The needs of clients coming to counselling following an experience of second harm: A Q methodology study.

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Abstract

Introduction

Successive reports identified that psychological harm (second harm) can be caused to patients by poor responses of healthcare providers to initial errors or neglect.

Aim

To explore the needs of clients coming to counselling following experience of second harm.

Method

A Q methodology study involving ten participants UK wide was undertaken. Participants sorted 42 statements online constructed from a concourse comprising sources on experiences of second harm. Concourse sources focused on the deficits of interpersonal relationships, therefore statements focused on what participants needed from interpersonal relationships with counsellors moving towards recovery.

Data analysis

Factor Analysis via PQMethod was undertaken on the Q sort data. The interview data was used to elucidate the nuances of the Factors as viewpoints.

Findings

Two Factors were extracted from the Q sort data that demonstrated the viewpoints of participants:

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

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

From these two viewpoints 11 perceived needs were identified. Nine were identified as generic needs within the counselling relationship; however, two were identified as specific to those attending counselling for second harm. Counselling needs specific to second harm were; the 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.

Conclusion

Findings of this study revealed people who seek counselling following experiences of second harm have specific needs beyond those expected from a general counselling relationship. Furthermore this study was able to define second harm for the first time and offers this to the research and practice community in the hope it will advance the field by helping counsellors to understand the concept, nature, and impact of second harm in addition to the expected skill set for any counsellor supporting those who have experienced second harm.

Further research is required to evaluate the impact of educating counsellors in second harm and further testing of the definition of second harm.

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This thesis is dedicated to the memory of Mr. James Tweedy, without whom I would not have made it to my 48th birthday.

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Key terms

Concourse – the total knowledge of what is known on any given topic gathered from diverse sources

P set - Group of participants

Q set - Set of stimulus items that are to be sorted (in this case, statements)

Condition of instruction – A question against which the Q set is sorted

Q sort - The distribution against which the Q-set is sorted (set out in a ‘forced’ or ‘non-forced’ grid)

Factor – viewpoint that is informed by the data from the Q sort

Factor Array – a single Q sort configured to represent the viewpoint of a particular Factor

Statement of Authorship

This thesis is written by Linda Kenward and has ethical clearance from the Health Research Authority and the University of Derby Social Care Research Ethics Committee.
The author is wholly responsible for the content and writing of the thesis and there are no conflicts of interest.

1 Chapter One – An introduction to the study

1.1 Overview of the chapter

This chapter begins by introducing the thesis in section 1.2 and giving a personal rationale for the choice of topic. In section 1.3 a rationale for the focus of the study is given with section 1.4 contextualising this study allowing for a basic understanding of why the study was needed. Section 1.5 introduces the wider topic and context of second harm and the key historical developments that have made the topic contemporary and of interest both to the researcher and to the wider healthcare community, including patients. which sets the scene for further discussions later in the thesis. Section 1.6 provides background information about current responses to second harm in healthcare, with section 1.7 considering what help and support might currently be offered through counselling, and the expectations of an integrative model of counselling used by the researcher. This further sets the scene for the research design. This first chapter is then summarised in section 1.8.

1.2 Introduction to the thesis

This thesis presents the methods and findings of a study that examined the counselling needs of clients who had experienced second harm in the healthcare system. These are specifically the needs that are perceived by the client themselves. The study used a Q methodology approach. As both a registered nurse and practicing counsellor I had witnessed the devastation caused by harm in healthcare and the subsequent damage that a culture of delay, deny and defend has had on individuals and their families. Through contact with patients, nurses and counselling clients I experienced a growing recognition of ‘something more’ that went beyond the initial harm, but was in itself also harmful and made the initial harm more devastating and painful. In discussion with individuals it became evident that this ‘something more’ was difficult to define but often was articulated as a series of interactions and attitudes that resulted in a deficit in the professional relationship with patients that led to further psychological harm. This experience was the initial catalyst for this inquiry and underscored its importance and relevance to practice.

1.3 Focus of the study

The focus of this study was the counselling needs of clients who have experienced second harm in the healthcare system. First harm is defined as the harm that happen as a result of an error, mistake, neglect or mismanagement of treatment (Vincent, 2006). A second harm occurs as a result of the poor response of the health care provider or professional to the first harm and may include; non-disclosure, denial of error, lack of empathy and 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 (Vincent 2006, Sokol-Hessner, Folcarelli and Sands, 2015). This second harm often results in emotional and psychological distress and impacts significantly upon the recovery from the first harm.

1.4 Why was this study needed?

Panagioti *et al.*, (2019) undertook a systematic review and meta-analysis of records involving 337025 patients. The results of this analysis allowed them to estimate that around one in 20 patients experience preventable harm. In 2014, Frontier Economics estimated that the cost of harm was between £1 and £2.5 billion annually to the NHS. Considerable research is therefore directed at reducing harm, identifying factors around never events and in working towards quality healthcare that takes account of human factors, evidence-based quality improvement methodologies and the influence of cultures (Yu *et al.*, 2016). There is wide recognition that no matter how well-trained staff are, how cognisant of factors impacting upon quality or how careful staff practice, errors still occur (Ham, Berwick and Dixon, 2016). Despite this recognition, the psychological long-term response to harm and support to those harmed remains under researched. More recently, evidence is beginning to emerge 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 error (Ocloo 2010, Dyer 2014, Titcombe 2015, Vincent 2006, and Sokol-Hessner, Folcarelli and Sands*,* 2015). However, the current evidence base has not been researched systematically and comprises anecdotal reports from patient organisations that have documented the impact of second harm (Action against Medical Accidents, 2016).

Recognition that patients may require support following harm is an important step in the way forward for the development of improved relationships between those that are harmed and those that may unintentionally harm them. Wu and Steckelberg, (2012) suggest that such recognition may go some way to reducing second harm. A recent report into the *Learning from Deaths Review* giving guidance to NHS Trusts on dealing with families after bereavement following errors or mismanagement of care, recognised that systems and processes should be designed to mitigate any long-term impact for patients and to regain trust in the healthcare services, thus allowing patients to be confident in future engagement with services and to input into services as valued partners

(National Quality Board, 2018). However, studies investigating the patient experience of second harm and the impact of harm are absent within the academic literature. Studies exploring the impact of harm from the patient perspective, the counselling and support needs of clients following harm, exploring second harm specifically or the journey to recovery for those that are harmed are also noticeably absent. While these areas of research might not be the first concern of clinicians in the immediate aftermath of a harmful experience, second harm should be a concern in relation to patient outcomes and future patient engagement with the health services (Vincent, 2006).

Given the psychological impact of second harm there is some evidence that suggests that patients do want counselling (NHS Improvement, 2018) but evidence for interventions are also absent in the academic literature, despite anecdotal evidence that suggests these patients are accessing counselling for issues relating to second harm. In addition, research into the long-term psychological impact of first and second harm for patients is similarly lacking.

1.5 Harm in healthcare

While the NHS is an organisation known for its caring practices and culture by the general public, there have always been cases of avoidable deaths and malpractice by healthcare practitioners (Kalra *et al.*, 2013). More recently the harm caused by those within healthcare settings has become widely reported on, talked about and debated (Youngson, 2014). Harm is unacceptable and several high-profile reports since 2013 have seen public concern in response to poor care and avoidable deaths within healthcare.

In 2013 four reports were published that acknowledged failings within the UK Healthcare systems and the negative impact failings had on individuals. Specifically these reports were; '*The Francis Report'* into the Mid-Staffordshire NHS Foundation Trust failings (Francis, 2013), the '*Solihull Hospital Kennedy Breast Care Review'* on the work and professional behaviour of breast surgeon Ian Paterson (Kennedy, 2013), the '*Keogh Review'*, which reviewed care quality and identified 14 hospitals which had significant failings in care delivery (Keogh, 2013), and the '*Promise to Learn Report'* drafted by patient safety expert Don Berwick (Department of Health, 2013) in response to the Francis Report. These reports recognised that the culture of the organisations involved and, importantly the wider NHS, could contribute to poor outcomes, negative experiences and distress to patients.

In 2015 the Report into the Morecambe Bay Investigation (Kirkup, 2015) also highlighted the issue of an organisational culture of competitive hierarchies, but went further in noting the mismanagement and deliberate deception within the Trust that led to families not being able to have a full understanding of what really happened to their relatives. From this point there was a subtle change in the recognition of the influence on care delivery whereby organisational cultures of damaging hierarchies, competition between departments and teams as well as organisational bullying began to be recognised as a potential feature of poor care, neglect and errors. The negative impact of these cultures began to be seen in subsequent reports. In 2016, the *Learning From Deaths*: Care, Quality and Accountability report was published into failings at Southern Health NHS Foundation Trust (Care Quality Commission, 2016) and this report began to specifically document the harm that a poor response to error and neglect had on patients and relatives.

Since 2016, *the Learning From Deaths* Final report (NHS England, 2017) and the *One Year On report* (NHS Improvement, 2018) recognised that a culture of second harm may exist, and that the response of an organisation should not exacerbate the distress of patients and families. The Inquiry into Hyponatraemia-related Deaths in Northern Ireland in 2018, supported this recognition and led to calls for the Duty of Candour, the legal duty of organisations to be open when something goes wrong, to be extended to that part of the UK (Hyponatraemia Inquiry Team, 2018).

The issue of second harm was further recognised in 2018. Three reports were published acknowledging that second harm happened and recognised the impact of second harm including that perpetrated by regulatory bodies. In May 2018 the *Professional Standards Authority Investigation into the Nursing and Midwifery Council's (NMC) response to the Morecambe Bay Families*, was published (Cayton, 2018). The review concluded that as a consequence of the NMC's failure to take the concerns of families seriously they had not protected the public in a timely manner by investigating emerging issues at Morecambe Bay and therefore further avoidable deaths had occurred. The report went on to catalogue a number of obstacles and attempts to discredit individuals and families that had been initiated by the NMC towards the families concerned in order to undermine the concerns they raised. Following the publication of the report, and in recognition of the unacceptable nature of this behaviour and the impact that this response had on prevention of avoidable death, the Chief Executive of the NMC was called to account for the behaviour of the organisation to the Commons Health Select Committee by which time she had resigned.

Within a week of that report being published the report into deaths at Gosport Hospital, (Gosport Independent Panel, 2018) and Tawel Fan Hospital in Wales (Johnstone, 2018), highlighted the same systematic treatment of patients and relatives, in ignoring and minimising concerns raised about care and possible avoidable deaths. Within a few days of the Gosport and

Tawel Fan reports being published the National Quality Board published '*Guidance for NHS Trusts for Working with Bereaved Families*' (2018). This guidance recognised that second harm happens and that the impact of a poor response to error exacerbates the original harm (National Quality Board, 2018).

1.5.1 Definition of second harm

Despite the recognition of harm, and subsequently second harm in all the reports and reviews cited above, these terms are poorly defined, if at all. Within the psychology literature the most frequently used definition of harm is the description of trauma from the Diagnostic and Statistical Manual 5, (American Psychiatric Association, 2013) in which trauma is defined as 'directly experienced traumatic events' (p 274).

However, second harm is not a well-established term. The closest definition comes from Vincent (2006) who acknowledges that a '*second trauma*' (p175) may occur as a result of the response of the healthcare provider to the patient after an original harm, and that this may result in physically and/or emotional deterioration, long-term disability and psychological distress, including Post Traumatic Stress Disorder (PTSD) and other anxiety disorders. In this thesis the term 'second harm' will be used rather than the use of a definition that includes the word trauma. The decision not to use the word 'trauma' was made because while 'harm' may include trauma 'harm' also encompasses a wider range of experiences that patients describe in the therapy room including harm that is non-traumatic in nature but may still have a lasting impact. Nevertheless, the empirical literature on trauma is still relevant to this Thesis and will be referred to.

1.6 Responses to second harm within healthcare

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).

1.6.1 Deny, Delay, Defend

Triggle, (2013) stated that the organisational practice across the UK known as '*Deny, Delay and Defend'* (p1) is one that sums up the kinds of responses described above. LeCraw *et al.* (2018), also drew attention to the fact that this practice is not restricted to the UK and commonalities can be found, for example in the USA. The news stories and personal accounts of patients whose relatives' death had at best, been poorly investigated and at worst, covered up, displayed consistent themes that resonated with the findings of the patient safety reports published more recently (Verita, 2015), (Kirkup, 2015), (Cayton, 2018).
Those themes of deny, delay and defend, along with the impact of this approach are also reported in non-fatal cases of harm where patients had been left with debilitating physical and psychological outcomes not just from the original error or neglect but from the distress of having to pursue an apology, an explanation or acknowledgement (Walsh, 2018).

1.6.2 Litigation as a response to second harm

For patients and families experiencing these events the only remaining means to gain an official explanation often comes through litigation. Walsh (2018), suggests that most would prefer not to have to use litigation because of the additional distress this can cause. In 2017 ongoing discussions began within the sector about the cost of litigation, the limitation of compensation packages and the reduction of support for patients bringing litigation following error or harm (Wu, 2018). The focus on reducing costs continues. Despite such attention to harm within healthcare, the numerous reports of harm and the strategies to reduce harm in 2019, there remains no coherent government policy that supports harmed patients specifically even though a number of reports in later 2019 began to acknowledge the issues of the impact of culture on second harm, and the indeed the need for fairness in dealing with staff following errors (Glasper, 2019; NHS Resolution, 2019).

1.7 Help and support following second harm

Current responses to harm within healthcare either exist at a local level, with the support of specialist bereavement nurses or counsellors, or not at all (National Quality Board 2018). There is little specifically about second harm, yet those who experience second harm, according to patients themselves, are often left with feelings of loss, betrayal, worthlessness, anger and of being personally violated (Titcombe, 2015; Ryan, 2017). This anecdotal evidence is corroborated by experts in the field of patient safety (Vincent, 2006), and by research findings on the impact of first harm (Trew, Nettleton and Flemons*,* 2013). Such individuals may or may not access their GP with symptoms of a physical and psychological nature often seeing the GP as part of a system that they no longer trust (Woodward *et al.*, 2010). Treatment and support for psychological distress may take a number of forms but generally patients are offered access to psychological therapies through their GP or may decide to access a private counsellor who may provide a range of different interventions including traditional counselling using a variety of modalities (Perfect, 2016).

1.7.1 Treatment offered by GPs for psychological distress

First line treatment offered by GPs for psychological support is typically Cognitive Behavioural Therapy (CBT) (Paintain and Cassidy, 2018). Access to CBT can be difficult with long waiting times despite continuous increases in funding over a number of years (Mind, 2013). At first glance current research seems to suggest that CBT provides effective outcomes for most individuals and remains the recommended first line treatment offered within a primary care setting (Scott, 2018). A systematic review by Hill *et al.,* (2008) suggests that traditional counselling is equally as effective for depression, which may be part of the range of symptoms evident following second harm. Further research on outcomes also support the assertion that other influences may be a factor in positive outcomes rather than the modality of the psychological support on offer (Scott, 2018, Cuijpers *et al.*, 2008; Hill *et al.*, 2008; Pybis *et al.*, 2017). For other presenting conditions, such as Post Traumatic Stress Disorder (PTSD) generally, CBT is still regarded as the first line treatment in primary care, but patients may often access counselling via a variety of modalities that they have arranged themselves, particularly if there is a delay in accessing CBT locally (Mind, 2013). CBT is delivered within primary care as an outcome based medical model with considerable evidence gained during high quality Random Controlled Trials and systematic reviews demonstrating efficacy (Hall *et al.*, 2016; Santoft *et al.*, 2019).

Prior to the *Layard Report* in 2006 psychological services consisted of a mix of treatment options; some CBT and a variety of counselling modalities. These options have been severely reduced and services now give patients limited choice, with the focus on measurable outcomes of CBT that lend themselves predominantly to quantitative research (Perfect, 2016). The focus employed by CBT on identification of current unhelpful thoughts and behavioural management, although useful and effective, may not appeal to all clients. Given the nature of the harm that patients experience and the lack of trust in the healthcare system reported by harmed patients, they may be less likely to engage with healthcare through the usual channels. For example, if it was the GP who caused the first, or second harm, it is reasonable to assume the individual may be reluctant to seek support for the psychological consequences of this harm in the traditional way through primary care services.

1.7.2 Traditional counselling

Pybis *et al.*, (2017) recognise that modalities, the kind of counselling offered, is somewhat less important than other factors, such as the quality of the personal relationship within the counselling room. The range of traditional modalities include practical based therapies; equine-based therapy, art therapy or play therapies, therapies with a broadly based spiritual (often non-religious) basis; existential therapy or gestalt therapy, person-centred, self-actualisation therapies that focus on the goals of the client, and psychodynamic therapies that focus specifically at the defenses, barriers and resistance employed by an individual in their daily lives (Feltham, Hanley and Winter, 2017). The reduction in traditional counselling and the loss of roles within healthcare for counsellors has seen most counsellors either retraining in CBT, or move to private practice or to the few services that happily site more than one modality (Scott, 2018). The loss of roles for traditional counselling has led to the cut in counselling training programmes and a feeling of traditional counselling being somewhat ‘second class’ compared to CBT, often citing the lack of Randomised Control Trials in traditional counselling as evidence of poor outcomes, and the annexation of the qualitative research base of traditional counselling not being recognised. There remains considerable concern within the counselling community and the wider healthcare economy regarding the perceived prevalence of CBT that limits patient choice and restricts the ability of services to reduce long waiting lists (Keely and Lamb, 2019).

Traditional counselling focuses on the relationship within the therapy room, and believes itself to be more client led, considers past issues, current thoughts, behaviours and motivations, being flexible and person centred (Mearns and Cooper, 2018). This kind of modality, being focused on the client leading the therapy, lends itself to those that have experienced harm on an interpersonal level rather than a modality, such as CBT that can sometimes be delivered using a more medical model of care that is more outcome driven (Binnie, 2018).

1.7.3 Integrative counselling

In my counselling work I utilise a model of integrative counselling as my prime modality. An integrative approach to counselling is quite different in nature to a solely person-centred approach or to traditional CBT. Integrative counselling is a model of counselling that draws on several different streams of theory and is developed by the counsellor into one single consistent approach (Worsley, 2011). The underpinning theoretical approach tends to be one of a person-centred nature as originally developed by Carl Rogers, a humanistic psychologist whose ground breaking work on supporting clients to work towards a goal of self-actualisation became internationally recognised (Rogers, 1951). The integrative approach, although valuing the concepts of Rogers person-centred theory such as self-concept, conditions of worth, the actualising tendency and the organismic self, goes beyond the therapeutic relationship of focusing purely on the client and focuses on the working alliance and relationship developed through the work done by the client (Clarkson, 2003). The relationship becomes an important focus of the work with a client that models a relationship in which the client can begin to become fully themselves, can trust and be trusted and can see the possibilities of new relationships (Worsley, 2011). It is in this relationship that ‘repair’ can begin to take place. This may mean repair of fractured relationships with family, with self, with others in the client’s social group, but in the case of harmed patients it may be the restoration of trusting healthcare relationships, among others, in a corrective emotional experience (Bridges, 2006).

1.8 Chapter summary

Within this first chapter a clear progression has been demonstrated within recent investigative reports that provides an underpinning recognition of second harm. This is documented via reports on clinical incidents and poor care which focus on the organisational failings and culture, through to some accepted recognition that these issues may impact on the individual after the error, and on to the damage caused by the 'delay, deny defend' culture to a final recognition of the devastating interpersonal impact of second harm as is evident in the Learning from Deaths Guidance (National Quality Board 2018). From the impersonal organisational report to the interpersonal patient and family centred reports it has been a journey that has been challenging. However, there remains as indicated in the Learning from Deaths Guidance (National Quality Board 2018), a deficit in support for first harm that contributes to further distress as well as a clear narrative from patients of second harm experiences. Additionally, the recognition from the National Quality Board that support is required following a bereavement as a result of harm does go some way to recognise that those that have been harmed require support and subsequent additional care. However, the report stops short of being specific about the detailed nature of this care. The context of this understanding, and the recognition of a poor organisational response as being harmful provides a timely context for this study.

2 Chapter Two – Literature review

2.1 Overview of the chapter

Chapter Two considers the wider literature that is relevant to this study. Within section 2.2 a rationale is presented for undertaking a literature review and the approach to the review is outlined. The literature review focused on a general overview of counselling needs identified by clients in a variety of settings and in section 2.3 an overview of the research papers is given. Section 2.4.1 – 2.4.9 moves on to present the findings from the literature review considering the themes found in the review. A discussion of the wider context of the review is presented in section 2.5 that contextualises the findings before moving on to section 2.6 that brings the focus back to the research topic and the relevance of the review to this topic. This chapter brings together the main findings of the review in a conclusion in section 2.7, with section 2.8 summarising the chapter and setting the scene for the research presented in this study, including the formulated research question and identification of the aims and objectives.

The literature review is the first component of the data that moves this study toward a conclusion. This literature review underpins the stated aims and objectives of the study. Additionally, data also comes from the concourse, which provided a basis for the generation of statements for participants to sort as well as a definition of second harm, and data gathered from participants providing evidence of the client experience of second harm. Data on participants experience helps to answer the research questions underpinned by the definition of second harm from the concourse and the context provided by the literature review.

2.2 Rationale and aims of the literature review.

An early initial literature review was carried out for this study in 2015 and produced no peer reviewed studies that looked specifically at counselling for second harm or indeed studies that looked at second harm itself. As an alternative to looking at studies on counselling for second harm, it was first hoped that a review that focused on specific features that might be identified as contributing to second harm could be completed. However, it soon became apparent that peer reviewed studies whose focus was not on second harm did not explore second harm in sufficient depth, if at all. Therefore, an alternative review was carried out that considered counselling needs more generally and contributed to the understanding of what individuals say they need from the counselling relationship. This understanding provided a theoretical basis for comparison of what individuals coming to counselling need with what individuals say they need from counselling after an experience of second harm.

2.3 Approach to the literature review on counselling needs

The review used Cooper's (1982) five-stage integrative review as modified by Whittemore and Knafl (2005) as a suitable framework for integrative research reviews. An integrative review is a method of systematically amalgamating knowledge from research and applying the results of the relevant research studies to practice (Dela and Gross, 2017). This application to practice is an expected objective of the wider research study. The modified framework devised by Whittemore and Knafl, (2005) was chosen as a structure for the study. This framework provided a means of demonstrating integrity when bringing together a diversity of different study philosophies and methodologies encountered in healthcare research by the many professional groups working within that sphere, as well as being simple in its structure.

Dela and Gross (2017) reviewed six types of integrative review frameworks and documented the purpose and methodology of these frameworks. They cited the modified framework of Whittemore and Knafl, (2005) as being a tool for thematic review and as a framework that explains the method of an integrative review simply. Although Dela and Gross's paper (2017) is predominantly aimed at post-graduate masters level nursing students, their review provided a useful basis for consideration of literature review approaches at any level. Boote and Beile (2005), discuss how to measure the quality of literature reviews in doctoral thesis at some length, but do not recommend any particular framework that might be used as a 'gold standard'. The framework allows for the straightforward presentation and explanation of complex and diverse data and directs the process of review logically and systematically, which helps to promote a coherent and transparent approach to the data. Therefore, the structure of the review focused on establishing the main themes and considering the papers that contributed to those themes. The choice of framework was one with which I was already familiar having used it in the past. The five stages of the framework involved; problem identification, data collection, evaluation of data, analysis and interpretation of data and presentation of results (Whittemore and Knafl 2005).

2.3.1 Stage One - Problem identification

The first stage of the process was problem identification. The problem in this context was understanding what clients, with a variety of issues, felt they needed from counselling.

Initial search terms were established using PICO (Table 1). A number of experimental searches helped to refine the use of key search terms and assisted with the formulation of the question in that:

1. The 'patient' was relatively straightforward to define and included the main terms within the search used to describe 'patients' from different professional perspectives.
2. The intervention was less straightforward but included any type of therapy or counselling. This gave a fairly broad approach and deliberately did not exclude approaches such as counselling psychology or other types of therapy.
3. The comparison focuses on the relationship within the counselling room and the different descriptions of this within counselling literature.
4. The outcomes were more problematic in that the tension between outcomes, as used as a measure by services, expectations, as an anticipatory sense of what might be wanted, requirements, which might be more about what is needed to facilitate the counselling and needs as seen by the client are complex.

