be indicate by a high correlation of sorts and factors, such as too many statements being similar and participants agreeing with too large number of statements as a result of having too narrow a concourse (Brown, 2019).

Box One. Criteria for factor extraction

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Despite the focus of the viewpoint expressed in each Q sort, there will always be, within each factor, expressed differences. A process called ‘rotation ‘was therefore undertaken which allowed for the overall solution to be the most effective. This process maximises variation, the results of which are demonstrated in the tables for each factor, thus approximating the position of the Q sorts to that factor in a spatial manner. Factor rotation also prepared the data for future interpretation by making the factors more distinctive, simple and identifiable (Kline, 2014). The statistical programme rotated factors physically around a central axis on a graph via the varimax solution in PQMethod. The factor loadings of both factors changed following rotation. Factor rotation adds focus to the data and does not change the actual viewpoints expressed by the Q sorts (Watts and Stenner 2012).

**Post-sort interview data**

Usually, in Q methodology post sort interviews are not coded or themed as in a traditional analysis of interview data and a holistic approach is taken to the data gathered (Watts and Stenner 2012). Watts and Stenner also suggest that the ability to apply some flexibility of approach to data is a key aspect of a Q methodology researchers toolkit and thus a variety of different approaches are taken to how the interview data is described. In Q methodology studies the focus is on the centrality of the viewpoints. Methods such as traditional thematic analysis are seen to be at odds with Q methodology and emphasis on interview data, and its interpretation, detracts from the viewpoints instead of adding insight to them. Therefore, in this study a more traditional approach congruent with contemporary Q methodology was used which uses the interview data purely to deepen understanding of the viewpoints identified from the factor analysis

## Findings

Two viewpoints were identified from the data in this study: *Needs that are both past and present focused: being understood* and *Needs that are both present and recovery focused: making me well*.

The viewpoints are described below with the factor array for each viewpoint. An EV for each viewpoint is also provided. Data from the post-sort interviews are also presented.

## *Viewpoint 1 – Needs that are both past and present focused: being understood.*

Viewpoint 1 had an EV of 2.12 and explained 21% of the study variance (Figure 1)

Figure 1. Factor array for factor 1.

Table

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Wanting to know and understand about the possibilities of what happened to them was articulated as a specific need. Additionally, a need for a two-way honest and particularly respectful communication and dialogue in the exploration of those possibilities with a counsellor is also clearly articulated.

In the process of trying to make sense of what had happened to them it was recognised that the client would have to be honest about what had happened to them. Participants recognised that this was necessary to help the recovery journey move along, and to establish the counselling relationship as being a place where honesty can be displayed.

‘*if you’re not honest with your counsellor then you can’t get very far, and if they’re not honest with you, then equally’* (Participant 2 P1).

The need to be listened to and to be heard to ‘talk out’ their experiences without feeling judged was articulated as part of the need for respectful and honest communication. Participants saw the ability to be heard and for what they had experienced to be valued by somebody who was able to demonstrate being kind and encouraging as important. This was equated with being treated as a human being. This was ranked more highly than the counsellor being able to demonstrate and understanding the enormity of their experience.

Core values, such as honesty in the counselling relationship, were identified as a specific need by participants who saw these values as adding to the relationship with the counsellor**.**

Participants were not specifically cognisant of the ethical frameworks, policies and procedures to which counsellors must adhere. The participants did convey an underlying assumption that counsellors would behave in a particular professional manner. As a result, participants consistently rated the need for policies and procedures as being low, not because they did not believe them to be important, but primarily due to an assumption that ethical practice and correct procedures would be adhered to regardless of whether these existed.

‘*Never really thought about that before and so I sorted those statements as not being important because, well, you take it as read don’t you, that they can to be fair and trained properly and ethical and follow their own procedures, but then I thought, well, the NHS professionals that looked after me didn’t do the right thing, but I have a sense that counsellors would. But doesn’t really make sense does it?’* (Participant 5 P2).