The focus of this literature review was tightly focused on clients that came to counselling with a wide variety of issues and what their needs, as identified by them were.

Table 1 PICO for literature review

Patient (P)	Intervention (I)	Comparison (C)	Outcome (O)
Clients Patients Service-user	Counselling Therapy Psychotherapy	Relationship Working alliance/therapeutic relationship Therapeutic relationship	Needs Requirements Outcomes Expectations

2.3.2 Stage Two - Data collection

The second stage of the framework was to undertake the collection of data for the literature review. This was done using databases. Suitable databases were selected; CINAHL PLUS, Medline, and PsycARTICLES. A limit was placed on reviewing studies published since 2000. The rationale for this date limitation was that since 2000, the counselling and psychotherapy landscape has been characterised by discussions about statutory regulation, about the similarities and differences between counselling and psychotherapies and the change in the offer to clients as a result of the development of Improving Access to Psychological Therapies (IAPT) (Aldridge, 2017). This professionalisation of counselling and psychotherapy has brought about a body of academic knowledge, the advent of voluntary professional registration and accreditation, frameworks for training, education and ethics and a more public representation of counsellors and psychotherapists that was a significant change to previous ways of working. Counselling as offered by the NHS is now predominantly IAPT and, traditional counselling such as being discussed here, has been moved to private practice in the UK or has been subsumed into a few services that identify counselling as being one option that clients can choose. Counselling needs may not be different since the advent of IAPT, but the offer to clients is more limited with regards to choice.

Information for the literature search was retrieved between February 2019 and April 2019. Having established the key words, these were used as in Table 2 to conduct a search.

Table 2 Full electronic search strategy

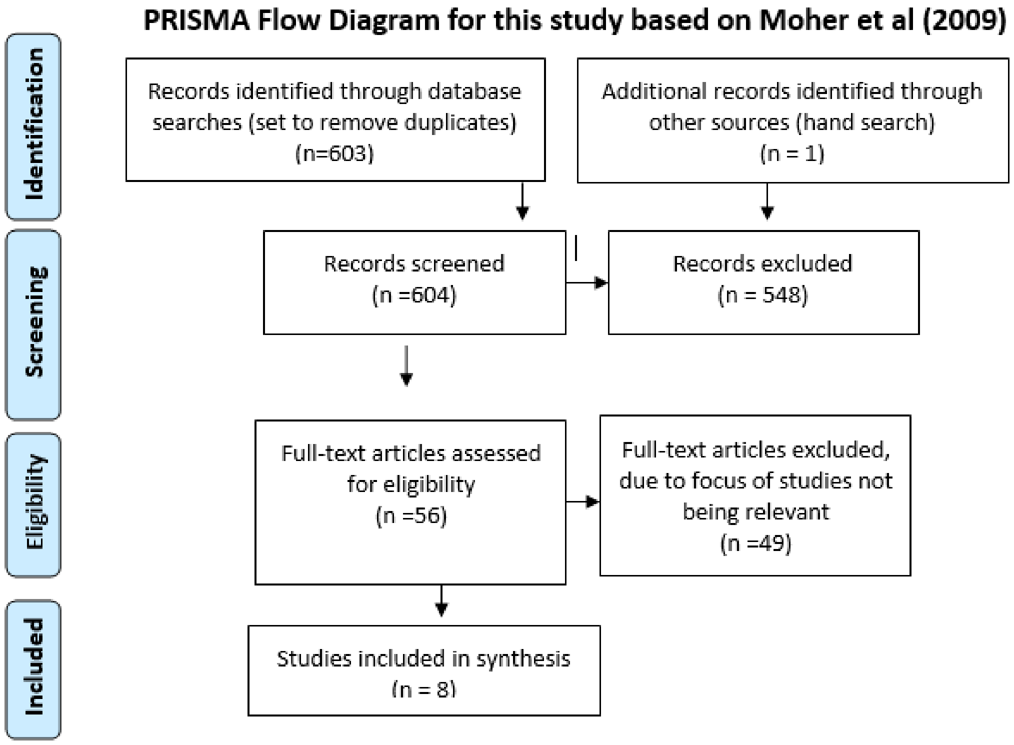
Full electronic search strategy conducted in Cinahl Plus, PsycARTICLES and AMED			
No	Activity		N =
#1	AB Clients OR AB Patients OR AB Service users	Subject term in Abstract	**1,209,085**
#2	AB Counselling or counseling (USA spelling) OR AB Psychotherapy NOT AB CBT or cognitive behavioural therapy	Subject term in Abstract	**47,665**
#3	AB Relationship OR AB Working alliance/therapeutic relationship OR AB Therapeutic relationship	Subject term in Abstract	**267,556**
#4	AB Needs OR AB Requirements OR AB Outcomes OR AB Expectations	Subject term in Abstract	**798,433**
#5	Combine #1 AND #2 AND #3 AND #4	Subject term in Abstract	1,399
#6	Limiters on results	Date of publication was after 2000	
	Limiters on results	Peer Reviewed Academic journals	
	Limiters on results	Language - English only	**603**

The databases were searched utilising only combinations of keywords and limits that were transferable across the three databases. Therefore, with the searches being combined, the removal of duplicates occurred during the first stage of records identified (See modified PRISMA diagram in Figure 1. (Moher *et al.*, 2009).

Search terms were combined with OR, then combined with AND which identified a total of 1399 results. Limiters were then placed on the articles including date, peer reviewed academic journals only, to ensure at least a basic quality of articles prior to the quality appraisal part of this study, and articles in the English Language, as being the language of the researcher.

An additional forward citation review was carried out as well as a hand search of reference lists from the selected articles and potential titles and their abstracts were explored for relevance. From this search a total of one additional article was identified as shown in Figure 1.

Figure 1 PRISMA flow diagram from http://www.prisma-statement.org/



2.3.3 Inclusion and exclusion criteria used in screening

Each of the 604 articles gained through the electronic and hand search were screened using the inclusion and exclusion criteria below as per Table 3.

Table 3 The inclusion and exclusion criteria used during the screening process.

Inclusion Criteria	
Types of studies	Studies using any primary research design or methods of analysis but with the paper being on: • The needs of clients coming to counselling from the client perspective only • Counselling that was accessed for any reason • Any kind of counselling setting • Studies that included original studies, studies involving secondary analysis of data such as literature reviews, and any secondary design.

Types of participants	Adults (>18 yrs). Accessing counselling or considering accessing counselling for any reason
Clarification of key terms	A focus on ‘needs’ as defined by a requirement for wellbeing and self-determination (Deci and Ryan, (2015).
Exclusion Criteria	
Types of studies	Grey literature / not published in a peer reviewed journal. Dissertations /theses. Proceedings. Published abstracts. Studies that identified only counsellors’s opinions, needs or expectations Studies that identified only intended outcomes for therapy only Treatment guidelines documents. Commentary articles, written to convey opinion or stimulate research /discussion, with no research component.
Types of participants	Children (<18 yrs) Those not accessing or not intending to access counselling No discussion on counselling, accessing counselling or intension to access counselling
Focus on key terms	A focus on outcomes as defined by clinicians including measurements of efficiency, engagement, satisfaction with the service or similar or solely focused on expectations defined as ‘anticipatory belief about outcomes, or any facet of the intervention and its delivery’(Midgley *et al.*, 2016 p2).

This led to 548 articles being discarded leaving 56 articles. These 56 articles were then screened by title and abstract, followed by full text review for eligibility to go into the study. Eligibility, in this study is specifically about whether an article was relevant. The criteria for eligibility with respect to relevance can be seen in Table 4.

Table 4 Criteria for eligibility for inclusion in the study

Criteria to establish eligibility (relevance)	How eligibility was met/not met
Relevance to study topic defined by whether:	Client needs were explicitly discussed as a factor in the study
	Salient needs were considered in the context of the kind of counselling (such a bereavement)
	Any client preferences were based on some identified client needs in the study
	Some client needs identified in the study
	Needs were discussed around client expectations of outcome, for example if specific needs were identified as having been met at the end of counselling
	Expectations that were articulated as an identified client need (rather than merely an expectation)
Lack of eligibility (relevance) to study topic defined by whether:	Client needs were not discussed, considered or identified
	Focus was solely on outcomes
	Focus was solely on the therapeutic relationship with no discussion of client need
	Focus was on other topic that did not take account of needs articulated by client.

Following screening for eligibility eight papers were eligible to be included in the review.
This reduction in the quantity of relevant articles was predominantly due to the low number of studies that considered needs from the perspective of the clients. Studies that considered only expectations with regards to the needs of counsellors rather than clients were excluded as not being relevant to the literature review question. A considerable amount of research was noted on topics such as the quality of the therapeutic relationship generally, the convergence of the client and counsellor perception of the therapeutic relationship during and after counselling and the impact of counselling, however none of these specifically focused on the perceived needs or expectations as an articulation of needs of clients. While there may well be significant gains in having a good relationship/rapport with the counsellor as well as a need to feel a positive impact/gain from counselling, if these were not articulated by clients specifically then the study was not included.

The final number of papers was lower than anticipated but may be explained by a number of factors. First, the preference of counselling for research that is either outcome or process focused (McLeod, 2014), secondly, the focus on the counsellor rather than on the client and thirdly, the focus of research on expectations rather than needs. The focus on the expectations of the client in the literature rather than the needs of the client is predominantly due to the high correlation with eventual outcomes and thus the success or failure of treatment, whether clients will engage and continue with counselling (Frankl, Philips and Wennburg, 2014, Dew and Bickman, 2005). Expectations can be defined as an *'anticipatory belief about outcomes, or any facet of the intervention and its delivery'*(Midgley *et al.*, 2016 p2) whereas needs are more about wellbeing and self-determination according to Deci and Ryan, (2015). Expectations and needs then are clearly not the same. Whilst reading the literature, it became evident that one of the client expectations is that their needs will be met by undertaking a course of counselling. The needs identified from the client perspective often include for example, a need for recovery and regaining functionality. During phase one of the thematic analysis, a number of articles were discarded purely because the expectations served as a comparative measurement for the outcomes as defined by the researcher or counsellor. For example, in research by Beitel *et al,.* (2009) the aim of the study was to explore the relationship between psychological mindedness and the client's expectations about counselling. The research looks at whether psychological mindedness, a known clinically relevant personality construct identified by Appelbaum (1973) shaped how clients approached counselling, engaged with it, and thus influenced outcomes. Whilst a highly interesting piece of research, the identified needs of the client were not evident or discussed within the research and it was therefore not included in this study. This was typical of a number of research articles that were excluded.

2.3.4 Stage Three - Quality evaluation

The third stage in the review of the literature was a quality evaluation of the studies prior to the data extraction process. Using an integrative review method as the framework for this review, it is not usual for specifically detailed quality evaluation criteria to be used due to the range of different methodological approaches found in the literature (Whittemore & Knalf 2005). The importance of having a systematic method that is transparent and can be used for evaluation is important for consistency, robust analysis of the data and enabling replication of the study. Therefore six descriptive criteria, modified and based on Bowling (2014), were adopted to consider the quality of the selected articles (Figure 2)

Figure 2 Descriptive criteria for quality evaluation

- Aims and objectives clearly described
- Study design adequately described
- Research methods appropriate
- Explicit theoretical framework
- Limitations presented
- Implications discussed

All articles were included in the quality review and underwent the evaluation process against the six criteria using the indicators ‘yes’, ‘no’ or ‘not indicated’ (Table 5). All articles met the criteria and were judged to be of sufficient quality to go forward for inclusion in the review.

Table 5 Quality evaluation for literature review

	Quality appraisal criteria					
	Aims & objectives clearly described	Study design adequately described	Research methods appropriate	Explicit theoretical framework	Limitations presented	Implications discussed
Keleher *et al*	Yes	Yes	Yes	Yes	Yes	Yes
Klassen *et al*	Yes	Yes	Yes	Yes	Yes	Yes
Walls *et al*	Yes	Yes	Yes	Yes	Yes	Yes
Dew and Bickman	Yes	Yes	Yes	Yes	Yes	Yes
Bachelor	Yes	Yes	Yes	Yes	Yes	Yes
Patterson *et al*	Yes	Yes	Yes	Yes	Yes	Yes
Manthei	Yes	Yes	Yes	Yes	Yes	Yes
Frankl *et al*	Yes	Yes	Yes	Yes	Yes	Yes

2.3.5 Data extraction

Data was extracted by undertaking an initial reading of the articles. Each article was recorded by author(s), years, country, participants/sample size type of client, type of counselling, research design, approach to analysis, data gathering method, data gathering tool, findings and relevance to the topic of this research, client needs. A data extraction table was compiled and can be found in the Appendix 1. This table allows for a simple comparison of the kinds of data extracted, the key features of the studies undertaken and summary of the findings of each study. A column is also included that considers the relevance of the study topic to this literature review.

2.3.6 Stage Four - Analysis and interpretation process

The fourth stage was data analysis and interpretation (Cooper 1982). This stage was shaped by Braun and Clarke's (2012) six phase approach to thematic analysis, illustrated in Table 6.

The data analysis was conducted by the researcher and due to the mix of both qualitative and quantitative papers the results were presented as a thematic analysis. A thematic analysis is an inductive approach that allows for analysis of the data based on the content and broad themes that emerge from the data itself (Braun and Clarke 2012). This is in contrast to, for example a more deductive approach where the researcher applies topics, concepts or ideas as specific codes to the data (Joffe, 2011). A thematic inductive approach was taken in this case to preference the client experience, in line with the critical theory underpinnings of this study.

The purpose of the stage was to systematically generate initial codes in order to identify themes for discussion and consideration of the review (Ryan and Bernard, 2003). This stage commenced with all papers being read through again with the express purpose of gaining a comprehensive overview of the content and the general direction of the study, method and findings.

Table 6 Braun and Clarke's Six Phase approach to thematic analysis

Phase	Steps in each phase
1.Familiarise yourself with the data	Actively read text as an overview and make notes A more thorough reading of the text x 2
2.Generate initial codes	Label the features of content
3.Search for themes	Identify similarities, overlaps and clusters
4.Review potential themes	Define and label for selected themes
5.Define and name themes	Ensure each theme has clear scope, focus and purpose
6. Report findings	Order themes to provide a coherent story, provide evidence and analysis.

The coding process was undertaken first utilising a descriptive coding approach as suggested by Saldaña, (2013). Codes were then generated by reading through and noting the specific features highlighted in the text as related to needs of clients. Each code was given a number (See Table 7). Then, following the process in Table 6, a second cycle was initiated utilising a thematic coding approach by taking the initial codes and theming them as suggested again by Saldaña, (2013). Table 7 demonstrates the coding to the themes process.

A range of different practical approaches to coding were considered as suggested by Liamputtong, (2009), including coding all text or coding some text that specifically related to the issue under investigation. As so many of the texts discussed needs of clients, but only as a factor in, for example the therapeutic alliance (Bachelor, 2013), the early termination of psychotherapy (Keleher *et al.*, 2019) or mechanisms of counselling (Klasen *et al.*, 2017), the coding specifically focused on any discussion, findings or suggestions of clients needs. Even then, the 'need' in order to meet the criteria of this study had to be a need that was identified by the client. This clearly limited the data as identified by Liamputtong (2009), but also had the advantage of ensuring a real focus to the data.

Table 7 Coding to themes process

Initial code no.	Initial Code name (the need identified in the study)	Theme under which this code was later grouped including final code number ascribed to theme (in brackets)
1	Physical needs	Safety (Final theme 6)
2	Safety	Safety (6)
3	Belonging	Relatedness (Final theme 2)
4	Self esteem	Self-esteem (Final theme 8)
5	Self actualisation	Self-actualisation (Final theme 5)
6	Outcomes for recovery	Outcomes for recovery (Final theme 3)
7	Reparative relational processes	Relatedness (2)
8	Proactive in seeking help	Autonomy (Final theme 1)
9	Self-determination theory	Personal competence? (Final theme 4)
10	Autonomy	Autonomy (1)
11	Competence	Personal competence (4)
12	Relatedness	Relatedness (2)
13	To talk to someone who understood	Relatedness (2)
14	Creativity	Self-actualisation (5)
15	Social support	Outcomes for recovery (3)
16	Meaning making	Self-actualisation (5)
17	To be directed	Directedness/management (Final theme 7)

An initial seventeen codes were generated that focused on the needs of clients expressed in the study, either explicitly or articulated as an early expectation of therapy. Once these codes were attached to each particular feature, as expressed in the research articles, the codes were grouped and mapped onto a matrix to identify similarities, overlaps and clusters (see Table 7). The seventeen codes were reduced to overarching themes that encompassed all codes, the features of which were established and rechecked by reviewing the articles again for any further information that would inform the code features. From the analysis of the papers in this review eight themes were identified.

2.4 Stage Five – Findings: Overview of reviewed research papers

The fifth stage of the process was the synthesis and presenting of findings of this literature review. Findings are presented within this section by first summarising the data extracted and the patterns noted from the data. The themes are then presented in Table 8 and then discussed in detail.

2.4.1 Research settings and issues specific to these settings

Research papers identified were from studies carried out in a range of settings which included two university counselling services (Patterson, Uhlin and Anderson, 2008; Keleher *et al.*, 2019), one multi-site setting which included a university counselling service, a private clinic and a community setting (Bachelor, 2013), one bereavement service (Klasen *et al.*, 2017), one substance misuse and one alcohol dependency service (Walls, McLeod and McLeod, 2016), and one walk-in counselling service (Manthei, 2006). One article was a systematic review on ‘expectancies’ reviewing 36 articles, only some of which were relevant to the topic of this study due to the expectancies being on the part of the clients and being in connection with the meeting of needs, therefore this was included in the review (Dew and Bickman, 2005). The range of settings that were represented were limited in that most were within larger and complex organisations with only one private clinic represented as part of a multi-site study (Bachelor, 2013). The most frequent setting was within a university counselling team with three studies utilising these services (Patterson, Uhlin and Anderson, 2008; Bachelor, 2013; Keleher *et al.*, 2019). These studies highlight the high drop-out rate of university counselling service due to a variety of variables that are non-specific. Therefore, the issue of attrition within those services may not make these settings the most useful for a study that might want to make inferences that connect the meeting of needs or positive outcomes with satisfaction.

2.4.2 Countries in which these settings were located

The articles were from studies undertaken in six different countries including the UK (Walls, McLeod and McLeod, 2016), New Zealand (Manthei, 2006), Australia (Klasen *et al.*, 2017), USA

(Patterson, Uhlin and Anderson, 2008 and Dew and Bickman, 2005), Sweden (Frankl, Philips and Wennburg, 2014) and Canada (Keleher *et al.*, 2019 and Bachelor, 2013). While this was limited, this may be due to the language in which each study was written as well as a much greater engagement with counselling in the European counties and the USA than in for example the Asian or African continents.

2.4.3 Number and types of participants involved in the studies.

Participants ranged from five individuals in an alcohol dependency unit (Walls, McLeod and McLeod, 2016) to 125 in one study across three sites, including a university counselling service, a private clinic and a community setting (Bachelor, 2013). Information about the participants was generally sparse and not included in the discussions within the studies. In some instances, the setting and focus of the counselling clearly influenced the kinds of participants. For example, the university-based counselling services were for students and therefore had generally a younger group of participants than other settings. Similarly, the bereavement service had participants that were young adults to aged 81, perhaps predictably so given that many of these were widows but this is not the case in all settings. The researchers indicated the gender of their participants in typical binary fashion of male/female. No discussion was offered as to whether any participant identified as non-binary and the gender balance in the papers that indicated gender for their participants was heavily female. This reflected the general trend of counselling although in 2014, the BACP noted the steady increase in men accessing counselling in the UK (BACP, 2014). There remains however, a sense that more individuals who identify as women access counselling services than those who identify as men.

2.4.4 Types of counselling

All research articles that stipulated the kinds of counselling on offer in the setting offered a range of different counselling, including person-centred, CBT, existential, gestalt therapy group or family therapy, analytical therapy and psychodynamic therapy. From the research papers, it was difficult to establish whether clients were able to choose what kind of counselling they had or whether the kind offered hinged on the availability of a therapist that worked in a particular kind of approach. It was clear that across the settings, a range of different counselling was still being supported by the services and offered to clients. This cuts across the trend within the UK to focus on CBT within the NHS, predominantly due to the emphasis on outcomes that attract funding. It is likely that the variety of different modalities offered across the papers is predominantly due to the studies being completed in non-NHS settings, even those studies completed in the UK.

2.4.5 Research design

The design of the research within the papers varied considerably with some studies adopting a mixed methods approach (Dew and Bickman, 2005; Keleher *et al.*, 2019), some a qualitative approach (Manthei, 2006; Walls, McLeod and McLeod, 2016; Klasen *et al.*, 2017) and some a quantitative approach (Patterson, Uhlin and Anderson, 2008; Bachelor, 2013; Frankl, Philips and Wennburg, 2014). Most papers did not specifically give space to discuss the methodological approach taken to their research but the three that did, briefly mentioned the methodological approach as being realist (Klasen *et al.*, 2017) or naturalistic (Patterson, Uhlin and Anderson, 2008; Frankl, Philips and Wennburg, 2014). While it is recognised that research papers are limited in space to discuss this aspect of studies, it is also disappointing that so few studies did not at least mention their specific methodological approach.

2.4.6 Data gathering methods

Data was collected in these studies using either questionnaires, previously completed or completed before or after the counselling sessions, (Bachelor, 2013; Patterson, Uhlin and Anderson, 2008; Frankl, Philips and Wennburg, 2014) or data collection using semi-structured interviews with participants (Walls, McLeod and McLeod, 2016; Klassen *et al*., 2017). Two studies used a combination of these approaches (Manthei, 2006; Keleher *et al.*, 2019). One study was a systematic literature review that looked at expectancies about therapies (Dew and Bickman, 2005). This was included as within this there was some brief discussion of client needs when coming to counselling. Studies that used tools to gather data, specifically questionnaires completed by participants used validated questionnaires or versions of questionnaires that are often utilised extensively in psychotherapy. These tools are mostly utilised in relation to measuring outcomes as seen by the counsellor or measuring the fulfilment of needs as a means of satisfaction with the services. The instruments used for each study can be seen in the data extraction table in Appendix 1.

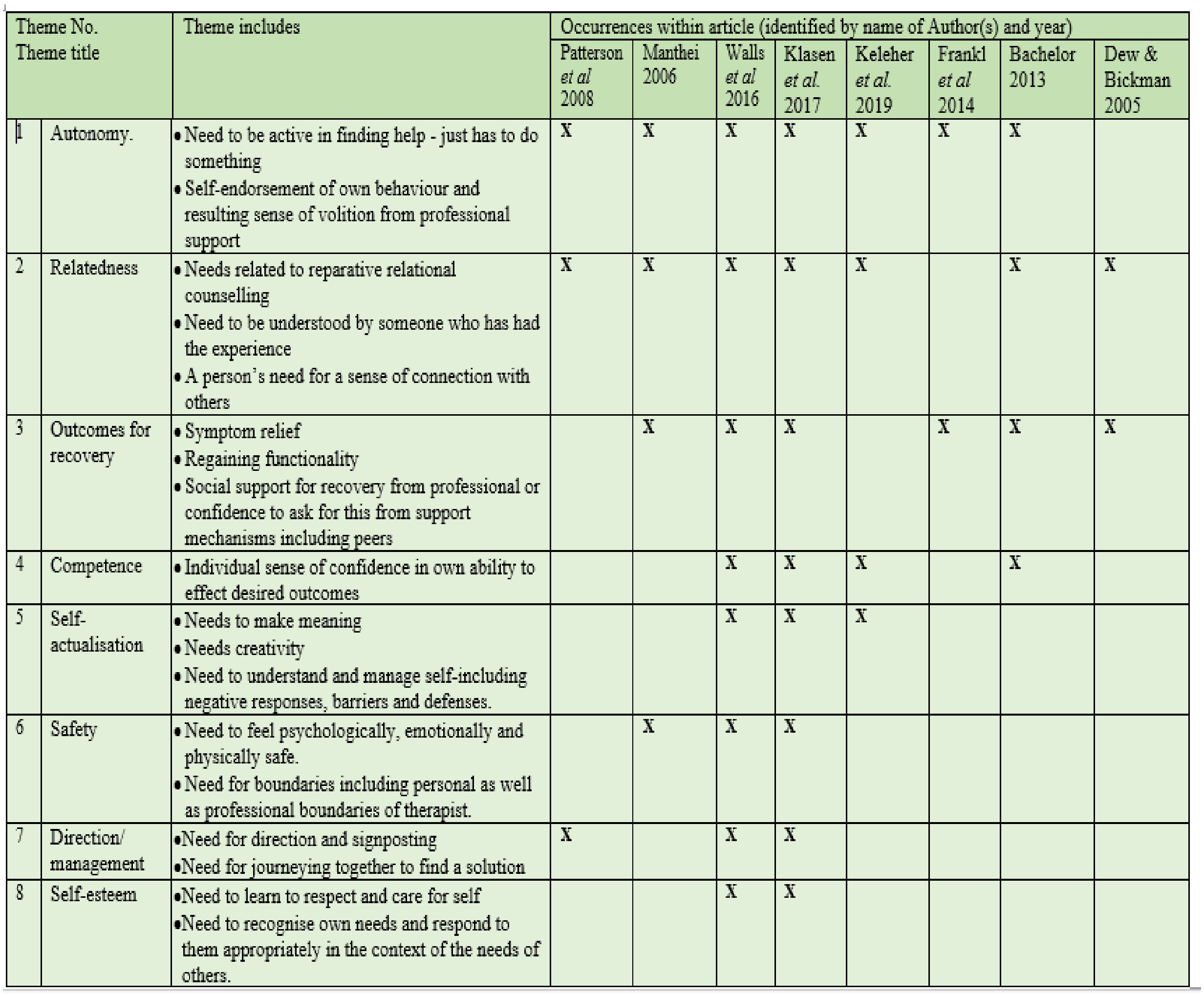
2.5 Review of findings

2.5.1 Summary of themes

A theme, according to Ryan and Bernard, (2003) is a step in the process of analysing cultures using defined units that describe dynamic actions. These are limited and are generated from data by the researcher who looks for patterns that include; repetitions, categories, metaphors and analogies, transitions, similarities and differences, linguistic connectors, missing data and theory related material (p93).

The findings of this review are summarised within eight themes. Specifically, these were; Autonomy, Relatedness, Outcomes, Competence, Self-actualisation, Safety, Directed/managed and Self-esteem. A summary of themes is presented in Table 8. Where a theme is present in a paper this is indicated by x.

Table 8 Summary of found themes from the review of literature.



Theme No.	Theme title	Theme includes	Occurrences within article (identified by name of Author(s) and year)							
			Patterson *et al* 2008	Manthei 2006	Walls *et al* 2016	Klasen *et al.* 2017	Keleher *et al.* 2019	Frankl *et al* 2014	Bachelor 2013	Dew & Bickman 2005
1	Autonomy.	• Need to be active in finding help - just has to do something • Self-endorsement of own behaviour and resulting sense of volition from professional support	X	X	X	X	X	X	X	
2	Relatedness	• Needs related to reparative relational counselling • Need to be understood by someone who has had the experience • A person's need for a sense of connection with others	X	X	X	X	X		X	X
3	Outcomes for recovery	• Symptom relief • Regaining functionality • Social support for recovery from professional or confidence to ask for this from support mechanisms including peers		X	X	X		X	X	X
4	Competence	• Individual sense of confidence in own ability to effect desired outcomes			X	X	X		X	
5	Self-actualisation	• Needs to make meaning • Needs creativity • Need to understand and manage self-including negative responses, barriers and defenses.			X	X	X			
6	Safety	• Need to feel psychologically, emotionally and physically safe. • Need for boundaries including personal as well as professional boundaries of therapist.		X	X	X				
7	Direction/ management	•Need for direction and signposting •Need for journeying together to find a solution	X		X	X				
8	Self-esteem	•Need to learn to respect and care for self •Need to recognise own needs and respond to them appropriately in the context of the needs of others.			X	X				

Two themes, Autonomy and Relatedness, were identified in seven papers while, Self-esteem in only two. The occurrences of themes and the means by which a researcher searches for them is discussed by Ryan and Bernard, (2003) and although the number of times a theme occurs may not necessarily denote the strength of the theme, they are clear that '*The more the same concept occurs in a text, the more likely it is a theme*' (p89)

2.5.2 Autonomy

Autonomy, along with relatedness was the most frequently noted need in the literature and is defined as the sense of agency and self-endorsement of one's own behaviour (Keleher *et al.*, 2019).

Seven papers within the literature review documented autonomy in relation to a variety of different activities that demonstrated agency in coming to counselling or during counselling. For example, a need to be active in finding help was demonstrated in the study by Klasen *et al.*, (2017). Recognising that there is a need to actively engage in therapy and be willing to do so was demonstrated in the studies by Bachelor (2013) and Patterson, Uhlin and Anderson, (2008). Having to 'do something' (Manthei 2006), to have a sense of self-endorsement and volition as a result of professional support (Walls, McLeod and McLeod, 2016), and to actively choose not to avoid difficult topics in therapy (Frankl, Philips and Wennburg, 2014) were also demonstrated in the studies. Very clearly, autonomy was about undertaking some activity and having the motivation to act in a way that would see the movement towards a solution even if this was not labelled as autonomy specifically. Clients and therapists seemed to recognise autonomy and its importance in the process and this recognition of the usefulness of autonomy links well with the person centred, client led expectations of so many modalities of counselling.

2.5.3 Relatedness

The need for relatedness was the second most frequent need articulated in the literature and related to the need for human connection (Keleher *et al.*, 2017). This theme was present in seven of the studies reviewed.

Relatedness is defined by Keleher *et al.*, (2019) as being the need for connection to others and also includes a person's need to be understood by someone who has had a similar experience. Relatedness, for the purposes of this review also includes needs related to reparative relational counselling that mends the relationship that one has to oneself by modelling the ability to be congruent, to be non-judgmental and to be oneself.

In the literature this theme emerged predominantly not as recognition of 'relatedness' but as actions that facilitated connection. For example, Dew and Bickman, (2005) identified the collaborative relationship towards agreed goals as being an aspect of relatedness while Manthei (2006) identified the development of rapport, sometimes an almost '*instant*' development (p 532) as being relevant to first impressions of the counsellor and thus the client's willingness to engage with the therapist. This was supported by the study by Keleher *et al*., (2017) that linked the positive client perception of the relationship between client and therapist, known as the working alliance, with completion of therapy and thus positive outcomes. It seems that the need to talk and to be understood by someone whose purpose it is to do just that, as well as for the client and therapist to engage in repairing the ability to relate or to be related to is seen as positive and valued by both client and therapist.

In the study by Klasen *et al.,* (2017) much is made of the need for genuineness of relationship that facilitates connection. This includes the counsellor demonstrating respect, empathy and dynamism but also given that the setting is in a bereavement service, a recognition that for some clients the knowledge that the counsellor had themselves been bereaved develops connection, an almost shared bond that reassures the client that counsellors really do understand. While this might reassure the client, it brings up the issue of if therapists disclose their own experience how professional boundaries might be maintained and how the uniqueness of the client experience, rather than the experience of the client seen through the experience of the counsellor is the focus of the work. However, in the study by Walls, McLeod and McLeod (2016), clients rated the preference for therapist to show their personality as being important to them as well as counsellors being open about their thought processes with clients. It seems that openness is part of relatedness for these clients and that there is an expectation of transparency that links to relatedness. That sense of genuineness as a requirement for relatedness and the therapist-client relationship is reiterated in the study by Patterson, Uhlin and Anderson (2008), in the discussion of the core conditions of person- centred therapy and the need for a strong therapeutic bond to facilitate outcomes. The focus of Bachelor's work (2011) is wholly on the therapeutic alliance and the needs of the client within that alliance. His work unsurprisingly has much to say about the requirements to facilitate this alliance and the expectation of connection. The focus of what clients report in relation to the working alliance is on the need for collaboration, agreement, understanding, confidence and trust that is mutual and that is demonstrated.

2.5.4 Outcomes

Needs that were specific to client identified outcomes came out of the literature as the third most frequently mentioned need occurring in six of the studies.

Outcomes were needs that were specifically mentioned by clients within the studies that were related to the anticipated or hoped for end result as a result of coming to counselling.

These needs included the need for symptom relief, as in the case of grief, alcohol or substance dependency (Klassen *et al*., 2017; Frankl, Philips and Wennburg, 2014 and Walls, McLeod and McLeod, 2016), the need to regain functionality when symptoms had become unmanageable and when these symptoms impacted on the ability of the individual to function normally (Klassen *et al*., 2017; Frankl, Philips and Wennburg, 2014; Dew and Bickman, 2005; Bachelor, 2013; Manthei, 2006 and Walls, McLeod and McLeod, 2016) and the need for social support for recovery from professionals or confidence to ask for this from support mechanisms, such as peers. The sense that social support can be offered by a professional that was different from that of a friend of family was recognised in the discussion by Walls, McLeod and McLeod (2016), as was a sense that talking to a professional might also serve to maintain good family and other relationships by protecting family and friends from distress and strong emotions. Similarly Manthei (2006) discusses the sense that clients felt family and friends could be impostioned or uncomfortable with what was discussed. Clients within the literature reported that they had tried a range of strategies to improve their symptoms or to manage their mental health before they accessed counselling (Manthei, 2006; Klasen *et al*., 2017) yet still felt that these strategies did not meet the needs identified.

2.5.5 Competence

Personal competence, a closely related concept to autonomy, relates to an individual's sense of ability to effect one's own desired outcomes (Keleher *et al*., 2019). In the papers reviewed the need for personal competence was evident in four studies (Bachelor, 2013; Walls, McLeod and McLeod, 2016; Klasen *et al*., 2017; Keleher *et al*., 2019), which looked at needs specifically in connection with outcomes that were measured as part of the study or needs as outcomes expected by clients. For example, in the study by Klasen *et al.,* (2017) and Walls, McLeod and McLeod, (2016), clients had a need for improvement of functionality as an outcome. However, they needed to be able to have help to effect their own recovery and thus had a need for developing and recognising their own personal competence in managing grief (Klasen *et al*., 2017) or their alcohol dependency (Walls, McLeod and McLeod, 2016).

Autonomy and personal competence are both aspects of self-determination and the ability to feel as though one has some agency. As two of the three key aspects of Self -Determination Theory these sit together. Within the literature reviewed which ostensibly looks at needs, engagement and therapeutic relationships as predictors for outcomes and retention, there is a clear recognition of how both clients and counselling organisations and counsellors recognise the value of autonomy and personal competence as a means to move towards recovery and regain functionality.

2.5.6 Self-actualisation

The need for a self-actualisation process was highlighted as being the fourth joint most frequently recognised need (Walls, McLeod and McLeod, 2016; Klasen *et al.*, 2017; Keleher *et al.*, 2019). Self actualisation is the pinnacle of Maslow's Hierarchy of Needs and is defined as the 'desire for self-fulfillment by Maslow (1943 p7). and includes the need for self-development and understanding as well as the need to make personal meaning and be creative in developing personalised solutions to problems, a need to understand and manage one's self, including negative responses, barriers and defenses as well as a need for creativity and mastery. This further supports the drive towards recovery for clients and specifically gives the responsibility to them for their recovery, albeit with assistance from a therapist. Alongside the two concepts from SDT, autonomy and personal competence, the need and desire for self-actualisation helps to drive personal goals and insight to help individuals to become more resilient.

2.5.7 Safety

In the themes identified within the studies, safety was also highlighted as being an important need specifically psychologically safety in three studies (Manthei, 2006; Walls, McLeod and McLeod, 2016; Klasen *et al.*, 2017). Safety is defined by Maslow as predominantly physical safety (1943 p4). Within the literature safety included concepts of trust and friendliness (Manthei, 2006), personal warmth (Klasen *et al.*, 2017) and confidentiality (Walls, McLeod and McLeod, 2016) and psychological safety encompasses all of these but also the ability to be oneself without fear, criticism or judgment as suggested by Newman, Donohue and Eva (2017).

2.5.8 Being Directed/managed

The need for direction and management was also highlighted in three studies (Patterson, Uhlin and Anderson, 2008; Walls, McLeod and McLeod, 2016 and Klassen *et al.*, 2017).

This was defined by clients as counsellors offering advice, being directive, knowing how a client was feeling (Patterson, Uhlin and Anderson, 2008), taking the lead and challenging appropriately (Walls, McLeod and McLeod, 2016) and the sessions being planned and directed in a way that facilitated the feeling that the therapist know what they were doing (Klassen *et al.*, 2017). In the discussion of this need, Walls, McLeod and McLeod (2016) suggest that this need can only be met following the development of the relationship and thus directiveness might be observed during the middle and later part of the counselling relationship. Given that person-centered counselling is mostly non directive this is perhaps surprising that clients note that this is happening or has happened. Considering that clients see that challenge and knowing how someone is feeling is viewed as being directive this definition may account for the fact that this need is highlighted. It may also be the case that counsellors, particularly those utilising a person centred or integrative model may not demonstrate this.

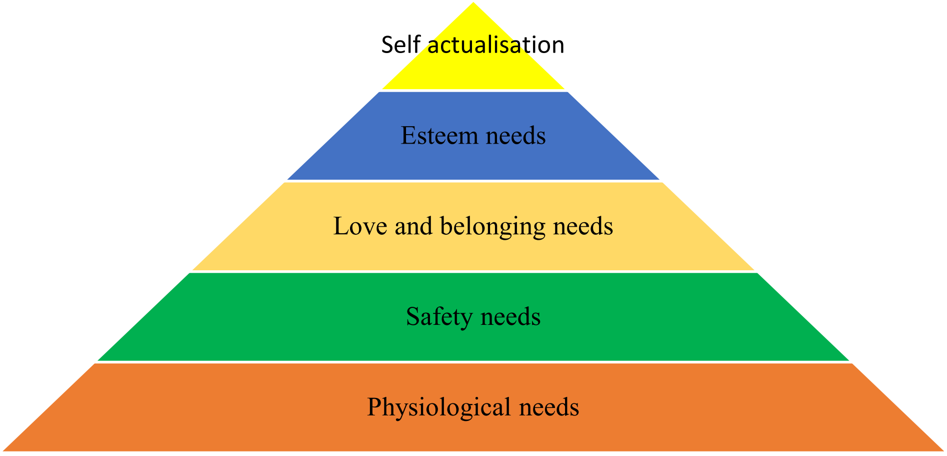
2.5.9 Self-esteem

Finally, the need for self-esteem came less frequently than all other needs identified in the literature in two studies. The need for self-esteem is defined by Maslow as the '*desire for strength, achievement, adequacy and confidence in the face of the world and for independence and freedom'* (1943 p 7). Self-esteem as a need was identified in the work of Walls, McLeod and McLeod (2016), and Klasen *et al.*, (2017) and can be defined from what clients reported as being recognised as a 'good' person by their counsellor, having abilities and strengths acknowledged (Walls, McLeod and McLeod, 2016, p115), and by themselves recognising that being honest was acceptable and indeed preferable to enable needs to be met in counselling (Klasen *et al.*, 2017 p366 and p368).

2.6 Discussion of findings from the literature review

This review identified eight themes relevant to the counselling needs of clients generally. These themes should be considered within the wider context of the empirical and theoretical evidence base. Discussions within the academic literature about human needs are often contextualised in relation to motivations or goals. Motivational theory looks at the wants, needs and desires that influence an individual to work towards an outcome, whether it is related to motivations for occupational work, toward personal goals or choices. Ryan defines motivation as being concerned with '*energy, direction, persistence and equifinality--all aspects of activation and intention*' (Deci and Ryan, 2015 p 68). Theories on what motivates individuals offered by academics and researchers may focus on the internal and/or external influences on motivation, the rewards and punishment that influence motivations, what has been learnt and what motivates an individual purely out of social or cultural pressures (Deci and Ryan, 1985). These theories are used to shape organisations, businesses and marketing in an attempt to motivate the targeted individuals for the purposes of the organisation or business, or for the benefit of the wider community or individual. In this case, two theories, the theory of Hierarchy of Needs and Self Determination Theory (SDT) can help to understand the needs of clients as described thus far in the empirical evidence. First, Maslow's Hierarchy of Needs with the needs at the bottom of the hierarchy requiring to be met before the individual can progress up the hierarchy to the point of self-actualisation (Figure 3). This popular theory is relevant to this study as it remains widely used in healthcare and is the basis for the work of Carl Rogers in relation to the development of person-centred counselling.

Figure 3 Maslow's Hierarchy of needs



The need for self-actualisation, safety and self-esteem were part of the Hierarchy of Needs developed in 1943, a key concept in health, psychology and wellbeing (Maslow, 1943). Maslow's theory is that humans all have similar needs. These needs as set out in a pyramid, go from physiological needs to maintain the basic human organism at the bottom of the pyramid, through to safety, love and belonging, esteem and finally at the pinnacle of the pyramid, self-actualisation. The needs are primarily utilised to motivate, as are needs in SDT. The theory suggests that individuals cannot move upwards to the top of the pyramid in satisfying needs until the needs below them are satisfied. This model is not without its critics who cite Maslow's failure to take account of anything that is part of the external environment and may influence the individual, preferring to focus solely on the innate drive toward self-actualisation as the pinnacle of human motivation and achievement (Trigg, 2004). Often cited in the critique is the point that Maslow's view of individuals within society is ostensibly western in nature and focuses on individualism (Fallatah and Syed, 2018). In the original work of Maslow, this is acknowledged by him as being the case, and a strong rationale presented for the work being able to be extrapolated across culture. This is rarely acknowledged by his critics (Maslow, 1943). In a multicultural society an uncritical approach or overreliance on Maslow's theory as an underpinning for Carl Rogers' approach to therapy that does not take account of the collectivist underpinning of non-western society might be unhelpful, perhaps even may contribute to discrimination and lack of diversity in a therapeutic approach. How an individual sees themselves through the lens of the society and context, including gender, in which they live influences their motivation and their needs. The collectivist versus individualist approach that might be said to characterise the differences in how individuals see themselves in a western or an eastern society is discussed in a paper by Kashima, Kim and Gelfand, (1995) who make the point that concepts of individual agency and autonomy, can be viewed differently across gender and culture. Nonetheless, Maslow's concept of self-actualisation, the movement of an individual towards their total potential, remains a key concept in person-centred counselling and of other modalities such as an integrative approach as well as person-centred approach to health and wellbeing generally and this is unlikely to change quickly. The drive to remain 'person-centred' rather than to be process driven is a fundamental aspect of many counselling approaches, although the recognition of diversity in the cultural aspects of clients' lives may well begin to challenge a blanket approach to the individualist underpinning of person-centred ideals. Given the person-centred background of counselling and psychotherapy that was developed by Rogers, it may be surprising then that the recognition that client needs are a driver for the formation of outcomes is not made more explicit in the narrative about counselling and outcomes (Cooper & McLeod, 2011). This is evident in the literature reviewed in that only one study explicitly focused on needs, the study that specifically used SDT as a clear underpinning framework for the research (Keleher *et al.*, 2019).

The second theory relevant to this study in particular is SDT developed by Deci and Ryan, (1985). SDT suggests that, similar to Maslow, there is a drive for a better self, but within this theory there is a recognition of the integration of the personality that is similar to the concepts described by Rogers as 'congruence', a sense of being truly oneself (Rogers, 1951). Research on SDT is driven using what Deci and Ryan (1985) describe as an 'organismic metatheory', in other words a theory of why an organism (the human individual) does what it does. Within this theory three specific needs have been empirically researched; the needs for competence, relatedness, and autonomy and are suggested as being essential for the individual to facilitate self-development, personality integration, social learning and well-being (Deci and Ryan 1985). The theories of motivation are therefore closely linked with the understanding of needs and although the impact of client needs not being met is highlighted in the reviewed literature, there remains little evidence to suggest that there is a will to actually establish with clients what their needs actually are. The needs of clients are, as evidenced in the literature what brings them to counselling, what motivates them to stay long enough to do the ’work’ of counselling and are likely to be what allows them to judge whether the counselling has been successful. With clients typically leaving counselling early when needs are not met, it is incumbent upon the counsellor or the service to establish early goals, and to articulate the needs of the client to enable these to be prioritised in treatment. This would be expected to be a very person-centred approach. The three needs highlighted in SDT are particularly evident in the studies and the themes that are established; the need for autonomy, relatedness, and the need for outcomes for recovery. These needs bring clients to therapy, and may be articulated as needing to do something, needing to talk to someone who understands and a need to get on with their life or to regain function that has been lost.

Reviewing the literature in relation to the themes identified it was evident that the expressed needs could fit into the two motivational theories discussed. The findings are borne out by theory that is already well known on both the Hierarchy of Needs (Maslow, 1943) and the drive for self-determination (Deci and Ryan, 1985). While these needs are seemingly quite general, it is important to come back to the topic of the counselling needs of those that have experienced second harm, and what relevance this literature review might contribute to understanding the needs of these clients.

A wider consideration of the literature brings up two main issues that were evident from the review overall. First the visibility of the needs of clients within the counselling literature, and secondly how the motivational theories discussed earlier of Self-Directed Theory and Maslow’s work on the Hierarchy of Needs are linked to the needs that have emerged as themes in the review.

2.6.1 The visibility of client needs in the literature

The needs of the client have been less visible in past research. Research in psychotherapy and later counselling focused predominantly on a medical approach that was utilised as psychotherapy developed from psychology. Research in counselling and psychotherapy can often be swayed by the need to demonstrate outcomes, to enable bids for funding to be underpinned and to demonstrate efficacy against other treatments or indeed other modalities. This may mean that the expressed needs of the client become less of a focus for research. Given that clients come with the purpose of having needs met and not to contribute actively to the success of the service by demonstrating that these needs have been met, this is possibly of concern when reviewing the literature on client needs.

Most papers discuss at varying lengths the issue of the attrition rate as an indicator of satisfaction and needs being met (Manthei, 2006; Frankl, Philips and Wennburg, 2014; Klasen *et al.*, 2017; Keleher *et al.*, 2019), therefore most studies suggested that an early curtailment of counselling by the client who was dissatisfied was an indicator of unmet needs. Clients end counselling for a variety of reasons, many of which may have no connection with their satisfaction or failing to have their needs met (Swift *et al.*, 2012). Research by Barratt *et al*., (2008) found that the variables that influenced early termination of therapy could be categorized into six groups; client characteristics, enabling factors and barriers, factors related to need, environmental factors, perceptions of mental health problems and perceptions of and assumptions about treatment. Hatchett, (2008) explores the issue of early termination and acknowledges that an understanding of shared goals among other strategies would enable better engagement for clients with the process and improve outcomes. These studies acknowledge that the counselling needs of clients are what motivates engagement, but there is little exploration of the recognition of the needs of clients and that these needs might change as time goes on, or that clients might come to therapy with more of a sense of need generally than specific needs. This lack of discussion and the inability to contextualise the debate in relation to wider factors leaves much of the literature lacking in depth in relation to the questions of needs.

2.6.2 The link between motivation and need

Eight themes were identified in the literature and analysis of these needs suggest that these are closely linked with motivation. The fulfilment of needs has long been an accepted motivator for humans and the recognition of this is particularly strong in theories of work and social organisation (Green *et al.*, 2017). The drive to have one's needs met even those needs that may not be articulated, motivates individuals to action. In coming to counselling, the action of making an appointment, arriving and, perhaps more difficult engaging with the process, even when a client has to face uncomfortable truths about themselves, is undertaken to meet needs. The predominance of the needs that are connected with motivational theories within this study therefore is not surprising.