Participants referred to their experience with their care and, while recognising that policies, procedures, and ethical practice had not been adhered to in that setting, clearly saw the counselling setting as quite different. The challenging journey for those that have experienced second harm may have involved re-evaluating themselves, sometimes with positive outcomes,

*‘I expect to have that kind of relationship with a counsellor and am used to people treating me with respect, but when my incident happened, I was very young and it wasn’t like that for me. So, if I was seeing a counsellor then that was what I would have expected, and even now’ (Participant 7 P1).*

Although across both viewpoints no participant felt it was important for the counsellor to have legal knowledge or expertise. However, it was highly ranked that the counsellor needed to convey that they could support the client through the legal process. Participants were also clear that they needed counsellors to understand the trauma of the process and the impact of going through the legal process. Individuals that choose the route of undergoing a complaint or a litigation process often referred to the situation as a ‘fight’ that is difficult, or as participant 5 called it:

*‘harrowing and traumatising’ (Participant 5, P 1).*

Often, this ‘fight’ constitutes a search for answers as a means to understand what happened with the only way that seems open to them being through an acrimonious legal process in order to force dialogue with the disengaged care provider.

Participants, perhaps surprisingly, given their experiences were not overly concerned about being part of decision-making about their psychological care. They did however want to be assured that the counsellors themselves would be accountable for their own actions with policies and procedures being in place and be adhered to as part of the process.

*‘the counsellor is accountable for her actions. Well, obviously that is important in some respect, in the scheme of things, but on the list of statements that was fairly far down the line of what’s important for me’* (Participant 2 P1).

Thus, the participants expressed the need to start their journey of acceptance by gaining some understanding from the past through the counselling process of what had happened to them and for this to be understood and acknowledged by others where possible.

### *Viewpoint 2 – Needs that are both present and recovery focused: making me well*

Viewpoint 2 had an eigenvalue of 0.99. This did not quite reach statistical significance, being just under the value of 1. It was however retained in this study on the grounds of its considerable importance to understanding the participants needs and that even through it did not reach significance it did still explain 10% of the study variance (Figure 2).

Figure 2 Factor array for factor 2.

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This viewpoint’s most highly placed items denote a need for participants to be safe, supported, believed, and validated. Again, this need sits well with the expectation of core values and ethical working where safety, validation and recognition of the client perspective is part of a counsellor’s ethical framework (BACP 2018).

*‘You kind of expect them to be don’t you, to provide that (in reference to safety and support) for you’ (Participant 10)*

Participants did not want to be involved in a counselling process where they were perceived as “being a problem”. What they wanted was for their experience of harm to be validated within the counselling process. This was more than merely an opportunity to ‘talk it out’ and participants wanted the counsellor to understand and be able to demonstrate their understanding of the enormity of what had happened to them.

In this viewpoint participants wanted to explore the difficult terrain of emotions but were willing to go further than in viewpoint 1 both in depth exploration of their own emotions and the impact of what happened, although they were not at all concerned about being seen as betraying the National Health Service or wanting blame or retribution. The participants that loaded significantly on to this viewpoint had life changing events happen and seemed to be less worried about expressing this dissatisfaction with the system than those participants in viewpoint 1, even though they had significant issues of second harm. Participants did want to be heard and have a counsellor that was kind, encouraging, valued what they had to say and treated them with humanity.

In Viewpoint 2 participants ranked the working practices of the counsellor not particularly highly, for example the issue of counsellors following policies and procedures. Participants on viewpoint 2 suggested within the interview data that there was already the assumption of core values and ethical working in relation to their narrative of what happened being believed. The participants cited negative experiences with others as a reason for this need for fundamental values and frustration that these values were not universal.

*I’ve experienced the other side of this, is that people believe you and acknowledge what’s happened. I haven’t told you this but my son doesn’t believe me (Participant 6 P 2).*

Similarly, participants with this viewpoint did not expect a counsellor to help them feel empowered, understand aspects of the law or feel that there was a need to explore the possibilities about what happened to them. This latter point conflicts sharply against viewpoint one in which understanding possibilities was a key feature.

Unlike viewpoint 1, viewpoint 2 participants were focused on the present and the future, with less of a focus on the past but had, or specifically needed to utilise counselling in working towards recovery, noting how counselling helped people keep going until they could ‘*fall apar*t’ (Participant 3), when it felt safe for them to do so.

The specific need to know about counselling, accessing services and coming to counselling was identified by four participants in viewpoint 2 from the statement sort and within the interviews.