SDT was developed to enable the study of human motivation and personality and the three psychological needs on which this theory is based occur in the top four needs in the reviewed literature. These three needs; autonomy, relatedness and personal competence and the extent to which individuals have these or can be facilitated to develop these through counselling are thought to foster volition and levels of motivation (Keleher *et al.*, 2019). The meeting of these needs and the internalisation and recognition that these needs are met or not being met provides, according to Deci and Ryan the means to motivate individuals to act and thus seek help. Similarly, Maslow's Hierarchy of Needs (1943) seeks to give some structure to human motivation and of the eight themes three of these are identified by Maslow within his work. While these two theories do clearly add to the picture of what is need by clients, there remains two themes from the eight that do not fit into either of these theories; Outcomes and the need to be Directed/Managed. These might be said to be context specific in relation to the counselling setting and as in the context of outcomes dependent on the kind of counselling, and motivation of the client to engage and continue with counselling. This motivation is often governed by other needs being met, such as the level of relatedness. In the case of being directed and managed, whilst this might be uncomfortable for some person-centred therapists to admit that this is useful for clients, there are times when clients simply cannot move in their processing of the therapeutic work towards their ultimate needs without some gentle direction.

In some sense the needs explored in this review might be seen to be fundamental and predictable however, in talking about harmed patients it is often the case that their needs have not been met or have been overlooked during the course of their interactions with the healthcare system.

2.7 Relevance of literature review to research question

The needs of clients within the literature on counselling are generally not the focus of research. Given the context of counselling and psychotherapy in the UK today, the focus for much research is outcome driven. The research that was found during this review demonstrates that clients are attending counselling with needs that are both explicit, such as the needs for an outcome, and implicit, such as the need for safety. Services often consider the need of clients in relation to outcomes and how having needs met is likely to enable clients to maintain their commitment to therapy. The actual needs themselves, for example the need for safety, is generally not considered alone by services, but by clients it certainly is. This kind of need is often articulated in other ways rather than safety, such as the recognition of trust, respect or being comfortable with talking about personal issues.

Regardless of why individuals come to counselling all those who come willingly have an expectation and hope that their needs will be met, even if those needs are not clearly articulated or remain implicit. It is incumbent upon the counsellor to help clients recognise and articulate their needs, both in the counselling relationship and in the wider world, and to empower individuals to have those needs met in a constructive manner.

What is clear from the literature is that the needs of clients have the potential to be met within the relationship with the counsellor and through the counselling process in how the counsellor is with the client and how they work together in facilitating the meeting of needs.

The review identified a number of issues in relation to the study of the topic of clients' needs in coming to counselling following second harm. First, it was evident that none of these studies included the counselling needs of those with second harm due to this topic not being researched. This point is significant in that it is not known if the needs of those experiencing second harm are the same or different to those attending counselling with other issues. Secondly, having undertaken an initial review that found no studies of clients coming to counselling following second harm, it was evident that second harm is both poorly defined and under researched. While this might be evident from anecdotal evidence, a literature review was required to confirm this assumption and to ensure that any study undertaken was either set within what was already known or was beginning to construct an evidence base.

2.8 Conclusion

The review identified eight pieces of literature. Within this there was some exploration of what the needs of clients were when coming to counselling but this was not wholly the focus of all studies. The analysis of the needs identified in the literature suggested a close link with motivational theories. The eight identified needs were articulated within two specific theories although the needs were not all encompassed in these two theories. It is evident that some needs are what might be seen as global, such as the needs articulated in the motivational theories discussed and some are situation specific, in relation to the counselling client's access.

2.9 Summary of chapter

This chapter considered the wider literature that was relevant to this study in reviewing key pieces of research on the needs of clients that were coming to counselling with a range of issues. The chapter presented a rationale for the literature review, the process and the findings of the review and concluded that there was a significant gap in what was known about the counselling needs of those with second harm. The literature links needs very clearly with motivation and this was supported by two main theories on motivation. With such a considerable gap identified in the literature and a recognition of the lack of understanding of second harm, it would not be an appropriate assumption to generalise the findings of these studies regarding clients coming to counselling for a variety of issues to clients experiencing second harm. A study that focuses on the counselling needs of those with second harm specifically is required. This fits with the anticipated aims of this study and the initial research question.

The research question therefore is:

- What would clients say they need from counselling following experiences of second harm within the healthcare setting?

Following the literature review the aims and objectives were formulated as follows:

Aim: To explore the range of perspectives on what clients say they need from counselling following experiences of second harm within the healthcare setting

Objectives:

1. To identify common needs of clients coming to counselling following second harm
2. To identify key factors that are both common and novel in relation to counselling that clients believe would be most helpful following second harm.
3. To establish clear recommendations for counselling that can be utilised by those working with harmed patients.

3 Chapter Three – Methodology and introduction to Method

3.1 Overview of the chapter

Chapter Three will present the methodology and introduce the method used within this research. This chapter begins in Section 3.2 by explaining the choice of the method; Q methodology and goes on, in 3.3-3.4 to give a rationale for that choice and explain how that choice will help to meet the study objectives. In section 3.5 the research paradigm is introduced and the chosen philosophical approach, critical theory is discussed. Section 3.6 -3.7 considers how the epistemological and ontological approach linked to critical theory and met the needs of the chosen method. Section 3.8 brings the chapter to a close in a short summary.

3.2 The choice of method for this study

The chosen method for this study was that of Q methodology. The use of the word 'methodology' when referring to Q methodology could be seen as somewhat confusing given that this chapter also goes on to set out the wider methodology for the study. This therefore requires some explanation.

Q methodology is a methodology in its own right with a philosophy of science stance on epistemology and ontology (Stephenson, 1994). This methodology takes a particular approach to data that is both scientific in its approach and flexible in its interpretation. It is this underpinning ethos in the approach to data that stays true to the original methodological approach of Q methodology in this study.

3.2.1 A Q methodology study – what is it?

A Q methodology study, is used to study subjectivity (Stephenson, 1994) and was developed by psychologist William Stephenson (1902-1989) as a means to research opinions on a topic (Brown, 1993). The name "Q" comes from the form of factor analysis that is used to analyze the data. While traditional factor analysis, called "R method," finds correlations between variables across a sample of subjects, Q methodology looks for correlations between participants across a sample of variables known as Q sorts. Q factor analysis reduces the many individual viewpoints of the subjects down to a few "factors," which represent shared ways of thinking (Coogan and Herrington, 2011).

The unique approach adopted by Q methodology in comparison to other approaches is that subjectivity, as expressed by differing viewpoints, is explicitly recognised, valued and used as data

that can be systematically researched. Q methodology allows the integrity of opinion on a subject to be respected, results to be recorded anonymously and the strengths of qualitative and quantitative research to be combined (Cross, 2005).
Any Q methodology study consists of these four basic steps:
Stage 1 Developing the Q sort pack (including reviewing the concourse)
Stage 2 Administering the Q sort (including selecting the P set, ethics and the participant journey)
Stage 3 Factor analysis and data handling (may include post-sort interviews)
Stage 4 Factor interpretation as viewpoints
(Corr, 2001)

3.3 Why choose Q methodology for this study

The choice of Q methodology, with its claim to be able to articulate the voices of the marginalised, fits with the underpinning ethos of counselling and the approach articulated in the BACP Framework for the Counselling Professions (2018). In his paper of 2006, Brown discusses Q methodology as having been itself marginalised. Invented in the 1950s Q methodology was initially used ostensibly to undertake personality assessment, but with the inception of psychometric testing Q methodology became less used. In the last few decades Q methodology has been developed as a research methodology and accompanying method that have been at first used in the USA in the late 1930s with the UK coming somewhat late to Q methodology in the 1990s.

3.3.1 Q methodology as a means to reach subjectivity

In his contribution to a book on empowerment in 2005, Brown suggests that qualitative interviews may not always have the potential to measure the implicit (Brown, 2005. p98), but that Q methodology might be a more robust means of allowing implicit opinions to be seen within the data. This suggestion is very much based on the sense of objectivity and scientific method that is part of the narrative of the Q methodology community around the method. While that sense of ‘science’ is to some extent understandable on the basis of the use of the statistical method of factor analysis, this study also had to employ a qualitative approach to the interpretation of the data. Brown acknowledges that this often happens, but fails to give sufficient recognition that the researchers, regardless of method, come to the data with their own limitations of experience, perspectives and knowledge as well as the limitations of the chosen methodology.

The tension between the use of Q methodology and dissatisfaction with a binary qualitative/quantitative choice is discussed in Capdevila and Lazard's paper (2009) as a false distinction and unhelpful to the debate about the usefulness of Q methodology. Capdevila and Lazard (2009) reiterate the use of Q methodology for the study of what is implicit, yet Q methodology is also able to make explicit dominant perspectives and opinions. Whilst theoretically this can be claimed to be the case, it might seem disingenuous to claim this whilst utilising a method that in a practical sense forces the individual to make hard choices about the hierarchical importance of particular statements related to the topic of interest.

As discussed further in later chapters, participants in a Q methodology study are asked to sort pre-determined statements into a specific order related to their overall importance. This is achieved using a grid. The grid can be a ‘forced distribution grid’ or a ‘free distribution grid’. This process, when using a forced distribution may suggest that participants cannot sort the statements in the way that they want and indeed that the statements themselves might be seen as limiting. The classic Q methodology paper on this discussion is one by Brown, (1971) that discussed the advantage of using this technique and he gives a sound rationale for why this technique does not limit the data gathered. Cross (2005), also makes it clear that a forced distribution is usually designed into the Q sorting process to limit the number of uncertain answers and to deliberately force individuals to make hard choices. This was the rationale for the choice of a forced grid for this study as there may well be a temptation for participants to see many statements as equally important.

The tension between allowing participants to be heard and the need to provide a very clear focus to enable data gathering and sound interpretation, will always be an exercise in balance, which is why Stephenson (1994) refers to Q methodology as both an art and a science. In considering the range of topics to which Q methodology is applied it is evident that it is applicable to a broad range of individuals across many sectors and in various situations. Q methodology has been applied to pictures, statements, artefacts or other material that participants can sort thus being accessible to a more diverse participant group. The accessibility of Q methodology adds to the ease with which it can be a means to articulate the views and preferences of different groups.

3.4 How will Q methodology help to meet the study objectives?

With the ability of Q methodology to make accessible a full range of viewpoints that constitute opinions about a topic, the approach was chosen specifically to enable the development of an in-depth understanding of what counselling clients themselves perceive their needs to be following an experience of second harm. While other approaches were considered, for example structured interviews, there was also a need to be able to explore the topic in depth, but without participants having to relive their experience of harm by describing the specific circumstances of their first and second harm experience. Although it was acknowledged that a structured interview could potentially be carefully controlled to ensure that this does not occur, the method was partly chosen to also ensure that the opportunity for explicit ‘control’ by another individual, namely the researcher, did not feel as though harmed patients’ narratives were being dismissed. A Q sort allows for a focus on the primary objective of the study and while facilitating an in-depth understanding of this it can prevent deviating into other subject matter, primarily due to the limitation of the sorting of defined statements.

3.5 Choice of research paradigm: Critical Theory

Critical theory was chosen as the most suitable research paradigm to meet the needs of the Q methodology study as it took account of a number of issues in the context of research including absent voices, social justice, hierarchies and power. The recognition of the power relationships within harmed patients search for justice, apology and understanding of what happened was a fundamental aspect of this study and shaped the choice of critical theory as the chosen paradigm. This approach engages people and their experiences as valid, as having something that can contribute and gives voice to a marginalised part of society. This was important within the context of this study because patient voices of harm are limited or absent in the empirical literature. As a philosophy underpinning this study, a focus on the empowerment of individual harmed patients was an underpinning principle to ensure the people were heard and acknowledged and their experience of harm translated into something useful, ensuring that the harm would not be exacerbated in any way.

The critical theory paradigm came predominantly from education and has its roots in Marxist theory (Morrow and Brown, 1994). The paradigm is essentially constructivist in nature, and recognises issues of oppression, control, class, work and social movements. These concepts can be applied to questions where power relationships are unequal, where the voice of one group is prioritised over another and where justice and equality may be an issue (Blaikie and Priest, 2017). There is often a historical narrative to critical theory research that explores the complex relationships and development of social movements that seek change, explore and encourage social struggle and a drive for recognition and emancipation of specific groups (Morrow and Brown 1994).

3.5.1 Absent voices

In undertaking this research one of the key factors was to articulate the importance of a just approach to patients and to ensure that the voice of the patient was heard in relation to harm The work of Ocloo (2010) suggests that the voice of harmed patients is often lost in the conversations about patient safety and the aftermath of errors.

There is an abundance of empirical studies on the experiences of second victims, the healthcare professionals that makes mistakes (Wu, 2000; Edrees *et al.*, 2011; Seys *et al.*, 2012; Wu and Steckelberg, 2012; de Wit *et al.*, 2013; Mira *et al.*, 2015; Pratt and Jachna, 2015), yet there remains a paucity of empirical work that talks about the experiences of the ‘first victim’.

Given that most research carried out in healthcare is not done by patients, or that patient narratives and experiences may be seen as less ‘valid’ or reliable knowledge (Greenhalgh, 2016), perhaps it is not surprising that researchers may not want to explore the topic of the second harm.

3.5.2 The search for justice following second harm

One of the fundamental aspects of second harm for many patients is the lack of apology and access to any kind of justice. The stress of what Ray and Gray, (2015) call ‘justice denied’ has been researched in spheres ranging from the wrongful convictions, as in Ray and Grays’ research, to the research carried out by Berlinger (2003) on apologies in healthcare. A sense of an absence of justice is often a key feature of stories told by families in relation to both first and second harm. Two high profile cases which resulted in the publication of accounts of both the original and the second harm by Titcombe, (2015) and Ryan, (2017) document the devastating impact of the search for justice and the impact of injustice on the individual and the family.

3.5.3 Hierarchy and power in patient staff relationships

Historically, clinical staff have been seen as having a body of knowledge that cannot be accessed by patients, with power relations being unequal and paternalistic with an expectation that clinical staff, especially doctors would be deferred to in all decisions about patients and their care (Vincent, *et al.*, 2013). Over time these aspects of the relationship have changed and these changes in relationships are critical to the background of second harm and fit well with the historical change that is so much part of critical theory.

Critical theory seeks to give voice to the vulnerable and unheard (Kushner and Morrow, 2003). The ‘unheard’ nature of second harm is evidenced by the lack of studies that have explored the experience of harm from a patient perspective, and none that have gone further to consider the needs of harmed patients in relation to counselling following experiences of second harm.

The critical theory paradigm is a complex one, it is also one that is uncomfortable and challenges the status quo of the current structures, practice and institutions. Applied to health care, traditionally it has been the voice of professionals that has been preferred, with mistakes being seen as shameful and embarrassing with professionals often struggling to take responsibility for failure in care, errors and neglect (Vincent*,* Burnett and Carthey*,* 2013). While rhetoric has changed over time and the voice of patients has been recognised as being important, significant structures and processes have come about to manage patient voices and information that might be said to support the voices of patients in raising concerns.

The choice to take a critical theory stance within this research fitted well with a professional counselling and person-centred background as an integrative counsellor and supported the choice of Q methodology as a method for this study. A counsellor is expected to prioritise the voice of the client above that of professionals and to work with the client to be an advocate for personal empowerment and autonomy (BACP 2018). Additionally, the critical theory paradigm expects a dialogue between the subject of the investigation, in this case counselling following an experience of second harm, and the investigator. As a counsellor, a nurse and as an NHS previous service user it was impossible to come to this research without a hope that the research might make some impact, elicit change or promote awareness. This dialogue with the subject of the study that focused on the study as a means for change was congruent with the topic, the methodology of critical theory (Ray, 1993), of a research justice stance (Ray and Gray, 2015) and with the researchers professional values (BACP, 2018).

3.6 The underpinning epistemology and ontological premise employed for this study.

Any study that proports to consider new knowledge, particularly the generation of new knowledge as this study did, has to be able to identify what knowledge looks like from the perspective of the researcher (Howell, 2013). This presents a fundamental challenge to all researchers that in defining knowledge they must also consider the recognition of the nature of reality, truth, and theory as well as knowledge and that this recognition should shape the consideration as to how and why a study should take place as well as the fundamental approach to the study.

3.6.1 Ontology

Within this study the nature of **reality** was acknowledged as a subjective construction of the mind that includes the input and experience of others and their reality and experience. The acknowledgement of the nature of reality is termed **ontology**, in other words what is the form or reality and what can be known about it as well as how it can be researched (Howell 2013). For empirical science a real world exists that is measurable, is based on empirical data that focuses on the precise rules and nature of occurrences. It is believed that these occurrences are separate to humans and cannot be influenced by them. This is the stance of positivism, with a stance of post positivism believing that immutable laws and rules can evolve or change but remain provable through empirical data. Considering that the focus of this research was people and their subjective experience, a more social science view of reality, it would not be appropriate to consider approaches such as positivism or post-positivism that suggest that reality is fixed or semi-permanent, and that reality exists outside of humanity and is independent of it.

3.6.2 Epistemology

Similarly, in relation to **knowledge**, positivism and post positivism do not acknowledge that knowledge is subjective, therefore approaches that fail to acknowledge that the knowledge and the individual with that knowledge are inseparable or approaches that do not recognise the constructivist nature of subjective experiences would not be appropriate (Howell 2013). A recognition of the role of the 'other', predominantly the participants in this study, in the generation of knowledge was also important as an understanding of the ability to provide those others with a forum in which to articulate the difficult experiences of their lives was an important aspect of the study. The recognition of the relationship between the researcher and what is being researched is termed **epistemology (**Howell 2013). In this case, the researcher had to acknowledge that her own experience of second harm both shaped the subject choice and the choice of methodology. It is often the case within critical theory research that the researcher is either an advocate or seeking change, recognition of the need for change or making explicit a historical, justice or social order perspective.

Knowledge, and for that matter, **truth**, for the purpose of this study were recognised as not fixed, but verifiable through the experience of others, and are ever changing with multiple perspectives (Howell 2013). Therefore, a pragmatic approach to 'truth' was taken, and a recognition of the external reality of experience that for patients is about subjectivity and their own experience rather than one fixed reality that could be objectively tested.

3.6.3 Theory

Theory is a means of articulating reality, truth or knowledge generated though data, research findings or outcomes (Howell 2013). Therefore, the approach taken to those influencing factors, reality, truth or knowledge impacts on the generation of and understanding of theory. Within this study, given the nature of the data as being subjective and phenomenological; being the lived experience of the participant, the theory generation was abductive – generated from the data that was available but recognising that the full data set (which would mean including everyone who has ever been subject to second harm), was not available. In view of the recognition of the consideration of reality, truth, knowledge and theory within this study, a critical theory approach was taken with acknowledgement that patients' stories are their own view of what happened to them. However, similar experiences may generate learning that can be shared and that is common to these experiences. This is where Q methodology can provide an approach that is useful.

3.6.4 Positioning theory, paradigms of inquiry and methodology

Reference must also be made to the relationships between theories, paradigms of inquiry and methodology. Howell (2013) suggests four main positions in relation to these factors; a correspondence approach that provides a clear relationship between truth and reality that is articulated through words and numbers, a coherence theory approach that sits truth and knowledge between and within systems, a pragmatic approach where truth and knowledge are verified though experience and practice, and a consensual/constructivist approach where truth is developed thorough construction and consensus participation. According to Howells categorisations, the use of critical theory in the study enabled the study to fit into the pragmatic category of approaches yet the method utilised to collect data was a participation and consensus method. The method therefore did not fit neatly into Howells categories but sits astride both a pragmatic and a consensus position.

3.7 Ontology linked to critical theory

Given that the study aimed to explore the range of opinions held by patients, it would be difficult, perhaps impossible, to justify any methodological stance other than that of a constructivist approach with a recognition that the individual and the knowledge held by the individual were inextricably linked. Weber (2007) suggests that critical theorists and constructivists share that same perspective that asserts the centrality of individuals, rather than social institutions and that what individuals do is influenced by '*who they are, and how they perceive themselves and others*'(p1) and that both approaches seek to identify and collect their study data in similar ways. For many researchers the acknowledgment of a constructivist stance leads naturally to an underpinning qualitative methodology with clear choices about the data collection and analysis method. The binary choice of qualitative or quantitative methodology and associated data gathering methods is challenged by the emergence of more mixed method studies, and particularly by, for example, Q methodology which does not sit comfortably in the 'either or' discussions on methodology or indeed method.

Sue Ramlo, a well-known Professor and proponent of Q methodology (Ramlo and Newman, 2011) considers the unique position of Q methodology that utilises a constructivist approach to truth, knowledge and subjectivity and also employs qualitative methods to extract the nuances of subjective meaning. This meaning, and subjectivity is what critical theory considers to be the narrative of an individual in a complex society that is hierarchical, oppressive and where some individuals are marginalised and powerless. Ramlo presents evidence that Q methodology is a mixed method and makes a sound case for Q methodology as being a mixed research method both that can be used to develop theory, a research activity that is often viewed as the prerogative of qualitative research, as well as to test hypotheses that confirms theory, a research activity that is generally viewed as the prerogative of quantitative research. Her suggestion is that Q methodology is a hybrid of post positivism and constructivism (Ramlo and Newman 2011). This is primarily due to the objectivity of the researcher to the particular kind of data collected initially, which constitute a set of statements, called the P set. These statements, although collected together by the researcher, are allowed to be interpreted and have their meaning constructed by the participants thought process during the sorting of these statements, and the subjectivity of the participant, in that the meaning that the researcher attributes to the statements is not communicated to the participant, with the participant constructing their own meaning as the sort process progresses (Newman and Ramlo, 2010).

The temptation to put this study at one end or another of the qualitative/quantitative continuum, particularly given the choice of Q methodology as a method is resisted as much as possible within this study. Other methodologies were considered, especially those of a quantitative nature, for example structured interviews. Given the nature of the topic there was a need to ensure that participants focused on the counselling needs of those with second harm and specifically did not revisit their experience of second harm itself. To put some limitations about the discussion with participants, yet to allow the deep meanings and richness of opinion to be drawn out without further distress to participants, and for it to be free of researcher values as much as possible, needed a particular kind of approach for which Q methodology was appropriate

3.8 Summary of the chapter

This chapter introduces the methods underpinning Q methodology that were operationalized in this research. This introduction sets a sound context for the following chapter where how this method was employed will be further discussed. This chapter defined the key terms of reality (ontology), knowledge, truth and theory, and how these fit with the epistemology, the relationship between what is to be researched, and the researcher. The chapter set out the methodological stance of this research study, that of critical theory and briefly considered the themes of justice and the participant voice within the context of the study and the chosen methodology. The themes of power and authenticity are touched on as key issues in researching patient experiences, especially those experiences that are negative.

The chapter positions the study between the apparent conflicting dichotomies of qualitative and quantitative approaches and the different methods of data collection as well as the paradigm within which the study is set.

4 Chapter Four –The Q Methodology Study

4.1 Overview of the chapter

This Chapter begins in section 4.2 by taking the reader through the first phase of the Q methodology study: phase one, a review of the concourse in order to inform the development of the Q sort statements. In section 4.3, the study departs temporarily from the usual Q methodology process to undertake a more in depth review of the concourse specifically with the purpose of defining second harm, a definition that can advance the discussion of the topic during the study. Section 4.4 brings together that review and offers a definition of second harm with section 4.5 bringing the chapter to a close.

4.2 Phase One Generating the Q-sort pack (Q set)

4.2.1 Theoretical issues in concourse generation

Regardless of the research topic, a review of the concourse is always the initial stage in the development of the Q sort pack (Watts and Stenner, 2012). The concourse is defined as the body of knowledge and experience that represents the range of common opinions and views about the topic (Exel and Graaf, 2005). The concourse is established from which to draw the Q sort statements, known as the Q-set. A Q methodology researcher is always mindful that the review of the concourse and the statement generation process is key to the study outcomes and results. Brown discusses in his seminal paper '*The Use of Variance Designs in Q Methodology'* (Brown, 1970) the issue of ensuring appropriate coverage of the concourse within the statements. Both Brown (1970) and Watts and Stenner (2012) note the need for the Q set to be both broad and balanced, free of values, and to enable participants to express their viewpoints. Debates about the different approaches of an R approach (a factor analysis method that finds correlations between variables across a sample of subjects) and a Q approach (which looks for correlations between subjects across a sample of variables), tend to underpin these critiques which might be philosophically thought of as an art/science debate (Stephenson, 1986). These debates may sit uncomfortably with novice researchers unused to Q methodology, for whom demonstrating the robust nature of their research is of prime importance yet are attracted by the novelty of a Q methodology study to allow for a sense of freedom and creativity in the research process.

This debate about different approaches to the stages of Q methodology, including the flexibility or not of these approaches is articulated across the Q methodology community and outside, particularly in relation to conducting the Q sort. Brown, a student of Stephenson's and a respected expert of Q methodology takes a flexible approach to all aspects of the method. For example, in the development of a Q sort, the statements are described as either structured or unstructured (Brown, 1993). Structured Q sorts very much use formal design principles to consider categories decided by the researcher prior to the statement generation process, or may utilise a framework that explicitly shapes the statement generation. These categories are not based on the probable content of the statement but are around more general categories. For example, categories that could have been considered for this study might have included aspects of patients' experience of harm in relation to, processes, ideology, or interactions. While some studies use this approach (Baker, 2006 and Chen *et al.*, 2016), others do not, preferring to take a broad view of the concourse and then define themes with which to construct the statements (Ahmed *et al.,* 2012, Bang *et al.*, 2015, Barr, Ormrod and Dudley, 2015). However, in this research study the Q sort was unstructured in that no pre-defined categories were used to limit the concourse to, for example, personal interactions or healthcare processes. Although there were ideas about what might be discovered in the concourse there were also some surprises, for example, quotes from the concourse material in relation to the reputation of the organisation, targets and lack of focus on the patient (see Appendix 3 for full set of statements).

Brown, in discussion with the online Q methodology community (2019) emphasises the need for a diverse concourse. He makes clear that the lack of a diverse concourse may later see an unusually high correlation of sorts and factors, in effect, too many statements being similar and participants agreeing with too large number of statements.

4.2.2 The review of the concourse

Stephenson (1986), the founder of Q methodology, believed that '*all subjective communication was reducible to concourses*' (p24) which as a new researcher to Q methodology can be both exciting and daunting in that to capture the range and diversity of a concourse can be challenging but is essential.

McKeown and Thomas, (2013) recognise that concourse material is likely to be diverse, as each person's meaning is different. A key tenet of Q methodology is that only a limited number of viewpoints exist on any given topic, the diversity of concourse material is both expected and manageable with diligence. It is therefore essential to be able to select the material that make up the concourse in a robust and replicable manner to ensure that the researcher has the best possible representation within the statements (Stenner Watts and Worrell*,* 2008).

As part of the review of the concourse for this study, an appraisal of the frameworks utilised by researchers to review the concourse in the field of health and social care was undertaken, resulting in a literature review that was published in a peer reviewed journal, *Nurse Researcher* (Kenward, 2019 See Appendix 18). The literature review of the use and development of concourse frameworks demonstrates that the Q methodology literature frequently lacks discussion around robust strategies in developing frameworks that contribute to the initial exploration of the concourse. Publications that focus on the specific constituent parts of Q method, in this case, concourse development, are lacking in the literature and should be a focus of future research. This can leave researchers without sound guidance and direction as to how to approach the particular concourse for their topic.

In response to this deficit in the evidence base, Kenward (2019) identified four possible types of frameworks to support concourse development: thematic frameworks, profession specific frameworks, broader health and social care frameworks and frameworks that the researchers themselves devised specifically for their own study. For this research the latter approach was utilised and a robust framework was developed to enable engagement with the topic concourse and identification of material that might make up that concourse. In order 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 (Figure 4.) and secondly, inclusion criteria that material should meet to be retrieved for this study (Table 9).

Figure 4 Framework demonstrating examples of sources from which quotes were taken to construct the Q sort statements.

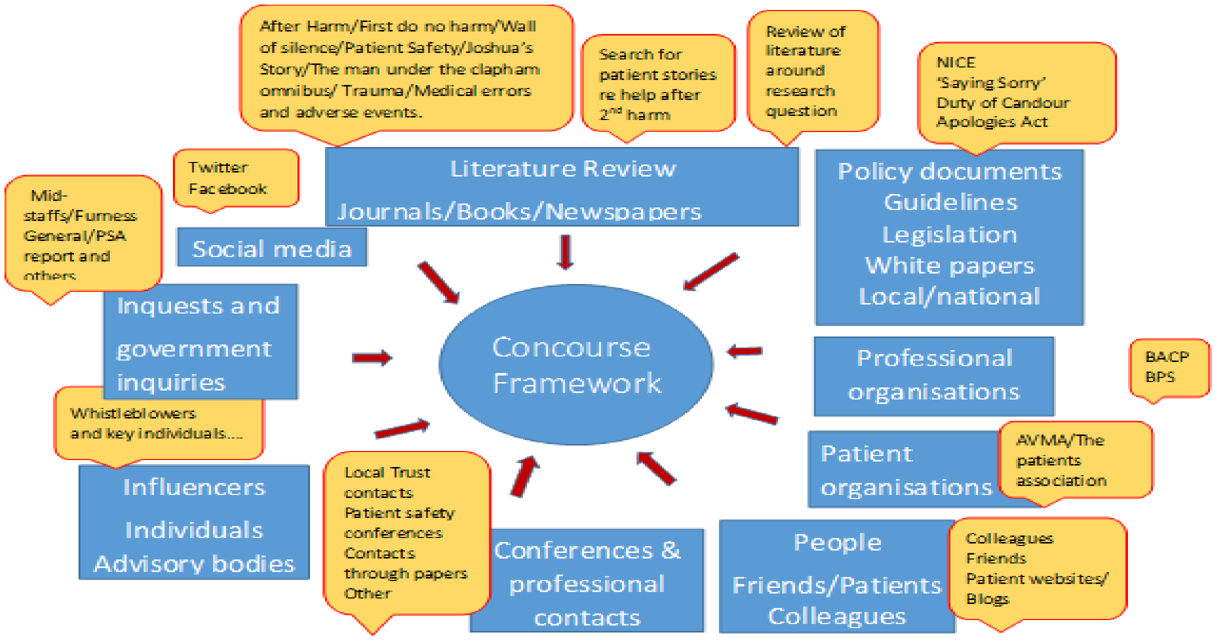


Table 9 Inclusion/exclusion criteria for concourse material

	Criteria	Comment on the inclusion/exclusion
1	The sources evidence the opinion or range of opinions about the patient experience of second harm.	The primary focus of the source may not explicitly be second harm, but opinions on second harm and its impact on patients were a valuable source of material and therefore included
2	The sources gathered contribute as a whole to a wide range of media and categories of sources in which the opinions of individuals about second harm are expressed.	Sources ranged from patient accounts online, government reports into poor care or errors and books written by patients about their experience
3	All sources should have the potential to add to the development of statements that were aggregated, not person specific, but were indicative of a theme that contributed to potential opinion statements.	Some sources were specifically in relation to individuals identified in the public domain for example, books or newspaper stories that identified individuals with similar stories. Other sources indicated the harm and the impact of harm identified by individuals but did not name them, for example NHS Improvement, (2018) which was a report into the events, and what could be learnt from those rather than a narrative of patient experience. Some sources contained no opinions on the impact of second harm and were excluded.

Having a framework and clear inclusion criteria for the concourse, such as those above, aids in demonstrating rigor in the concourse development.

4.2.3 Rationale for reviewing sources on second harm

The sources around second harm did on rare occasions, refer to counselling following second harm. If counselling was referenced, it was often incidental to the main narrative. What harmed patients did refer to in the sources on second harm was the inadequate and damaging manner in which patients were treated by healthcare providers and individuals which causes them harm. In describing this they often juxtapose the expected and hoped for relationship with professionals and responses within the same narrative. Therefore, searching through the sources expecting to find explicit detail on the counselling needs of those coming to counselling following second harm proved to be fruitless. A number of references have been made already to the interpersonal and relational nature of second harm and it is this that was evidenced in the sources on second harm. This focus within the concourse sources specifically informed the Q set statements. In indicating the deficit that they believed harmed them; they also indicate what they would expect from a professional relationship. It is this that they would have implicitly ‘needed’, to have as a suitable response to the initial harm and what they were likely to need in a counselling relationship; a relationship with the counsellor where the damaged internal world of the client is reconstructed as a joint process with the counsellor.

4.2.4 Criteria for inclusion within the Framework

The framework was developed by creating a diagram that noted all the potential sources of literature within which second harm might be discussed. These sources were used to search for possible statements about second harm to make up the concourse. The framework took a wide view of potential sources yet also recognised that within some sources patient experiences of second harm may be implied rather than explicitly stated. Within the framework a number of sources were identified and it was only after reading the source that the extent to which the source might be valuable as a contribution to the concourse became apparent. Each source was compared against a set of criteria that determined whether material within the sources would be included in the concourse or not. The criteria are set out in Table 9.

4.2.5 Ethical use of online material and personal comments within sources.

The personal opinions and experiences of individuals that are displayed online are sometimes assumed to be in the public domain and thus open to use by researchers (Turculeț, 2014). This assumption might also be made by researchers with regards to sources, such as books by named individuals that are clearly in the public domain. However Zimmer, (2010) makes clear that the use of material, from social media sites particularly, can be problematic in that individuals may be easily identified if sufficient care is not taken to achieve anonymity. The expectation that individuals who post online, who write books or who are identified in newspaper articles are giving implicit consent for researchers to take their comments for use in research cannot be assumed. Therefore, in this study, comments made on social media (predominantly Twitter), from books written by named individuals or quotes from individuals identified in newspaper reports were treated differently to non-identifiable quotes in recognition of the need for ethical treatment. Comments that could be attributed to individuals were noted verbatim, but were then aggregated together with other statements if appropriate, for example the issue of not being listened to (Figure 5).

4.2.6 Review of the concourse

The review of the concourse was carried out over a period of 14 months, between February 2017 and June 2018. To facilitate the review and to guide the search for potential sources the framework (Figure 4) was utilised. Sources were selected for inclusion as per Table 9 and were reviewed from the following sources:

- Newspapers -weekly internet search and search for stories
- Books search using popular internet search engines
- Results from a literature search conducted in fulfilment of 7DPRA99, a module within the DHSCP programme.
- 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.

Appendix 2 documents the range of concourse sources accessed and used to develop the Q sort statements.

4.2.7 Statement construction

To generate the Q sort statements the materials that made up the concourse were analysed in a thorough and in-depth fashion. A modified version of Braun and Clarke's model of thematic analysis (2012) (Table 10) was used because as previously outlined in Chapter Two the framework moves the reader from codes to themes. However, using the framework to develop the concourse meant it required subtle modification. The process was modified from the typical thematic analysis process, as the purpose of statement construction is to generate a statement for each aspect of the topic that is indicative of what is found in the sources rather than developing new themes from data that would be more akin to a true thematic analysis.

Table 10 A modified Braun and Clarke model (2012) used for statement construction.

Phase	Steps in each phase
Phase 1 Familiarising yourself with the data	Scan reading identifying initial quotes Discarded sources if criteria not met
Phase 2 Generating initial codes/quotes	Review list of quotes Review list of sources (ongoing)
Phase 3 Searching for themes/groupings	Identifying similarity, overlap & clusters Put similar material into groups
Phase 4 Reviewing potential themes for the group	Define key aspect of statements selected Name group themes
Phase 5 Generate indicative statement(s) of possible client needs in relation to the group theme	Ensure each statement allows for aspects of harm indicated in theme to be articulated as a need
Phase 6 Review of statements and amendments	Statements reviewed by 2 reviewers Complete amendments List of 42 statements

Each source was read once, due to the volume of the sources and then discarded if the inclusion criteria (Table 9) were not met. Coding was carried out at this initial reading stage. As each source was read any initial quotes that specifically identified an aspect of harm as defined by patients were noted and recorded as a code that was either a specific quote (if this was not able to be attributed to an individual), or as a general initial trend (if attributable), for example 'no one listened to us' would be recorded as 'no one listened' in recognition that this was a repeated trend for both individuals and families.

The concourse reached saturation point (at which no other quotes of different types became evident) when 160 quotes were coded. Initially, following the collection of the basic quotes, each was reviewed and grouped together with other quotes that were similar in content. This resulted in 42 groups of quotes (Table 11) with each group having between 1-8 quotes which described a similar issue in each. One of these groups, 'Workplace Bullying' pertained to only one narrative and so this was removed.

Every group was then reviewed for possible similarities, and clusters that were articulated within the quotes and final themes for the concourse were identified. Using the themes identified, the quotes were aggregated into one or two statements to represent that theme. See Figures 5 for how statements were developed and Table 11 for indicative themes identified.

Figure 5 An example of how statements were developed from themes

Three quotes were grouped together:

- We were treated like adversaries
- The atmosphere was hostile and defensive.
- We were not treated as equals in the process of investigation or in care but were treated as adversaries

These three quotes covered what might be best described as ‘adversarial relationships theme’

Having aggregated these, the defining statement became:

- I want to be treated as an equal from whom the healthcare system can learn.

Two themes could have been identified here, hostility/defensiveness and learning for the Healthcare system. However, hostility and defensiveness were implicit in a number of the themes therefore, it was more appropriate to focus on the aspect of being treated as an equal and not an adversary.

Table 11 Indicative themes identified for the concourse

No	Theme name	21	Power/decision making
1	Abuse/violation	22	Care, compassion and worth
2	Lack of support	23	Not following policies and procedure
3	Explicit contempt	24	Existential Crisis
4	Language about patients	25	Challenge as a problem/an inconvenience
5	Dehumanisation	26	Labelled as difficult
6	Survival strategies	27	Not saying sorry
7	Staff acted as victims	28	The inconvenient patient/family
8	The long legal process	29	Loneliness
9	Blamed for what happened	30	Finding out about what happened
10	Disengagement with the HC system	31	Betrayal of the NHS
11	HCP as 'saints'	32	HCP Dealing with what happened
12	Long term impact of harm	33	Being listened to
13	Adversarial relationships	34	HCP attitudes and behaviours
14	Ostracised and avoided	35	Power and control as second harm
15	Control of information	36	Feeling unsafe
16	Cover ups	37	Acknowledgment and minimization of harm
17	Lies	38	Collusion
18	Lack of learning for CI	39	Reputational repair
19	Lack of responsibility	40	Self-blame
20	Being fobbed off/ dismissed	41	Secrecy and acknowledgment
		42	Workplace bullying

Following the review of the concourse the next stage of selecting statements for the Q sort pack (the total of the statements) is crucial. Brown (1980) suggests that the researcher uses a structure to support them in this process. The criteria in Table 9 ensured that the quotes chosen were representative of the breadths and depth of the opinions offered on that subject and were sufficiently different to make the Q sort pack representative. Brown (1980), who writes one of the core texts on how to undertake a Q sort, suggests that despite the content of the Q set (the statements), as long as the Q sort pack is representative of the range of opinions, then the conclusions (the factors, demonstrating the viewpoints held by the participants, identified in the conclusion of a study) converge.

One of the additional challenges of constructing a Q sort pack is how a researcher knows when they have reached the full range of opinions on a topic. While a researcher may be able to achieve a full range of opinions no amount of consideration by the researcher could document the unique experience of second harm for every individual. However, in the case of this study the breadth and depth of the concourse was deemed to be suitable first, when saturation of statements was achieved, and secondly after a review of the statements by two 'expert' reviewers (see 4.2.9).

4.2.8 Refinement of statements

Initial quotes, and sometimes the thematic statements, may be too numerous to be manageable during the Q sort by participants. Stenner, Watts and Worrell, (2008) suggest between 40 and 80 statements are a workable number for any participant to sort. Therefore, a total of 41 statements were finally constructed that articulated the themes from the quotes within the concourse material as described above.

Development of the statements was challenging; but in 2012 I attended a 'Basic Q Methodology' two-day training workshop delivered by Wendy Stainton Rogers and Paul Stenner, two well respected and experienced Q methodology researchers. This workshop provided guidance for managing the concourse, selecting quotes and for constructing the statements. Advice within this workshop from experienced Q methodology researchers assisted in the consideration of how the statements could be written that would best enable clarity during the sort for participants. Recommendation for the construction of robust and meaningful statements include, for example, the avoidance of negative statements and statements with two propositions that are only loosely related. This avoids the issues of confusion in relation to where to place a negative statement on a scale where the measure is 'most likely – least likely'.

4.2.9 Review of statements

To ensure the statements adequately reflected the views of the concourse Stenner, Watts and Worrell (2008) recommend these statements are tested by 'expert' participants. This can be done utilising a focus group or by calling for participants to specifically undertake this role. For this study two participants who had been recruited to the main study expressed an interest in being expert reviewers. Therefore, in addition to participating in the Q sort activity for the main study they also reviewed the content and completeness of the Q sort statements prior to the main study which involved signing a separate consent form to that of the main study consent form and completing a Tester Feedback Form (Appendix 13). These Reviewers read through the statements and were asked the four questions in Figure 6.

Figure 6 Criteria against which reviewers assessed initial Q sort statements

1. Are the statements easy to understand? Please list any that you do not understand.
2. Is the wording clear? Please list any that you do not understand.
3. Do you feel that the statements cover every aspect of what individuals might want in response to the question: 'Following the experience of second harm, what would be important to you in the relationship with your counsellor?'
4. Do you have any further comments about the statements?

Statements were sent out via email in late July 2018 to the two reviewers who independently reviewed these statements against the four questions above. These individuals were asked to review the statements to establish their validity and further refine these so they were meaningful and understandable to participants, and to ensure that the statements were reflective of what they knew about the diversity of the concourse.

The expert reviewers returned their feedback and suggested revisions within two weeks of receiving the statements.

Appendix 3 shows the revisions that expert reviewers made to the statements highlighted in red. Amendments were made to the wording as well as the inclusion of one additional statement at the suggestion of the one of the reviewers. Therefore, following review by the expert participants 42 statements were confirmed as the Q set for this study.

In the later analysis this study is shown to have a robust correlation between factors, defined as being within the 0.40 that was manually calculated for this study as suggested by Watts and Stenner (2012). This is explained in later chapters. Additionally, participants who commented on the range of statements were positive in relation to the breadth. One participant in a post sort interview commented:

> *'I don't know who devised those points but whoever it was it was somebody who understood exactly what has happened to somebody in my position'* (Participant 7).

4.3 A literature review of statements: the method

As the statements had already been gathered and grouped for sorting into 42 indicative statements about patients experience of second harm to cover the totality of the concourse, the purpose of the approach to the review of the statements was to further aggregate the statement themes into broader categories that indicated categories of harm. Following a grouping exercise, twelve overarching categories that described the nature of second harm were established (Table 12) with the categories in one column and the contributing content from the concourse in the other.

Table 12 Overarching categories on second harm established from concourse material

No	Category	Related content from Q set
1	Abuse, both verbal and psychological	A sense of having been violated A sense of having been dehumanised
2	The withholding of basic need of individuals	Care Support Safety Worth and expertise Not being listened to
3	Negative behaviours	Adversarial relationships toward patients Explicit contempt
4	Derogatory and judgmental expressions of belief towards or about patients	Derogatory language about patients.
5	Powerful gatekeepers to health care that cause patients to feel threatened	The development of survival strategies to manage the harming situation Sense of loneliness Feeling unsafe Self-blame Fear of reprisals or repeats of harm Disengagement with the HC system Not being included in any learning from the harm No learning being attempted
6	HCP blaming patients for challenging the system	Staff acting as harmed Not saying sorry Being made to feel that challenge betrays the NHS
7	Process as a weapon	The long dehumanising and exhausting legal process
8	Superiority and maintaining hierarchy with the healthcare system	HCP as 'saints' Power/decision making in the hand of those that harm Not seeing the need or being able to say sorry (attributing to the 'legal issues') Being made to feel that challenge betrays the NHS HCP only interested in reputational repair Power as a second harm

		Workplace bullying challenge as a problem if HCP is also a patient Patients as an inconvenience Patient labelling as difficult HCP Dealing with what happened Workplace bullying Exclusion
9	Inability to take the perspective or understand the experience of harmed patients	Inability to understand the long-term impact of harm Inability to understand the existential crisis that happens as a result of healthcare harm Inability to acknowledge or attempt to mitigate or minimise harm or stop it happening further
10	Avoidance and exclusion	Being ostracised Being avoided Being fobbed off Being dismissed Being excluded Not being included in any learning Inability of HCP to deal with what happened
11	Control of information	Gatekeeping information Cover ups Dishonestly Secrecy Power and control as second harm Deception Not being able to find out what happened Lack of acknowledgment about the harm Collusion between HCP or organisations to cover up or deceive
12	Stepping outside of professional codes, expectations and roles	Not following policies and procedure HCP attitudes and behaviours Failure to take responsibility

4.3.1 The interpersonal and emotional nature of second harm.

When considering the categories generated by the concourse it is noted that the descriptions of second harm were viewed by patients as being attributed not to systems but to people within those systems. In the discussion of psychological harm in the wider literature, generally referred to as trauma, the literature makes clear that interpersonal harm, that which is caused by the acts of others, is known to cause greater psychological harm than that caused by a natural disaster (Brewin, 2003). Interpersonal and relational issues can compound any psychological distress, including second harm and, of the themes identified, all are ultimately interpersonal in nature and are often an emotional response of the professional to the harmed patient and related to behaviour that often sits outside the expectations of patients, professional and regulatory bodies and ethical codes. The perceived response of organisations is the response of the individuals within that organisation and therefore second harm emerges as an interpersonal fracture. As well as the interpersonal nature of second harm, the categories suggest that there are a set of attitudes, behaviours and responses to patients that have been harmed that are common to the experience. The twelve categories, in some ways could all be broadly amalgamated under category twelve, 'Stepping outside of professional codes, expectations and roles' as the behaviours and attitudes demonstrated in second harm do just that. This is however, not an adequate definition of second harm as it does not encompass the exact nature of second harm in sufficient depth. The fact that professional bodies, patients and healthcare professionals themselves recognise that attitudes that contribute to second harm are not acceptable, by whoever perpetrates it, is an important acknowledgment. Given that second harm is interpersonal and appears to be predominantly attitudinal and behavioural, then this understanding may help in considering the possible limited definitions already offered. Additionally, considering the key attitudinal features of this phenomenon from the concourse material, which may also be able to be identified as a named attitude or response to harmed patients, an eventual definition may emerge.

4.3.2 Discussion of the key features of second harm

The review of the concourse exposed a number of definitions of second harm not immediately obvious in the empirical literature. These definitions from experts in the field, family members, and organisations show to some extend the lack of clarity surrounding this term. Some discussion of the limitations of these definitions is necessary before going on to present an alternative that will be adopted within this study.

From the concourse, a number of behaviours and reactions to patients that are harmed indicate two possible attitudinal responses that may be indicative of second harm. These are blame and contempt, both of which will go on to be explored in this discussion.
However, two other viewpoints on healthcare harm, one described as '*harm by disrespect*' (Sokol-Hessner Folcarelli and Sands*,* 2015) and one that 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) (Trew, Nettleton and Flemons, 2013). These two viewpoints provide the debate with some key components that help to refine and inform the concept of what second harm is and is not. Therefore, to commence the discussion these two viewpoints will also be discussed.
The work of Sokol-Hessner, Folcarelli and Sands from the USA in regards to the emotional harm of patients explores 'harm by disrespect' and a broader sense as '*respect for actions that honor and acknowledge dignity*' *(p2)* (Sokol-Hessner, Folcarelli and Sands*,* 2015 and Sokol-Hessner *et al.*,2018b). These research teams acknowledge that their idea about what might constitute harm

includes harm that is not necessarily related to active disrespect, but also includes the lack of dignity given to patients. The suggestion that harm might be linked to disrespect was initially proposed by Sokol-Hessner, Folcarelli and Sands in 2015 and in 2018 Sokol-Hessner *et al.* (2018b) undertook an initial literature review with the aim of helping to recognise, describe and prevent harm by disrespect. The research team then went on to compile a framework for the facilitation of this aim making it explicit and addressing this as a patient safety and quality issue (Sokol-Hessner *et al.*, 2018b), with the recognition that the analysis of critical incidents using a structured framework can contribute to learning and to the improvement of systems and processes. Within the framework he notes both organisational and professional behaviours that include undue labelling of families, control of information, uncaring attitudes, deception, physical and sexual assault (p7). These are similar categories to those mentioned by patients in their experiences of second harm within the statements gathered for this study. Whilst these categories, and the discussion on disrespect are a useful addition to the wider understanding of harm, there is no suggestion by Sokol-Hessner that the behaviour described is in response to the patients following a first harm, but rather are occurrences within everyday episodes of care.