Despite the possible benefits in moving toward recovery, there was a belief that accessing counselling might be challenging, in terms of services available, particularly specialist services and that this may hamper the journey to recovery.

‘*but it’s often getting the information out to people, where to access counselling…*

*‘It’s often very difficult to get counselling, it’s not so bad if you live in a town*’ (Participant 10 P 2).

The need for the counsellor to understand the impact of the elongated and difficult complaints and litigation process on the day-to-day life of a client was cited as an important need by four participants. These included two participants whose sorts loaded significantly on to viewpoint 1, one that loaded on to Viewpoint 2 and one that loaded on to neither. This suggests that this need was again not viewpoint specific. All those that referred to the process of litigation and complaints agreed that it was long, exhausting and often hindered the process of recovery. In the case of those who complained, the process involved considerable energy and focus at a time when they were depleted in both. In respect to those who turned to litigation, the process was viewed as being designed to demoralize and ‘wear down’ potential claimants to deter people from undertaking the process. The impact of consistent and constant adversarial processes impact upon the lives of clients in a negative manner.

‘*It’s such a negative experience, it is so concentrated {..}It drags it out, and you know the other side drag you out to just before the trial. It’s a very wearing process {…..}. I didn’t want to fight much more (*Participant 3 P2).

Additionally, both viewpoints indicated the need to gain elements of power, autonomy and control over their lives as well as needing to cope with change as a means to come to terms with what happened to them and recover.

## *Identification of needs from the viewpoints*

Clear guidance on how to interpret factors is limited. The method used most extensively is the crib sheet method by Watts and Stenner (2012) and was used in this study predominantly due to its transparency and straight forward approach.

Two crib sheets were constructed, one for each factor. The sheets set out the information on statements that were ranked as most important in that factor, ranked higher in each factor array than in the other, ranked lower in each factor array than in the other and statements that were ranked as least important in that factor. In doing this, every statement was noted on the crib sheet for consideration. All statements were considered individually in an abductive process in relation to the meaning and implication of their placement in the sort.

From the viewpoints discussed above eleven perceived needs were identified, nine of which were considered generic and two were specific to those accessing counselling for second harm (Table 1).

Table 1. The needs of clients coming to counselling for second harm.

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**Discussion**

*Needs that are generic to individuals coming to counselling*

Within the counselling world there is recognition that the counselling process can be applied to a variety of presenting issues such as addiction, childhood sexual abuse, trauma, or depression and that basic principles can be applied across modalities. Counsellors, regardless of why clients come to counselling are expected to be able to provide a consistent therapeutic environment where the needs of their clients can be met (BACP 2018). There is an expectation that counsellors work ethically to provide that environment and can work with their clients to meet their needs, often when clients may not even be aware of those needs. The needs identified from the viewpoints as being similar to those coming to counselling generally are respect, need for the counsellor to sit with clients, the need for ethical working practices, the need to make sense of what happened, the need to understand, be understood and helped cope with change and impact, the need to use counselling as a means to recover, the need to regain control, power autonomy, the need for access to appropriate counselling and the need to develop competency in accessing and engaging with counselling. None of these needs sit outside the expectations of a usual counselling therapeutic relationship and the expectations articulated in ethical frameworks (BACP 2018, UCKP 2019).

# *Needs specific to individuals coming to counselling for second harm*

While the needs identified in the wider academic literature on counselling generally resonated with many of the perceived needs of participants in this study, two needs were identified as being specific to those coming to counselling for second harm; a need for participants to not be blamed for what happened and a need to have the have the counsellor understand the impact of the harm and the complaints and litigation system. Both were evident in the viewpoints and post-sort data.

### A need for participants to not be blamed for what happened

This need was identified through participants identifying that the apportioning of blame got in the way of a respectful counselling relationship and that one of their needs would be to not experience blame within that relationship. This seems to specifically be in relation to what happened to them within the context of the first harm, subsequent second harm relationships and their responses to these events. This need was closely linked to the relatedness in Self Directed Theory (Deci & Ryan, 2015) and a need to be connected to others, to be understood and to have relationships with self and others repaired. This includes the counsellor modelling respectful connection, understanding and encouraging self-compassion in the relationship to help develop these attitudes towards themselves.

While the need for connection is evidenced in wider literature on counselling, the specific context of blame and ascribing some personal responsibility for what happened to individuals that have been subject to poor care, errors or mistakes is evidenced within the concourse and therefore articulated in the statement pack around error (Adcock & Adcock ,2019; Ryan 2017). It is not uncommon, for patients to be ascribed elements of blame when care goes wrong. Indeed, Vincent & Coulter noted this trend in patient safety as far back as 2002.

Ascribing blame to patients in an attempt to detract from errors made in healthcare, further exacerbates second harm and hinders the grieving process as well as causing significant distress to families (Adcock & Adcock 2019). Being blamed by those who may have contributed to the harm yet fail to acknowledge or apologise is in sharp contrast to the perceived expectations of what healthcare professionals should do and behave in the event of an error. All healthcare professionals are subject to their professional body codes within which certain values and behaviours are espoused even when having made an error. In his work on blame, Sher (2006) highlights that ascribing blame elicits negative feelings, behaviours and actions both from the person blaming and the person being blamed (p96). Sher (2006) suggests that ascribing blame links to a ‘*commitment to morality*’ (p115) in other words, what might be described as ‘taking the moral high ground’ which has the potential to limit the likelihood of transparency and openness so highly valued by healthcare regulatory bodies in their codes of conduct. This stance reduces the possibility of dialogue including explanation and apology. Ascribing blame changes that relationship to one that is adversarial and undermines, if not erodes the unique, trusting and compassionate relationship required for the healthcare system to work effectively.

#### A need for the counsellor to understand the impact of the harm, and complaints system

This need was expressed within the two viewpoints, and was particularly evident in the interview data where this was explicit. This need; for the counsellor to understand the impact of the second harm in relation to complaints and litigation process exacerbating second harm emerged in the discussion of the ranking of other statements that were contextualised in others view of acknowledgement, validation, providing safety and support. Within accounts of harm, the long process in which barriers seemingly are put in the way of progress towards resolution in the eyes of patients that have been harmed, causes additional distress with the perceived purpose of dissuading individuals from the litigation route (Ryan, 2017; Duffy, 2019).

While the impact of litigation generally is recognised as being traumatic for litigants and witnesses (Fulcher 2004), impacting on health and psychological wellbeing, (Hickling, Blanchard & Hickling, 2005) it is the adversarial relationship with a provider of healthcare that is unique. Berlinger (2005) notes within her work that patients litigate in an attempt to receive explanations and apologies. The perception of those that have experienced harm is that these explanations and apologies can be offered and indeed should be given according to the values and behaviours outlined in many professional codes of conduct (Nursing & Midwifery Council 2020). When these explanations and apologies fail to happen then this exacerbates the feeling of wrong and causes additional second harm (Titcombe, 2015; and Ryan 2017). Frequently, those that are harmed go through extensive and intrusive scrutiny during litigation, (Hickling, Blanchard & Hickling, 2005), are disbelieved or are subject to public interest that results in being ‘trolled’or being subject to a campaign of character assignation (Titcombe 2015).

Although no participants felt legal knowledge was important for the counsellor, they wanted to be emotionally supported through the legal process. Recognition that the legal process may be grueling is given to professionals who are being litigated against, and who often have the full weight of the healthcare provider legal teams to support them, but this is rarely the case for individual litigants unless they are part of a larger claim (Ryll, 2015; Peyman, Nayeri, Bandboni, & Moghadam 2017). An imbalance of power often leaves patients that have been harmed feeling vulnerable and so the perceived inequality and unfairness at the system is almost inevitably something that will emerge in the counselling room. Participants believed this imbalance of power should be understood by counsellors for the impact it has.

In addition to the needs identified, the study has also developed a new and original definition of second harm. Second harm can now be defined as ‘*the impact on individuals of the contemptuous response from healthcare professionals towards patients that hold professionals to account for errors, failings and mismanagement of care’.*

**Recommendations for practice**

These findings advance our understanding of the counselling needs of those who have experienced second harm, and also contribute to counselling needs more generally. Given the definition, second harm is not necessarily solely a healthcare phenomenon this study may also be able to contribute to a greater understand of how to support those who have been through second harm both in healthcare and in other settings.