Whilst his definition of healthcare harm has some merit and encompasses many of the categories seen in the literature review or statements within my own study, no theoretical basis for why staff might disrespect patients during episodes of care or following an error is offered by Sokol-Hessner. He also explores the fact that this disrespect, can be organisational, for example, insufficient areas that provide privacy. Again, this is ostensibly for first harm as described in his study. A more explicit evidence base for why disrespect and why professionals do not treat individuals with dignity in relation to harm would have allowed for any extrapolation of this theory to second harm. Therefore, although a useful piece of work the definition of harm by disrespect, namely failure to provide dignity, is rejected as being suitable to describe the totality of the nature of second harm.

In addition to the work on harm by Sokol-Hessner, Folcarelli and Sands (2015) and Sokol-Hessner *et al.*(2018a and 2018b) work on second harm has emerged from Trew, Nettleton and Flemons (2013) who undertook a study in 2009 that was focused on the trajectory to recovery of patients that had been harmed and whether partnership working with healthcare organisations might help move harmed patients towards a more usual grief process. Their work recognised that the grief process for harmed patients, 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 (DSM5 2011). This work focused specifically on the nature of the trajectory and, although defining second harm, only gave minimal consideration to the discussion of second harm and failed to present an evidence base for their definition.

The work is based on a literature review of grief processes and suggest 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 original model proposed by Stroebe and Schut, (1999) recognises the swing between grieving activity and reparative activity during the grieving process and that these activities do not have a linear timeline, often changing from one to the other in minutes. 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. The model and description of second harm however, 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. Their work recognises that second harm may consist of many of the themes highlighted in Table twelve including exclusion, control of information, disrespect and lack of understanding the impact of harm. However, they also 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. Therefore, their definition of second harm is rejected as a basis for the definition of second harm in this study.

The recognition that previous empirical evidence did not provide a definition for second harm prompted consideration of what other material there are that might allow a construction of a definition. Within the actual categories of harm in the concourse material two specific attitudes, blame and contempt were named as being key to how professionals approached and interacted with patients. The question of how far one or both of these concepts might account for the features and nature of second harm therefore needed to be considered. First it was useful to consider some general theory from empirical research on the topics of blame, followed by contempt.

4.3.3 Blame as a possible component of second harm

Blame was a component of harm that was specifically mentioned in the concourse material. Blame featured as being an attitude that was indicative of the relationship between professionals and harmed patients. This was particularly true where patients were both blamed as contributing to the original harm and blamed for raising and escalating concerns.

In 2014, Malle, Guglielmo and Monroe, published their pathway model of blame. Previous to this theory the academic community within the field had lacked an agreed definition which had significantly hampered dialogue around the approach to blame. Alicke, (2015) noted the wider range of topics that have been researched in relation to blame, these include blame as a motivational force for control, psycho-legal issues, research on specific crimes, the effects of outcome information on blame ascriptions, how blame or responsibility attributions are influenced by other factors during a crime, and the link with causation. He notes that the nature of blame is described in these studies but only in relation to the perspective of the study and the wider perspectives of studies that focus on blame are problematic in being able to come to a clear and definite notion of what blame actually is. The pathway model suggested by Malle, Guglielmo and Monroe (2014), was open to critique by the academic community and the community agreed on the pathway but indicated that the theory could not account for all incidences of blame. Bauman and Mullen, (2014) note that Malle, Guglielmo and Monroe's model does not include private blame, which they believe to be equally important. Goodwin, (2014) offers further criticism as to the completeness of the model, while Schein and Gray, (2014), challenge the linear nature of the model and Sheikh and McNamara, (2014) the completeness of the model in relation to victim blaming in criminal cases such as rape.

All of those who offer a critique of Malle, Guglielmo and Monroe's work are clear that the basic tenants of blame are within the model and offer the most insightful and provocative contemporary theory of blame. Blame and responsibility are intrinsically linked together and the work of Chockler and Halpern, link blame particularly to moral responsibility (2003). However, despite recognising the close link of these two concepts, discussions about responsibility in relation to second harm would not help the formation of a definition of second harm therefore a philosophical approach to blame as linked to responsibly will not be pursued in this discussion.

In their work on blame Malle, Guglielmo and Monroe, (2014) suggest distinguishing features of blame that are useful to consider as possible features of second harm as described by patients in their stories of harm in the concourse. Malle, Guglielmo and Monroe, suggested that blame is a cognitive action requiring a personal judgement in response to stimuli, usually a perceived wrong, most often involving the personal emotions of the individual attributing blame, in this case the healthcare professional. Malle, Guglielmo and Monroe*,* (2014) also suggest that blame is a social act requiring a focus on goals, role and norms that relies upon a social recognition of norms and that the blame is directed at individuals that have violated those norms, goals or roles. This is particularly interesting in second harm where patients and families, as a result of highlighting an error or neglect, step significantly outside the role of patients as being passive and challenge staff or ask for explanations or apologies or simply when individuals recognise that it is their right to question clinical staff (Thornton, 2000). Malle, Guglielmo and Monroe, (2014) also suggest that blame functions as a means of social regulation and control, particularly of a group. Both blaming and praising is a means of controlling the group and maintaining status both within the group and maintaining recognition from those outside the group.

Again, this is relevant to the issue of second harm in the healthcare setting (Waring, 2005) where healthcare professionals including counsellors, nurses and others are regulated and must conform to very specific norms and standards set by their regulatory body with regards to their education, continued regulation, their continuous professional development and their codes of practice (BACP, 2018). When healthcare professional are successful and conform to these expectations, they are highly praised and rewarded by both their peers in terms of being successfully accepted as part of the professional 'in group', the public in terms of recognition, and by their registering body who enable them to remain registered and ultimately to continue working (Pettigrew, 1998). When healthcare professionals fail in their roles, their goals or step outside the expected norms they may be excluded and blamed by their organisations, subject to regulatory processes, and ultimately be unable to continue working (Wu, 2000).

While the suggestions from Malle, Guglielmo and Monroe, (2014) do account for a considerable number of features of second harm, particularly the blame attributed to patients about what happens to them, one aspect suggested does not account for anything seen in the features of second harm.

It is suggested that blame requires something that Monroe and Malle, (2019) call 'warrant', in other words '*evidence that one's moral judgment is justified'* (p215) in relation to being able to lay legitimate blame at the door of another. In other words, there must be evidence offered to back up the alleged wrong for which the individual is blamed, and that evidence must be transparent and readily available to be able to be recognised by others. This is particularly relevant when one considers that there is a social cost to blaming, particularly as highlighted by Munroe and Malle (2019) which, in the case of healthcare professionals blaming patients, might risk significant retribution from patients, organisations and professional bodies. Munroe and Malle (2019) also note that blaming where there is not blame and 'over blaming' are socially regulated, that to be blamed for something for which an individual believes they were not responsible or culpable elicits strong defense mechanisms. It would not be acceptable for a healthcare professional, for example to blame a patient for raising legitimate concerns about care, or challenging or holding to account a health professional that had made an error, as clearly the expectations about what patients can expect as well as the acceptable norms of behaviour are clearly laid out in, for example the NHS constitution, regulatory expectations and ethical codes. In second harm, patients may experience adverse reactions from professionals as a result of doing exactly this. Therefore, blame cannot account wholly for second harm, although like harm from disrespect, there are common elements.

4.3.4 Contempt as a possible component of second harm

Features of second harm including, withdrawing from interaction, belittling, blaming, and a superior attitude are also mirrored in the core characteristics of contempt. In her work on the moral psychology of contempt, Bell (2013) suggests that contempt is an emotion that has a very clear behavioural responses. Bell (2013) offers four criteria that any emotion and its response should fit to be deemed as contempt. First, that contempt is an outward response to an internal belief that the object of contempt (in this case the patients) has failed to meet a standard, an expectation of a particular norm. This fits well with the suggestions by Alderman, Dollar and Kozlowski (2010) and Rozin *et al.,* (1999) that suggest that contempt is a reaction against an infraction that challenges the ethics of a community, especially challenges to authority, hierarchy, duty and respect, as patients do when challenging the professionals, the systems and the organisations following an error. Secondly, Bell suggests that the failure in the eyes of the contemptuous person to meet the perceived standard set by that person (in this case, to remain within the relatively unchallenging role of a patient) is a judgement about the whole person, is often moral and about character, a more universal judgement rather than a judgement that is merely about a behavioural transgression. This judgmental stance fits well with what patients described as being about the derogatory language and judgements that healthcare professionals used about them.

Hutcherson and Gross, (2011) in their work on contempt, go on to further suggest that contempt is interpersonal, it feels personal for harmed patients, and that the person who is a target of the contempt is often seen as wasting resources, especially taking up time and valuable resources, for example by undertaking litigation. This is often linked to judgments about the personal values and morality of individuals with harmed patients seeking compensation as being seen as a lesser or almost inferior person.

The seeking of compensation, however legitimate, can sometimes be seen in the media as an end in itself and it is not uncommon to hear of individual who have ‘won’ compensation (Hyde, 2019). Given some of the considerable losses experienced by harmed patients this can be particularly distressing for them to read. This third criteria proposed by Bell takes the issue of perceived inferiority and suggests that it is the failure of the target, in this case the harmed patient, to behave as expected, to conform to norms or expectations that deems them purely on the basis of their lack of conformity, to be of low status and that this status evaluation has a purpose.

Fischer and Roseman, (2007) in their work found that contempt is used by the contemptuous person as a way of reducing the negative impact of outcomes by belittling or excluding the individual that is the target of contempt. They also noted that feelings of superiority felt by the contemptuous person were used as a mental means of having agency in a situation where one has no other way of exerting some control. In their work, they note that this was particularly noticeable in those high in self-esteem who are more likely to use contempt as a means to ostracise and avoid. Bell's (2013) final criteria for contempt, supported by the work of Fischer and Roseman, (2007) is that the individual exhibiting contempt avoids and withdraws from the object of contempt due to a sense of feeling threatened personally or that their own values, ideals or sense of self are under threat.

There is a considerable body of research on the topic of contempt, the focus of contempt, the purpose and the various manifestations of contempt. The work focuses on what is called the CAD triangle, the three emotions of contempt, anger and disgust that traditionally sit together as emotions of great strength with the purpose of managing the behaviour of others (Rozin *et al.*, 1999, Underwood, 2004, and Hutcherson and Gross, 2011). Bell's criteria are supported among the research community in relation to the nature and purpose of contempt. The four criteria she suggests as defining contempt fit well with the documented incidences of second harm. These criteria are summarised in Figure 7.

Figure 7 Summary of Bell's criteria for the features of contempt.

- that contempt is an outward response to an internal belief that the object of contempt has failed to meet a standard, an expectation of a particular norm.
- the failure in the eyes of the contemptuous person to meet the perceived standard set by that person, is a judgement about the whole person, may be a judgment about their morals and character and is a more universal judgement rather than a judgement that is merely about a behavioural transgression.
- it is the failure of the target to behave as expected, to conform to norms or expectations that deems them, purely on the basis of their lack of conformity, to be of low status, and that this status evaluation is used as a way of reducing the negative impact of outcomes by belittling or excluding the individual that is the target of contempt and by generating some agency in the situation.
- is that the individual exhibiting contempt avoids and withdraws from the object of contempt due to a sense of feeling threatened.

In looking for a description of what second harm is, taking into account the descriptions by patients themselves the features of contempt as evidenced in the research literature are a best fit to explain the features of what professional's exhibit to patients and what patients experience as second harm. Contempt when aimed at patients feels uncomfortable, feels personal and is harmful in that it undermines the sense of self in both the patient and the clinician. Recent work on harm generally has begun to understand the importance of a deep level of emotional intelligence and self-awareness that allows for relationships to be repaired, learning to take place and improvements to be initiated (Bell, 2019). Whilst contempt remains and is not tackled, learning cannot take place and patients will continue to be harmed.

However, contempt, like the other emotions in the CAD triangle, is a normal human emotion and reaction. There is an expectation that health care professionals are trained to manage their responses and not to be led by their emotions, for example exhibiting anger toward a patient would not be acceptable to peers, organisations, patients and regulating bodies, therefore contempt should similarly be recognised and made to be unacceptable.

4.4 A final definition of second harm

In Chapter One it was stated that harm was poorly defined and that a definition of second harm was entirely absent within the literature. However, through working with the concourse and identifying statements for the Q sort pack an informed understanding of second harm has been developed that goes beyond the current published discourse around second harm.

Current definitions of second harm have been demonstrated to be inadequate to describe the experience impact of second harm. Similarly, related concepts have also been demonstrated to not be sufficiently close enough to be representative of what second harm is. The need to define second harm is essential if it is to be understood and recognised as a concept. Additionally, a definition is necessary for the experience of patients to acknowledged and sufficient and appropriate counselling to be offered as a means for support and recovery.

Therefore, a definition of second harm in healthcare is offered for the purpose of this thesis and as a means to both recognise and acknowledge the experience of patients. Second harm can 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'.*

4.5 Summary of the chapter

This chapter moves thorough the first phase of the method; constructing the Q sort pack, also known as the Q set. Some considerable discussion was focused on the concourse in this chapter. Concourse development as an art is both a creative and iterative process that takes time and patience in being able to construct a sufficiently broad concourse capturing the range of opinions on a topic. The process and the product (the statements) are required to be sufficiently robust and replicable as far as breadth is concerned and therefore appropriate instruments and decisions need to be explicit and rational. The use of a framework for possible sources, a clear patient-centred process, and inclusion criteria for statement generation were essential tools in this development process. It is only with appropriate tools such as these that validity and reliability can be demonstrated in relation to concourse management. The concourse development process also allowed for a review of the statements that became a means to establish a new definition of second harm that, as any data driven aspect of a research study, will add to the conclusions of this study.

5 Chapter Five - Method

5.1 Overview of the chapter

This chapter begins by considering the issues in gaining ethical approval to conduct phase two of the study, the administration of the Q sort, and how ethical issues were managed in the study (Section 5.2). These include participant recruitment, discussion on sampling, recruitment, the participant journey, consent and confidentiality, protection from harm, giving advice, equality and diversity, and withdrawal from the study if requested. This leads into data collection, which is discussed in section 5.3 and the conduct of the interviews discussed in section 5.4. Section 5.5 summarises the chapter before going on the data analysis in Chapter Six.

5.2 Ethical approval prior to stage two.

This study gained a favourable opinion from the University of Derby College of Health and Social Care Research Ethics Committee on 17th November 2017 and from the Health Research Authority on 3rd July 2018 (ID no. 18/WM/0103) after which the study moved into stage two, the administration of the Q sort.

The research design was shaped by the requirements of these approvals and the expectations of the professional body, the British Association of Counselling and Psychotherapy, the best practice guidelines for the International Society of Traumatic Stress Studies (ISTSS), and legal frameworks such as General Data Protection Regulations (GDPR). The relevance of each of these is highlighted in the following discussions.

5.2.1 Sampling

In Q methodology the sample is considered to be the statements generated by the Q sort rather than the number of participants (Cross, 2005). Ramlo (2016) does acknowledge that this is a perhaps an unusual and unfamiliar technique if researchers are familiar with usual sampling processes. Where participants are recruited to complete the Q sort, they are referred to as the ‘P set’. In Q methodology the P set is more akin to traditional sampling procedures where a sample size and sampling criteria are decided upon. Ramlo (2016) suggest researchers may want to approach their sampling of the P set in a number of innovative ways including sampling the whole of a small group, asking for participants that meet very narrow criteria or having just one participant undertake the Q sort (Ramlo, 2016 p31). The P set met criteria that were not particularly narrow but were very distinct. In this case the criteria for P set can be seen in Figure 8.

Figure 8 Criteria for inclusion in study

Participants:

- Will have had an experience of second harm to themselves/a significant other i.e. Family.
- Would be willing to take part in the study.
- Are able to provide informed consent
- Should have access to a computer

One condition of the NHS Ethical Panel was that at initial contact, it would be established that the participant or their family member/significant other had been subject to second harm. During the study every individual, on initial contact, offered this information as a rationale for contact and wanting to be part of the study and thus this ethical requirement was met. Documentation associated with recruitment of participants is located in Appendix 4 – 12.

5.2.2 Recruiting the P set

The recruitment of participants took place between July to August 2018 and involved a three-pronged approach. The aim was to recruit at least ten participants. Watts and Stenner (2012), recommend no less than ten participants for a multi-person study to ensure a sufficient analysis. However, they argue that the range of opinions within the Q set is not dependent on the number of participants, which is why, within Q methodology it is the number of statements that are seen as the sample, as opposed to the number of participants in the P set.

The recruitment of the P set commenced by inviting participants from a patient group that support those who have experienced harm within healthcare, namely Action against Medical Accidents (AvMA). AvMA is an organisation with which I have had a long-standing relationship and am a Trustee. Therefore, the group were aware of the research and agreed, at the commencement of the study to include a call for participants on their website and within their newsletter. The call was included in the submission to all ethics committees. Eight potential participants responded to this call for participants.

Secondly, participants were invited from a body of individuals who were aware of this study though professional contacts at conference presentations, journal publications or through my twitter account documenting my research journey. This second approach drew six potential participants. It is worth noting that no previous or current clients of my own were approached.

Thirdly, a call was sent out on the designated Twitter account for my research activity set up at the commencement of this study. This third approach drew four potential participants. Individuals who knew of this research also told others, who then expressed an interest in being participants.

This drew two potential participants. This utilised a mix between traditional snowball and opportunistic sampling.

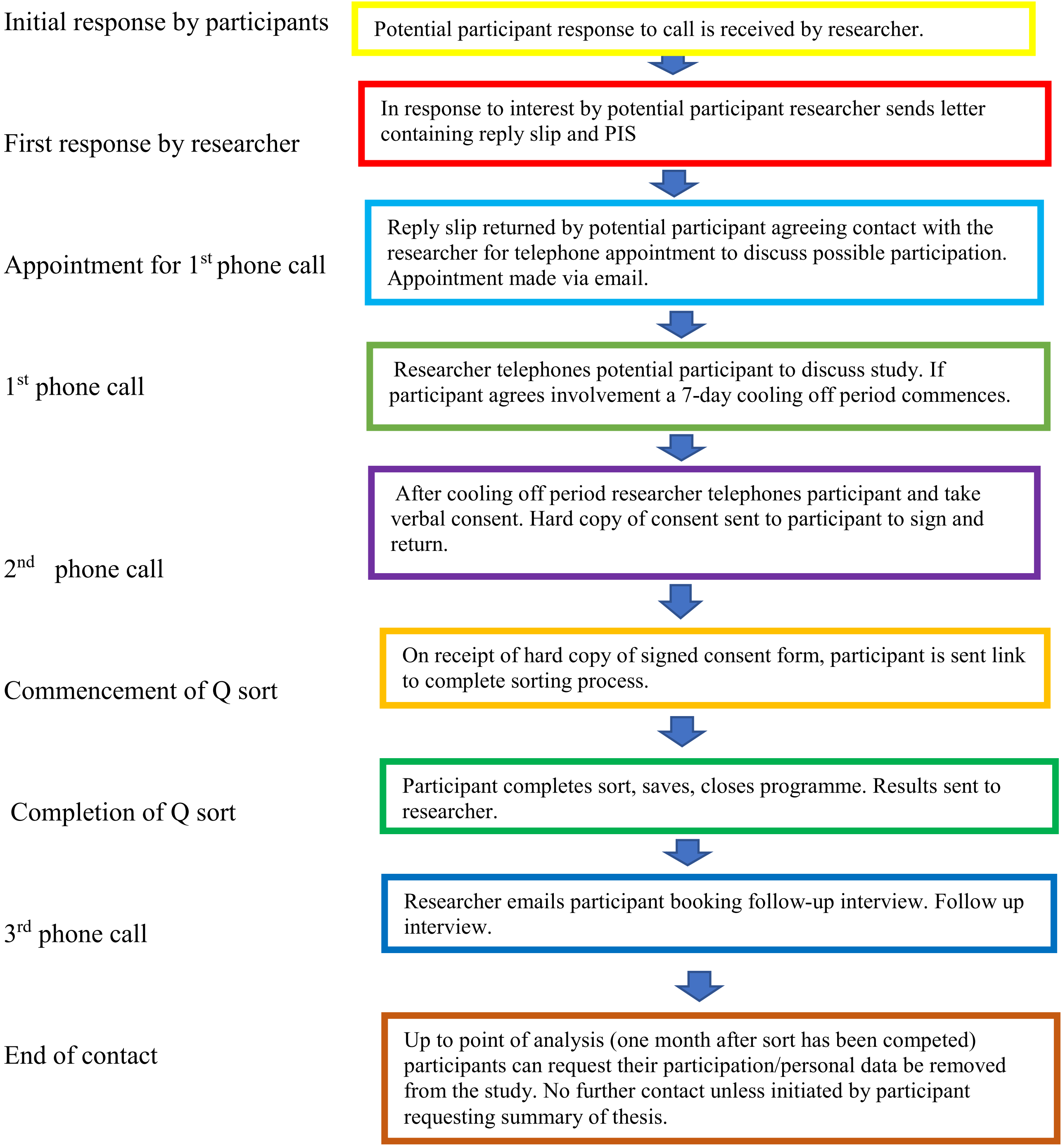
Of the total potential participants (n=20), ten finally participated in the study. The reason many potential participants did not commence the study was attributed to the requirement for their GP to be informed of their participation in the study, primarily as a means of support in the event that a participant became distressed or required psychological support, which was a condition of NHS REC approval. Six potential participants expressed this as a reason not to continue into the study (n=6) whilst others did not return their consent form therefore not being eligible for the study. Those that explicitly did give the reason for non-involvement as being the GP having to be informed all indicated that the GP had been either party to the harm or responsible for the second harm. Those that did indicate this as an issue spoke of mistrust of their GP, concerns about how they would be viewed and possible punitive treatment. Those that continued to participate expressed surprise and disappointment at this condition and having to consent to this as part of the study, however, many also expressed determination to participate regardless of GPs being informed, sometimes due to the fact that their relationship with their GP was already quite poor, or that their GP was fully aware of the issues that they had been through and therefore would not be surprised at their participation.

Whilst protection of the participants is absolute paramount in any study, this condition did not take account of the fact that a participant may have been subject to second harm from their GP. The condition was not discussed at the Ethics Committee and I was not aware that I could challenge this in any way without my Ethics Approval being rescinded. Of the letters sent to GPs regarding the participation within the study, no GP responded with queries. A copy of the letter can be seen in Appendix 10.

5.2.3 The participant journey – ethical issues and psychological safety

Ethical considerations are a means to protect participants from exploitation and harm. Considering the topic of this research relates to harm already done to individuals in the healthcare setting, then appropriate ethical engagement with participants was particularly important to this study. Further harm should not be caused, neither would it be acceptable for participants to feel as though they were not valued, respected or were simply important for the information that they could contribute. The BACP Ethical Framework (2018) makes clear that counsellors who are also researchers are required to comply with the ethical expectations of the Framework when working with research participants. Ethical approval should be gained and there should be a willingness to respond to ethical issues that arise during the research process (McLeod, 2014). The ethical considerations that were pertinent to this study are addressed in this chapter. Figure 9 shows the journey of participants from initial response to the end of contact and serves as an adjunct to the discussions on ethical issues and a visual aid to understanding of the flow of communication between researcher and participant.

Figure 9 Flow chart of participant Journey



Initial response by participants	Potential participant response to call is received by researcher.
First response by researcher	In response to interest by potential participant researcher sends letter containing reply slip and PIS
Appointment for 1st phone call	Reply slip returned by potential participant agreeing contact with the researcher for telephone appointment to discuss possible participation. Appointment made via email.
1st phone call	Researcher telephones potential participant to discuss study. If participant agrees involvement a 7-day cooling off period commences.
2nd phone call	After cooling off period researcher telephones participant and take verbal consent. Hard copy of consent sent to participant to sign and return.
Commencement of Q sort	On receipt of hard copy of signed consent form, participant is sent link to complete sorting process.
Completion of Q sort	Participant completes sort, saves, closes programme. Results sent to researcher.
3rd phone call	Researcher emails participant booking follow-up interview. Follow up interview.
End of contact	Up to point of analysis (one month after sort has been competed) participants can request their participation/personal data be removed from the study. No further contact unless initiated by participant requesting summary of thesis.

5.2.4 Consent

To enable participants to be treated fairly within the research process consent to participate is required to be taken prior to the entry to participation in the study (University of Oxford, 2019). To enable the consent to be valid, the participants must be fully aware of what processes they, their information and data will be subject to (McLeod, 2014).

For this study, once potential participants indicated an interest in being part of the study information about the study was given to them with a letter that contained a tear off slip expressing an interest and requesting a telephone discussion. If they were no longer interested in the study, then they did not need to make further contact. To help participants make an informed choice they were provided at this point with a participant information sheet about the research project, its purpose, aims and method and a copy of the participant journey flow chart (Appendix 4-12).

The participant information sheet also provided information on data protection mechanisms, the use and storage of data during and after the project, the ability of participants to withdraw from the research or to withdraw consent to use their data, how they could request support and the kinds of support that could be provided and from where. Information was also given about the researcher including training, experience and professional background.

The consent form (Appendix 9) was sent to participants, but they were asked not to complete this until seven days after the telephone call, at this stage it was for information only. Participants also had the opportunity to ask questions about the study via email at the initial point of contact or indeed at any point. Once received, the reply slips were logged onto a participant database and an email was sent or text (depending on the choice expressed by participants), arranging the telephone discussion. At the appointed time, the participant was telephoned, and the potential participant was talked through the project and once again had the opportunity to have questions answered about the project, but this time in person via telephone.

The participant was then given a seven-day cooling off period during which the participant could decide not to participate. Following the end of the seven-day period the researcher contacted the potential participant to take their consent to be part of the research. If participants required further information, they were able to contact the researcher for clarification at any time. The aims of the research were highlighted and discussed with participants during the consent process. Research highlight the challenges and benefits of asking participants about their experiences as a means to raise awareness of difficult topics, for example abuse and as an almost cathartic process for the participants (Becker-Blease and Freyd, 2006). In response to this work Ullman (2007) summarises research that suggests that it is not the asking about difficult topics that causes distress but the unhelpful and unsupportive responses to disclosure, as well as what might be described as the over involved empathic response of the listener. This points to ensuring a sensitive response that is right for each individual and protects professional and personal boundaries.

The British Association of Counselling and Psychotherapy (BACP) have an Ethical Framework for the Counselling Professions (2018) that makes clear the expectations around ethical practice and boundaries within practice and research. Within this study every effort has been taken to ensure that harm was not perpetuated and that due acknowledgment was given to those who have experienced both first and second harm as experts in their own experience. This approach is congruent with both critical theory and with a constructivist approach as discussed earlier in the chapter.

5.2.5 Confidentiality and data protection

The need for confidentiality of participants and protection of their data is both a legal, a personal and an ethical one. The data collected from individuals was minimal during which it became evident from participant addresses that most parts of the UK were represented. Of the ten participants two were from Scotland, one from the North of England, one from Wales, one from the Midlands, four from the Home Counties and one from London. Two were male, eight were female. No other data was collected.

The use and sharing of all information about individuals that can be identified is governed by the General Data Protection Regulations (European Union, 2016) and this study adhered to this as well as the requirements of the University of Derby, the stipulations of the College of Health and Social Care Research Ethics Committees of University of Derby and the National Patients Safety Agency National Research Ethics Service (NRES, 2010). These requirements espouse a number of ethical principles and expectations that protect the privacy of participants and ensure that they feel that they are not merely utlised as a tool that enables others to draw on their experiences.

To facilitate respectful participation and use of data, no personal data received during the research work was used for any purpose other than for that piece of research. Personal data was stored on a computer that was password protected to ensure that third parties did not have access. Documents with personal data were stored in a password protected locked safe. This meant that documents could only be access by a password known to the researcher. The researcher is already registered with the Information Commissioner with regards to storage of electronic data and continued to comply with requirements of registration. Additionally, an online training package on data protection was completed in May 2018 to keep up to date with data protection law and to be appraised of the new General Data Protection Regulations (GDPR).

Data collected from participants was made up of numbers and some text. An ID number was allocated to each person participating and used to identify the data from that individual. The details of the personal information relating to the ID number were kept in a locked safe along with contact details only of the participants. Details included name, contact details and the consent form of each. Names were not used during the study nor was information that could identify a person included in the study. All records provided or created for the purposes of this research, including any back-up records, were deleted when participants decided to withdraw from the research or did not progress their participation at any point.

5.2.6 Protection of participants from psychological harm during the study

Participants recruited to this study had experience of both first and second harm. It was therefore essential that participating in the study minimised the risk of further distress. This was primarily achieved through the research design which focused on their counselling needs and not their experience of harm. In addition, given their potential vulnerability, debriefing and sign posting was used if a participant indicated distress at any time.

As a Registered Counsellor with BACP the researcher's practice and research was covered by the Ethical Framework (BACP 2018). The Framework sets out a set of values, principles and personal moral qualities expected of registrants. The study was tightly focused on the counselling needs and not the experience of first harm.

Despite not being on the experience of first harm it was still important to be mindful of any negative impact of participation. Therefore tools as recommended by The International Society of Traumatic Stress Studies (ISTSS) were used to minimise any potential impact of participation (Becker-Blease, 2007). Two specific tools were appropriate for this study. These 'tools' are:

1. What the ISTSS describe as a 'quiz format' to explain consent within the information sheet, utilising the kinds of questions that potential participants might ask.
2. A participant reaction assessment (used in the post sort interview questionnaire Appendix 11), in the form of the three questions (see Figure 10) that are suggested by ISTSS as helping to identify impact. These questions enable targeted assistance should a participant need it.

Figure 10 Participant reaction assessment questions as recommended by ISTSS (Becker-Blease 2007).

Did you gain anything positive from participating?

Did you have any negative effects from participating?

Do you require any support following the sorting process?

The two 'tools' described above were used to shape the information to participants in the participant information leaflets, to identify impact of participation in the post sort interview and to help identify appropriate strategies for further support as required. Additional strategies to support participants also included, all participants receiving a telephone call after completing the data collection to ensure their well-being had not been impacted upon by undertaking this study. During the telephone call participants had the option to discuss with the researcher any impact on them and to consider if a referral might be appropriate to local services, including their GP. Participants could contact local services themselves or contact the organisations indicated on the Support for Participants Sheet (Appendix 12). No participants indicated that they would be contacting services or their GP for support and none indicated that participation in the study had caused further distress. All participants felt positive in contributing to the study in that they wanted to be able to feel that the study could raise awareness of second harm.

While it was not anticipated that there would be harm to participants in this research, it was recognised that there were other potentially harmful activities as a participant, such as the prolonged use of computers, therefore participants were advised to have a break from the computer at least every hour. The software used for the sort indicated the time taken to undertake the complete sort and no participant took longer than 50 minutes.

While the information sheet did not promise there would be an immediate benefit from participating in this study participants were told that benefits could include; an opportunity to contribute to a greater understanding of second harm which will be shared within the academic, counselling and health professional communities, the raising of awareness of second harm, an opportunity to contribute to a framework developed for those counsellors working with those who have been harmed secondary to a medical or surgical error and an opportunity to consider and reflect on participants’ journey towards recovery. These benefits were recognised by participants either during their initial discussion about entering as a participant in the study, or during their post sort interview.

The three support questions that were part of the research design to support the participant in Figure 10 were asked of participants but not recorded, as agreed.

5.2.7 Giving advice

The giving advice in research is considered inappropriate as this blurs the boundaries of the relationships between participants and researcher (Dickson-Swift *et al.*, 2006). Recognising the issues raised by Becker-Blease and Freyd, (2006) and Ullman (2007) in relation to appropriate and sensitive responses and boundaries, advice was not given to participants. As a researcher recruiting participants or during the post sort interview it was important that an objective stance was maintained. The relationship between the researcher and the participant is in some sense one that is a relationship of power (Thompson, 2001) in that the researcher might be viewed as the ‘expert’ within the relationship. It is therefore incumbent upon the researcher to ensure that the participants do not feel that the researcher holds all the power within the relationship. In this study, the participants and the researcher did not meet during the data collection process or during the interviews which were done by telephone. The autonomy of the participants was upheld as much as was possible by them making decisions about when they undertook the sort, had telephone conversations with the researcher and whether they returned forms, participated or withdrew. Should issues have arisen for which participants required advice then the participants would have been signposted to relevant support and advice services for participants. A range of organisations were able to offer support to those participants who may have required it including local NHS Trust Patient Advice and Liaison Service (PALS), offering independent advice that would help participants consider whether participation in the research was right for them and Action Against Medical Accidents (AvMA), the Charity that supports those that have been through these experiences and offer a range of different kinds of support. No participant requested this.

5.2.8 Equal access and diversity

Having gone through an experience of harm it is really important that participants are not unfairly excluded from this study as many harmed patients and family members feel excluded from the conversation about what happened to them and about how things can be improved. Inclusion criteria were therefore very wide. First, participants should have had an experience of second harm to themselves or a significant other such as family. This inclusion criteria recognises that second harm does not just happen to the patient but also to family members. This is particularly true in the

event of a death or serious injury where family or other individuals are required to advocate on behalf of the person to whom the first harm had happened. Secondly, as an inclusion criterion, the participant had to be willing to take part in data collection. Thirdly, the participant had to have access to a computer and lastly able to give informed consent.
All information was provided in written format using plain English as per the guidance from the Plain English Campaign (2018). Alternative formats or information in other languages could have been provided on request, depending on the availability of translators. No alternative formats were requested or any alternative language, as all had English as their first language.

5.2.9 Contact with participants following interview

Participants were given the option of a debriefing session after the follow-up telephone call. This session was not part of the data collection and was initiated only as required at the request of the participant. One individual requested this and a half hour debriefing session was conducted with them. On conclusion of the study, participants were written to and asked if they wanted to receive a summary of the findings.

5.2.10 Withdrawal from the investigation

Participants were able to withdraw at any time without penalty or impact and were able to withdraw consent for use of data up to the point of analysis of data. This was made explicit in the written consent and in the information that was given to participants prior to them agreeing to be part of the study. All data relating to an individual participant withdrawing from the study prior to data analysis would be destroyed. Those who initially expressed an interest but did not pursue participation had their data deleted when it became evident that they were not pursuing participation or once the sort was complete by the rest of the participants, approximately end of October 2018.

5.2.11 Protection of the researcher

During the study, especially in the reading of the concourse material, a large number of stories about the experiences of harmed patients were read. Additional clinical supervision was sought with my counselling supervisor as I recognised that I was beginning to become alienated from the stories, emotionally disconnected from feeling empathy and emotionally tired. Plans to mitigate this were in place and were successful including a break from analysis of approximately four weeks.

5.2.12 Preparation for the data collection phase

In September 2017 I attended a day seminar on software packages for Q methodology. This included both collection and analysis software. Data collection in Q methodology involves the P set, (participants) completing a 'Q sort' activity. The Q sort is conducted on a computer using software called 'Q sort ware' This was the preferred option as it required no data programming, was free and I had seen this demonstrated and believed that there was sufficient simplicity of use for constructing the Q sort and for participants in undertaking the sort. The decision to undertake the sorts remotely using an online package was taken predominantly for ease of access of participants. Given the specific nature of the potential individuals, who may not be able to travel to a central point, it was hoped that participation would be maximised if participants could undertake the sort in their own home. In this way participation would be open to all who could access and use a computer, and participants could undertake the sort without the researcher being present. In recognising that there was a risk to the study in relation to IT issues, it was also, in retrospect, a strength, given the wide geographical area of participants who may not have been able to participate otherwise.

The Q sort ware package was piloted in May-July 2018 by constructing a number of simple practice Q sorts in which participants ranked statements on topics such as the kind of coffee and cake they preferred. This enabled me to practice constructing the Q sort itself and to understand the experience of being a participant.

Following the pilot, the Q sort for this study was inputted ready for participants once recruited. Once participants were recruitment, their email address was inputted to the software and each person was sent a link to the sort. Clicking on the link took participants straight to the sorting activity and enabled them to commence the activity.

5.2.13 Rationale for the condition of instruction.

The Q sort is completed in response to a question called a 'condition of instruction'.

Given the research question was about what clients 'need' the condition of instruction could have been phrased in a way that asked about needs explicitly. However, because within all the statements that were collected individuals talked about the relationship between themselves and the health care professionals, the way that professionals talked or did not talk to them and how professionals used the relationship to connect or disconnect, show disapproval or indeed as we have seen in the previous chapter, contempt, it was thought that the condition of instruction should be phrased more subtly and broader to focus on their relationship with their counsellor.

Recalling the work of Brewin (2003) discussed in Chapter Four, when trauma, in this case the psychological distress of second harm is interpersonal, harm is known to be particularly traumatic. Herman (2015) in her work on trauma and recovery notes that the final stages of recovery require a reconnection with self and others. The counselling relationship is a reparative one and one that Herman believes to be key to this reconnection and the means by which reconnection happens and recovery occurs. Therefore, the condition of instruction was finally set as: ‘Following the experience of second harm, what would be important to you in the relationship with your counsellor?’

5.3 Data collection

The Q sort activity had two parts; an initial ‘rough’ sort followed by the final Q sort activity. This is usual for all Q sorts (McKeown and Thomas, 2013). The initial rough sort allows participants to manage what is often a large number of statements by doing an initial scope of what is and is not important to them generally. For the initial rough sort, on entering the software site each participant saw an instruction panel at the top of the page. See Figure 11.

The instruction panel at the top of the page contained the instructions for the sort. These instructions were kept simple and concise but sufficiently directive to enable anyone to undertake the sort. Participants also had an instruction sheet with more detailed instructions and were offered a tutorial by Skype or phone if required. One participant utilised telephone support for the sorting processes. The participants ‘dragged and dropped’ each statement into a box labelled as ‘most important’, ‘neutral, or ‘least important’ depending on how they felt about the statements in response to the condition of instruction.

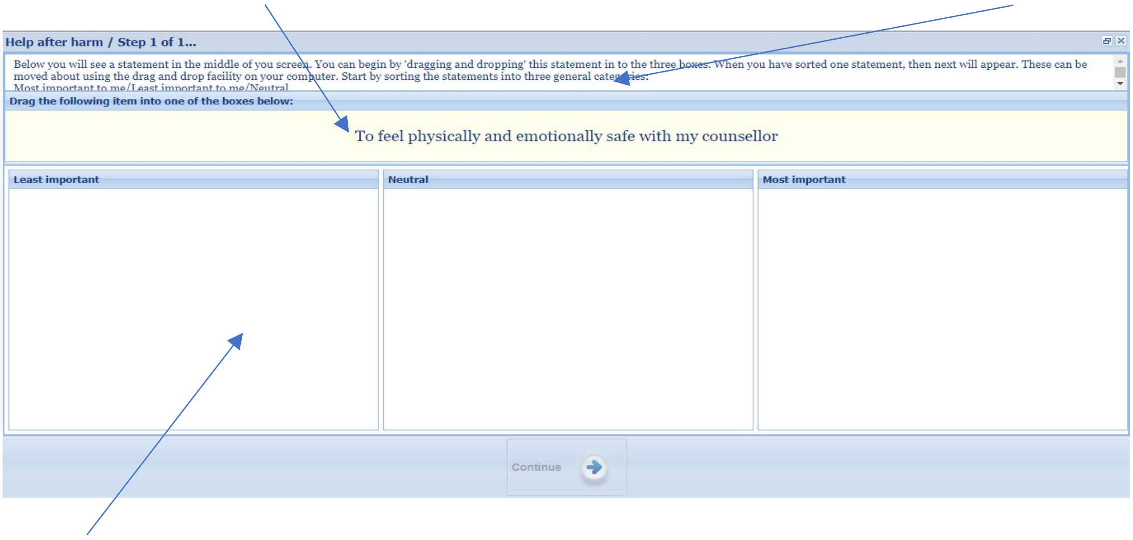
The statements to be sorted could be moved around between boxes and once a statement was ‘dropped’ the next one appeared. The participant would continue sorting each statement into one of the three boxes until all statements were sorted.

Once the rough sort was completed, the programme took the participant to the next screen to complete the main sorting activity (Figure 12).

Figure 11 Initial rough sort illustration

First statement requiring sorting

Instruction panel



Help after harm / Step 1 of 1...

Below you will see a statement in the middle of you screen. You can begin by 'dragging and dropping' this statement in to the three boxes. When you have sorted one statement, then next will appear. These can be moved about using the drag and drop facility on your computer. Start by sorting the statements into three general categories:

Most important to me/Least important to me/Neutral

Drag the following item into one of the boxes below:

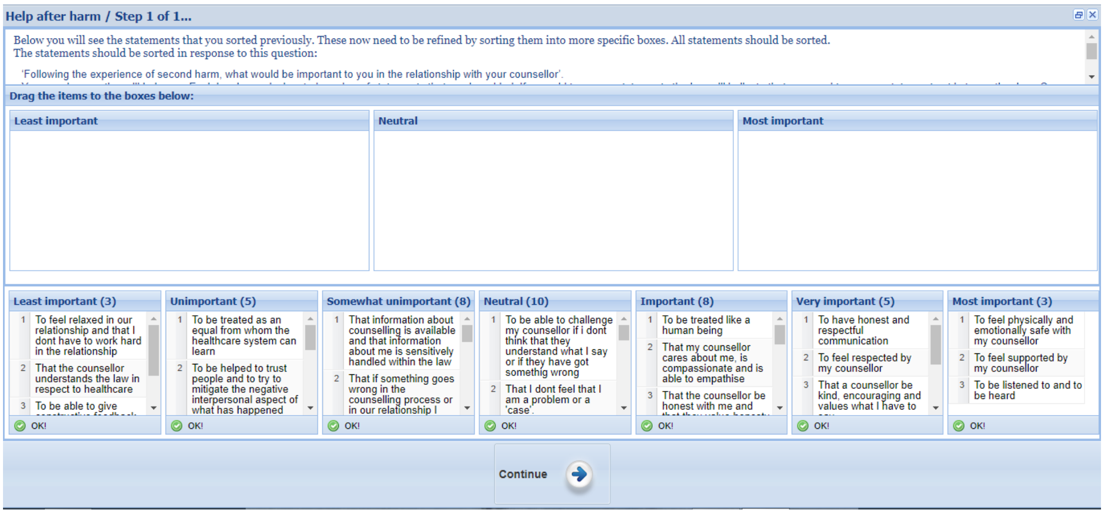
To feel physically and emotionally safe with my counsellor

Three boxes for drag and drop initial ‘rough sorting’ activity.

This next screen had the three boxes, ‘most important’, ‘neutral’, or ‘least important’ with the previously sorted statements at the top of the page, under which the seven boxes of the main sorting process were visible.

Participants are then asked to begin sorting the statements from each of the initial rough sorting boxes into the more refined seven boxes against the same condition of instruction. Again, the statements can be moved around between boxes to ensure that the participant is happy with their choice.

Figure 12 Main sort screen.



Help after harm / Step 1 of 1...

Below you will see the statements that you sorted previously. These now need to be refined by sorting them into more specific boxes. All statements should be sorted.
The statements should be sorted in response to this question:

‘Following the experience of second harm, what would be important to you in the relationship with your counsellor’.

Drag the items to the boxes below:

Least important (3)
1 To feel relaxed in our relationship and that I dont have to work hard in the relationship
2 That the counsellor understands the law in respect to healthcare
3 To be able to give

Unimportant (5)
1 To be treated as an equal from whom the healthcare system can learn
2 To be helped to trust people and to try to mitigate the negative interpersonal aspect of what has happened

Somewhat unimportant (8)
1 That information about counselling is available and that information about me is sensitively handled within the law
2 That if something goes wrong in the counselling process or in our relationship I

Neutral (10)
1 To be able to challenge my counsellor if i dont think that they understand what I say or if they have got somethig wrong
2 That I dont feel that I am a problem or a 'case'.

Important (8)
1 To be treated like a human being
2 That my counsellor cares about me, is compassionate and is able to empathise
3 That the counsellor be honest with me and

Very important (5)
1 To have honest and respectful communication
2 To feel respected by my counsellor
3 That a counsellor be kind, encouraging and values what I have to

Most important (3)
1 To feel physically and emotionally safe with my counsellor
2 To feel supported by my counsellor
3 To be listened to and to be heard

Each of these seven boxes has only a limited number of statements that can be placed in each box. This technique is called a ‘forced distribution’ and it is used in Q methodology to dissuade individuals from putting too many statements into the neutral boxes or, similarly in the very important box.

The distribution goes from negative values on the left to positive values on the right. In this study the steep distribution was considered with three statements being deemed to be ‘least important’, five being ‘unimportant’, eight being ‘somewhat important’, ten being ‘neutral’, eight being ‘important’, five ‘very important’ and three being most important’.

Once the participant was happy with the choices and all of the seven boxes had the designated number of statements in, then a green tick appeared at the bottom of the box. When participants finished the activity, a blue ‘Continue’ button appeared which they clicked after which they were requested to save their sort. Once saved, an email was sent to the researcher and the data was available for downloading.

All participants completed the sorting process, with one participant requiring help to access the live link. The link appeared to be not live when sent through a particular internet service provider. After discussion with the participant, I suggested that the link was copied into the web browser address bar. This did solve the problem and the participant was able to access the sort. Participants took between 38-50 minutes to complete the task. The data was available for analysis once the sort has been completed but analysis did not commence until January 2019 when all participants had completed the sort.

Following the sort, an email was sent thanking the participants and letting them know that the data has been received. A follow up call was requested in which a short interview would be conducted to ascertain the rationale for the sorting of the statements. Of the ten participants nine were able to complete an interview. One participant was unable to complete the interview due to personal circumstances.

5.4 The post-sort interviews

Post sort interviews with participants are a recognised step within Q methodology (Gallagher and Porock, 2010) and took place prior to interpretation of the factors. These interviews serve the purpose of enabling the data gathered via the Q sort of be better understood, to be explored to a relevant depth and therefore add to the understanding of the extracted factors as participant viewpoints (Stickl *et al.*, 2019). Of particular interest is why the participant sorted the statements in the way that they did. In this regard, post sort interviews are crucial to the correct interpretation of the sort data (Watts and Stenner, 2012).

5.4.1 Post sort interview design

The post sort interviews were designed specifically for two purposes. First, to gather data that can add to that already gathered from the factors in relation to the viewpoints of the participants, thus aiding interpretation. Secondly, to ensure that the interviews did not explore explicitly the distressing experiences of participants. To ensure that these two purposes were achieved, the interviews were kept short and succinct with no questions about the original harm that had occurred. During the initial introduction to the study most individuals revealed something about the nature of the original harm but during the post sort interviews, other than referring to specific incidents that illustrated briefly the rationale for their choices during the sort, participants did not discuss in depth the harm that had occurred and neither were they asked about it. Additionally, the post-interview questions were asked. The data gathered did serve the purpose of allowing more information to be gathered with respect to the sorting preferences of the participants and this data did elucidate the interpretation of the factors as viewpoints.

5.4.2 Limitations of the post Q sort interview design

While the interviews did meet the purpose for which they were designed, the constraints of the design, namely the concerns for participants' welfare and concern for ensuring that the interviews met the requirements of the Ethics Panel led to a perhaps shorter and less in-depth approach than was ideal. Conducting interviews over the telephone was useful in that participants did not need to travel but this also meant that relational aspect of interactions, such as body language, could not be taken into account.