This also study challenges counsellors to be proactive in improving their practice given the increasing incidences of harm seen in healthcare and second harm in other arenas. Counsellors may want to consider how they learn about second harm from the client perspective and how they understand the culture that contributes to second harm in organisations. The needs identified in this study as being generic will give counsellors confidence in working with clients that have experience second harm, knowing that many of the needs that those with second harm identify to be helpful for them are not unique. Counsellors can also be confident that those needs that are unique are within their reach through extending their knowledge of the topic and listening to those that have been harmed.

In addition, scholars and practitioners are invited to critically debate the definition of second harm proposed in this article in order to refine this definition for other settings and to provide different and perhaps alternative perspectives. It is only through robust and critical debate that an evidence base for practice is established and the lives of those coming to counselling for second harm are improved in order for them to regain functionality, agency and quality of life.

These findings must be a starting point for further research and understanding of second harm and the needs of clients in the counselling relationship.

**Limitations of this study**

The research was hampered by the fact that the subject of second harm has previously had no evidence base, no research and is not discussed within the academic and even practice literature. Second harm is an emerging area of interest, and this study paves the way for further research, potential challenge and as a discussion point for professionals and for patients. As well as the lack of definition of a clear second harm, there was also a lack of recognition of second harm impact and the needs of individual coming to counselling with issues of second harm, although this is beginning to change (Pyo, Ock and Han, 2019). The dearth of research is perhaps surprising, given that second harm occurs in more than just healthcare. The contempt with which complaints and issues were dealt with after two specific incidents that stand out in the life of the UK as a nation, the Grenfell Tower fire and the Hillsborough disaster, are evidence of this (Lusher, 2019; Taylor and Bowcott, 2019).

The number of participants was disappointing and the reason for the reduction in initial interest from individuals is discussed. A larger number of participants may have allowed for more viewpoints to be identified. However, this may not necessarily have changed the extraction of the factors as viewpoints and the findings of this study. The participants came from across the UK included a range of harming experiences and those who identified as men and those who identified as women. The online participation allowed for individuals who would not have been able to travel to be included in the sample and they were able to participate at their own convenience. One of the strengths of the approach has been the fact that the data was gathered in a way that limited the amount of conversation about the initial first harm. This design was deliberate, to ensure that participants focused on the second harm and not the initial harm. The approach to the sorting of statements did not allow for any discussion and the interviews were deliberately conducted as brief overviews to enable participants to again focus on the second harm and not on the initial harm. In some sense, this limited the amount of discussion and more could have been explored within the interviews. However, given that the interviews were merely to establish a rationale for the sorting, this was achieved. No data was taken with regards to ethnic diversity, and this may have added to the overall picture of the individuals if more detailed demographic information was taken.

## Conclusion

The findings of this Q methodology study identified two viewpoints: viewpoint 1: Needs that are both past and present focused: being understood and viewpoint 2: Needs that are both present and recovery focused: making me well.

These two viewpoints were distinct in their focus but also confirmed some clear commonalities within both. These two viewpoints contribute to the evidence base for both counselling generally, in what is common regardless of why an individual comes to counselling, and counselling for second harm in relation to the specific needs of individuals who have experienced second harm.

From these two viewpoints eleven needs were identified. Nine of these were what the academic literature confirms as being common to those who come to counselling generally. However, two of these needs were identified as being specific to those that are coming to counselling for second harm: A need for participants to not be blamed for what happened and, the need to have the counsellor understand the impact of the harm and the complaints and litigation system including issues of control, power, and autonomy. These needs may be seen by counsellors in other contexts but the specificity of these needs in second harm is in relation to the context of a trusting relationship with the healthcare provider that expects that further harm will not be caused or exacerbated, that professionals will behave as per their professional codes and the distress that any resulting development of an adversarial relationship causes when patients are blamed or required to litigate in an attempt to gain information or an apology. The viewpoints suggest that that those who come to counselling through an experience of second harm also come with other issues that may be further exacerbated by the experience of second harm.

This study has provided a preliminary understanding of the needs of participants with second harm from a counselling perspective. It has also enabled the development of a new and original definition of second harm. This can be used as the basis for further research.

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