5.4.3 Interview processes

The post sort interviews were recorded using a digital recorder. Participants were thanked for doing the sort and it was explained that the interview was a short interview to ascertain the rationale of statements in the Q sort activity. Participants had already seen the interview questions as part of the information given to them prior to commencing as participants. The interview began by asking them how they found the experience of doing the sort. Following that, each participant was reminded of the statements that were put in the two sections 'most important' and 'least important' (n=3 in each category) and asked about why they felt that those were the most

appropriate statements for that category. Participants were then asked about which statements they found the most difficult or easiest to sort. That concluded the short-recorded part of the interview. The three support questions were asked and not recorded.
Once the interview was over, the participant was thanked, the recording was checked and the interview transcribed. Interviews lasted between 8-12 minutes. Appendix 17 shows an example interview transcript.

5.5 Summary of chapter

This chapter discussed the method for the study including the ethical issues in undertaking this study. These were significant when considering the subject matter and the potential for ethical issues to be raised by the process. The ethical approval process, although slow, taking nearly a year to write and to gain subsequent approval, was a robust process in which the time was used effectively to reflect on the process and the needs of participants. Within this chapter the process of data gathering is described in a simple way and sets out the steps required, providing examples where appropriate. Additionally, this chapter provides a rational for the choices made by the researcher regarding these processes and sets the scene for the analysis chapter that follows.

6 Chapter Six - Data analysis

6.1 Overview of the chapter

In this chapter stage three of the process of Q methodology, the analysis, is described. This includes the consideration of the interview data that allowed for the nuances of the factors as viewpoints to be examined Section 6.2 also sets out the rationale for the decisions made to inform the analytical process and covers all the statistical steps required for analysis. Examples are presented that allow the process to be followed easily, with further data being presented in the Appendix 14-16.

In section 6.3 a discussion on quality indicators in Q methodology studies considers the rigour, reliability, credibility and reflexivity of the study and the chapter is summarised in section 6.4.

6.2 Phase Three data analysis process

Any Q methodology study has a clear trajectory of steps that must be followed for the data in order to enable data analysis and interpretation. The aim of data analysis in Q methodology studies is the extraction of factors that demonstrate participant viewpoints from the way that statements are sorted by participants. These factors are defined as common components that make up the specific viewpoints in relation to a topic.

The data analysis is not merely about a set of numbers, but also about what these numbers tell us about the participants' choices of ranking the statements. In order to go from the raw data to the recognition of viewpoints, the understanding of what the viewpoints mean, and to arrive at a coherent and useful interpretation of the viewpoints in relation to the research question, most Q methodology researchers use clear processes that are documented in the Q methodology community.

Watts and Stenner (2012) ideally recommend using Brown's 1980 text on political subjectivity as a guide but also recognise that the text is not an easy guide to follow for those who are not experienced in Q methodology. However, they do recommend that all Q methodology researchers at least read the text once they become more familiar with the process of Q methodology to enable a greater depth to the theoretical understanding and underpinning of Q methodology. Watts and Stenner themselves, in their 2012 book provide comprehensive appendices illustrating this process and these are currently the most accessible, comprehensive and clear manual available to Q methodology researchers. It is these appendices which were the guide for data analysis, along with attendance at two workshops delivered by members of the Q methodology community along with manuals for the software.

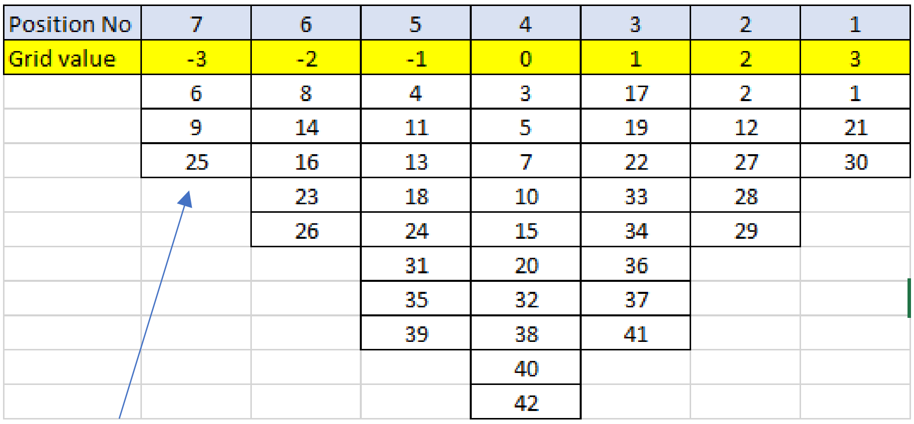
6.2.1 PQ Method data entry

The analysis software used was the ‘PQ Method version 2.5’ (March 2014), which is a free programme available to the Q methodology community. There were a number of possible options for analysis software, both free and at a cost to the researchers. The choice was governed by first being able to use the software on a windows computer, being free to use and being straightforward in data processing, for example no programming was involved in this software. PQ Method met these criteria. The software was easily downloaded and was provided with a manual and a supporting webpage. Instructions were followed to ensure that folders were named correctly and software was set up to enable input of the data from the Q sorts to be added and analysed (Schmolck, 2014).

6.2.2 Uploading of software and data entry

The data was inputted in one sitting. The parameters of the data included the number of each statements (1-42), the statement wording itself, the title of the study, the parameters of the sorting distribution (-3 to +3) and the rows required for each column (how many statements were allocated to each value when ranked). The individual Q sort data from each participant was added by entering the statement number for each ranking value in the distribution starting with the lowest ranking value to the highest. For example, the -3 ranking value which allowed three statements to be sorted as least important (Figure 13), Participant One put statements 6, 9 and 25. Each Q sort was entered separately then are saved in the data file. Figure 13 shows the Q sort data for Participant One.

Figure 13 Example Q sort data from one participant



Position No	7	6	5	4	3	2	1
Grid value	-3	-2	-1	0	1	2	3
	6	8	4	3	17	2	1
	9	14	11	5	19	12	21
	25	16	13	7	22	27	30
		23	18	10	33	28	
		26	24	15	34	29	
			31	20	36		
			35	32	37		
			39	38	41		
				40			
				42			

Statement numbers of the three statements sorted as ‘least important’

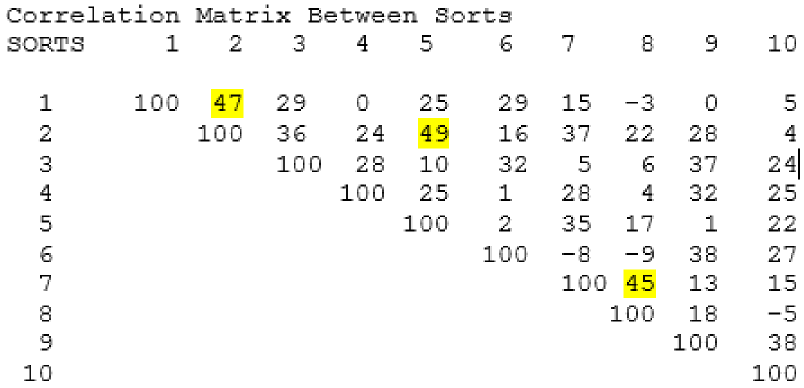
6.2.3 Generation of data sheets by the software

At this point the PQ Method software generated a set of data sheets that require explanation in order to make sense of the data in a meaningful way to enable factor interpretation.

6.2.4 The initial correlation matrix

An initial correlation matrix for the sorts was generated by the programme. This is detailed in Table 13. This matrix demonstrated the nature and extent of the relationship between all Q sorts in the study and a measure of their similarity and difference. For example, Q sort 1 had its strongest relationship with Q sort 2. Q sort 1 had no relationship at all to Q sort 4 denoted as 0, therefore the needs identified by the two participants who sorted on to these (Participant One and Participant Four) were very different and had little or nothing in common. Q sorts with a minus had a negative relationship denoted possible polarisation of opinion. This was particularly important in the factor interpretations stage. Any Q sort that had a correlation greater than 40 was significant and was shaded yellow in Table 13. It can be seen that there are three areas of note as likely significant sorts within each factor.

Table 13 Initial Correlation Matric Between Sorts



```
Correlation Matrix Between Sorts
SORTS      1    2    3    4    5     6    7    8    9   10

  1      100   47   29    0   25    29   15   -3    0    5
  2           100   36   24   49    16   37   22   28    4
  3                100   28   10    32    5    6   37   24
  4                     100   25     1   28    4   32   25
  5                          100     2   35   17    1   22
  6                                100   -8   -9   38   27
  7                                     100   45   13   15
  8                                          100   18   -5
  9                                               100   38
 10                                                    100
```

The two distinct areas of correlation (involving the relationships between sorts 2 and 1, and 2 and 5 in one area, as well as 7 and 8 in another area) gave a first suggestions as to how many potential viewpoints might be identified within the data. At this point it was not appropriate to make any real inferences, as these factors required extraction and further examination.

6.2.5 Factor extraction

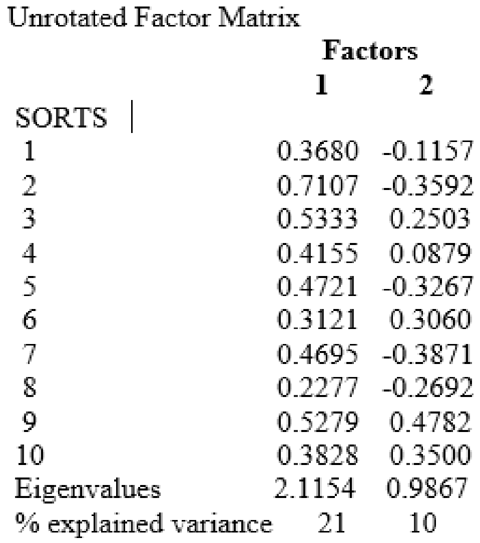
The extraction of factors was a relatively simple process for the PQMethod, and allowed the factors to be identified and what constituted factors to become evident in terms of presented data. Before the extraction takes place however, there were key decisions required by the researcher. First, the decision on how many factors requested for extraction via the software. Again, 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, four criteria were used in the decision-making process. First, for the initial request to extract factors two factors were requested. This was primarily due to the number of participants in the study as it is suggested that any study with less than 12 participants should not extract more than two factors (Watt and Stenner (2012). The programme extracted the factor with the most variance first, then looked at what is left and extracted the second, and so on. Therefore, only some factors describe sufficient variance to be statistically significant so the second criterion was to look for factors that have a Eigenvalue of 1 or more. An Eigenvalue (often written as EV) is a measurement of, in this case, statistical significance. In this study, Factor 1 had an EV of 1 or more but Factor 2 only had an EV of 0.9867. However, Factor 2 was retained as the value was so close, and also contributed to the overall picture of the data. Criterion three was that the factor should load on to two or more sorts. A factor 'loading' was determined for each Q sort, expressing the extent to which each Q sort is associated with each factor. Sorts undertaken by individuals with the similar views on an issue generally share the same factor. In relation to the Watts and Stenner criteria three, that factors should load on to two or more sorts, in this study this was true of both factors (see Table 16). Fourthly, Watts and Stenner also 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, having run the programme on day two 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 was chosen for this study. This is considered a sound option if a researcher wants more control over the process and works effectively for a small number of sorts (Brown 1980).

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. The flexibility of this approach sits well with the constructivist epistemology of this study.

At this point the programme generated what is called an unrotated factor matrix (Table 14). These factor loadings showed the extent to which each individual Q sort was associated with each of the factors following extraction. The eigenvalues and the percentage of the study variance for each factor are below. It can be seen that Factor 1ne 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 a too narrow a concourse (Brown, 2019).

Table 14 Unrotated Factor Matrix

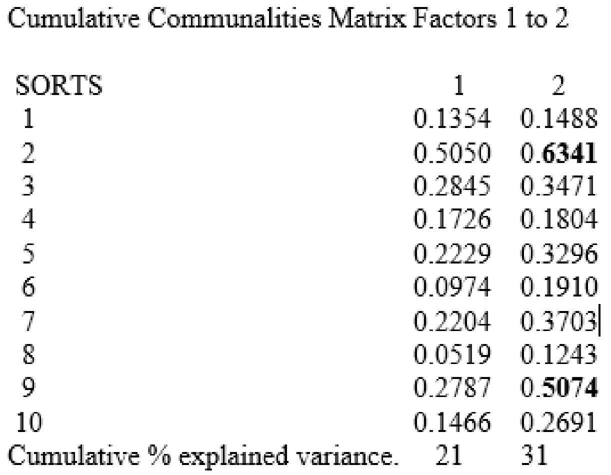


Unrotated Factor Matrix

	Factors	
	1	**2**
SORTS		
1	0.3680	-0.1157
2	0.7107	-0.3592
3	0.5333	0.2503
4	0.4155	0.0879
5	0.4721	-0.3267
6	0.3121	0.3060
7	0.4695	-0.3871
8	0.2277	-0.2692
9	0.5279	0.4782
10	0.3828	0.3500
Eigenvalues	2.1154	0.9867
% explained variance	21	10

In addition, the programme also produced a cumulative commonalities matrix by PQMethod summing the squared factor loadings of each Q sort (Table 15). The right-hand column (2) indicates how much variance in each Q sort was explained by the two factors in total, how much in common with all the other Q sorts in the study. Q sorts two and nine had a high communality (column 1) whereas Q sort 8 has a low commonality.

Table 15 Cumulative Commonalities Matrix Factors 1-2



```
Cumulative Communalities Matrix Factors 1 to 2

 SORTS                          1       2
  1                        0.1354  0.1488
  2                        0.5050  0.6341
  3                        0.2845  0.3471
  4                        0.1726  0.1804
  5                        0.2229  0.3296
  6                        0.0974  0.1910
  7                        0.2204  0.3703
  8                        0.0519  0.1243
  9                        0.2787  0.5074
  10                       0.1466  0.2691
Cumulative % explained variance.  21      31
```

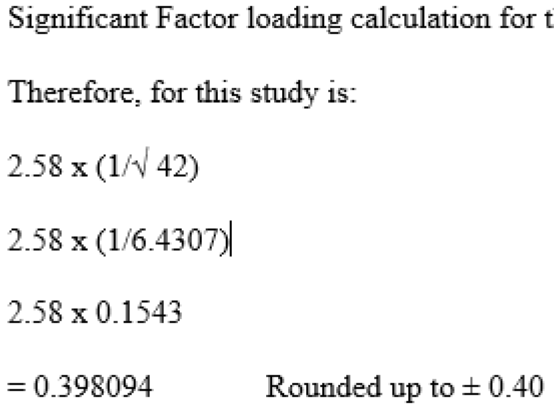
6.2.6 Factor rotation

Despite the focus of the viewpoint expressed in each Q sort, there will always be, within each factor, expressed differences. Just as, for example in a political party every member does not have exactly the same views about all aspects of politics but may broadly have a similar aim. 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 and identifiable (Kline, 2014).

The statistical programme rotated factors physically around a central axis on a graph via the varimax solution in PQMethod. This could also have been done manually. The factor loadings of both factors changed following rotation and these are provided below in Table 16. Factor rotation adds focus to the data and does not change the actual viewpoints expressed by the Q sorts (Watts and Stenner 2012). Along with a process called ‘flagging’ of the sorts, which is essentially the researchers asking the programme to take account of the highest loading sorts per factor, this enabled some clarity around the process of interpretation to be done later.

6.2.7 Factor loading

Table 16 outlines the factor loading for the two factors from this study. Each factor demonstrated a percentage of meaning with each factor loading representing a specific viewpoint that was held within an individual Q sort. The significant factor loading for the study was calculated by hand to enable consideration of which factors were significant for this study. The ‘loading’ was the extent to which each individual Q sort can be said to exemplify Factor One or Two. The equation to enable factors to be flagged was: 2.58 x (1/√ no of items (statements) in the Q set).



Significant Factor loading calculation for this study.

Therefore, for this study is:

2.58 x (1/√ 42)

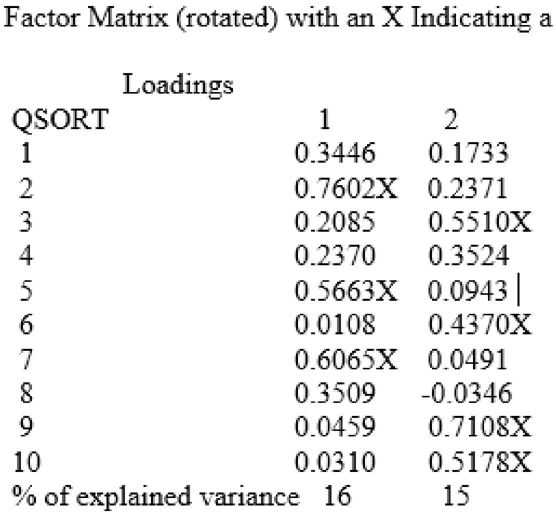
2.58 x (1/6.4307)

2.58 x 0.1543

= 0.398094 Rounded up to ± 0.40

Therefore, any Q sort that loaded as 0.40 or more was significant to this study and was ‘flagged’. This can be seen in Table 16 as having an X next to the Q sort of significance. These sorts brought additional clarity to the interpretation of the factors as participant viewpoints later on in the process. The two factors identified were associated with seven, 70% of the Q sorts in the study. No confounding factor loadings were found, those Q sorts that load significantly on to more than one factor. Three Q sorts were non-significant, not loading on to any factor specifically.

Table 16 Factor Matrix and defining sorts.



Factor Matrix (rotated) with an X Indicating a Defining Sort (flagged by x)

	Loadings	
QSORT	1	2
1	0.3446	0.1733
2	0.7602X	0.2371
3	0.2085	0.5510X
4	0.2370	0.3524
5	0.5663X	0.0943
6	0.0108	0.4370X
7	0.6065X	0.0491
8	0.3509	-0.0346
9	0.0459	0.7108X
10	0.0310	0.5178X
% of explained variance	16	15

Following the process of factor rotation and flagging, the data analysis was completed via PQ Method and a data file was prepared for review and future interpretation. A review of the data was carried out to ensure that the dataset was as expected and to ensure that all components had been included as per Watts and Stenner (2012) appendix as well as a 'sense check' to ensure that the data generally looked as would be expected for the number of factors.

The data process was relatively straightforward, but the next part of the processes was perhaps the most challenging, being able to provide some interpretation of the factors that was demonstrable and coherent. This process began by reviewing the factor arrays presented by the data for each factor.

6.2.8 Factor arrays

The PQMethod produces an array for each factor. A factor array is an exemplar Q sort that is merged to produce a single configuration of the Q-sorts of all participants who loaded significantly on a factor (Shinebourne 2008). The exemplars for this study can be seen in Appendix 14. These factor arrays aided interpretation. However, as with any statistical calculations, this would only be the case if the researchers utilises the data knowing what the data adds to the interpretation, how it was generated and why. Although PQ Method generates the data in this study, all data was used with a basic understanding of how and why it was generated and with an understanding of how this data contributes to the ultimate factors. Up to the point of factor rotation the PQ Method is predominantly producing data that makes the correlations between the data more manageable. From the point of factor rotation, the process predominately becomes about generating data in a number of ways that aids interpretation of the factors.

As well as the factor arrays the weighted score of each item in the factor array was calculated. This used all the significantly loading individual Q sorts for that factor and converted the score into a Z score that in effect measured the amount of weight the researchers should give to each statement when considering the factor array. If this is done by hand, then the researcher can choose the individual sorts to include if done by the PQ Method programme, as in this study, the flagged Q sorts are used (Watts and Stenner 2012). The Z scores are set out in rank order and add to the interpretation of the factor aiding in the consideration of which statements really matter in the generation of factor descriptions which is the next step in the data interpretation.

6.2.9 Interpretation of factors into viewpoints via the crib sheet method

The aim of interpretation of the factors was to enable a sound explanation of the viewpoint that make up that factor. Two different factors were identified, not from the statements per se but from the specific pattern of sorting that was done by the P set. Participants had different viewpoints about the statements and it was the nuances of these viewpoints that were articulated in the factors and reflected in the viewpoint descriptions.

Clear guidance on how to interpret the 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 (See Appendix 15 and 16), 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. In approaching the interpretation, the items ranked the highest are noted. However, there was also recognition that the items ranked towards the middle may not necessarily denote neutrality, but may indicate a specific point of agreements across the sorts and therefore may influence the view significantly. Additionally, those items that were sorted as least important could support the view of what was important in that viewpoint or indeed within another viewpoint. It is not unknown for one viewpoint to be the reverse of another and thus consideration of whether the viewpoints needed to be combined as one would happen in these cases.

Having considered the placing of each individual statement carefully and its importance in structuring the potential viewpoint, the viewpoint expressed in that factor was written out. These can be found in section 7.3.1 and 7.3.2. This was essentially a description of the viewpoints and meant writing and rewriting descriptions as the work progresses. The descriptions were written and some time was taken for reflection, rewriting and more reflection prior to undertaking the analysis of the interview data. The analysis of the interview data then informed the later viewpoint descriptions. Post-sort interview added further insight and enabled an in depth understanding of the viewpoints.

6.2.10 The process and purpose of analysis of the 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 is taken to how the interview data is described. This includes discussion of different '*discourses*' (Excel and Graaf 2005) or '*categories*' (Gallagher and Porock 2010), that are described as being used to '*inform, support or challenge'* (Ahmed *et al* 2012 p999), although the process of how this is done is not explored in detail in most Q methodology studies as the focus is on the centrality of the viewpoints.

Initially a decision was taken to undertake a more traditional analysis which aligned well to the constructivist epistemology of this study. This analysis was beneficial as it facilitated an in-depth understanding on this data. However, this in-depth analysis was at odds with the methods of Q methodology and emphasis on this data, and its interpretation, detracted from the viewpoints instead of adding insight to them. Therefore, in the final writing of the findings chapter, Chapter Seven, a more traditional approach congruent with contemporary Q methodology was used which uses the interview data to deepen understanding of the viewpoints identified from the factor analysis.

6.2.11 Transcribing the data

The audio recording was transcribed verbatim, a process completed by myself to ensure confidentiality of the data. A Word file was created for each interview with space at the margin to record initial comments. Data that elucidated the viewpoints was underlined and linked specifically to the numbered sorting statements that had been sorted by that participant. The purpose of the interviews was to specifically look at the issues for each participant in relation to the positioning of the sorted statement. Therefore, care was taken to ensure that the comment noted related to what was said in respect of the sorted statement itself.

6.3 Rigour, reliability, credibility and reflexivity – quality indicators in Q methodology

In Chapter Three it was debated whether Q methodology was a qualitative, quantitative or mixed methods approach, arriving at the conclusion that it was mixed methods (Newman and Ramlo, 2010). In making that case however, there needed to be a robust demonstration of credibility around both the numerical data and the qualitative data within the study. As a mixed method approach quality would be judged through demonstrating rigour; the thoroughness and careful process of the study, and reliability; the trustworthiness and credibility of the data and the processes, ensures that a study is credible, in other words is convincing and believable. Onwuegbuzie and Poth, (2016) propose extensive evidence-based guidelines that can be used to review mixed method studies and these detailed criteria encompass the above expectations of rigour, reliability and credibility.

6.3.1 A robust concourse framework demonstrating rigour

Rigour is demonstrated by the thoroughness and consistency of the researcher's methods over the course of the study (Howell, 2013). The most challenging aspect in which to demonstrate rigour in this study was the review of the concourse and the generation of the Q sort. The tools used, the framework and the criteria for inclusion of the concourse material were discussed in Chapter Four. These tools helped to guide the generation of the concourse material the construction and management on the concourse and as a means to demonstrate transparency and to ensure diversity and breadth of material that would demonstrate the full concourse. This was opportunistically confirmed by the discussions with some participants who indicated that they felt that the statements covered the experiences of those who have been subject of second harm. In addition to these discussions, a number of in-depth experiences of second harm that had been documented in the form of books were re-read as 'test cases' or comparisons and used to further check that the statements were representative of the viewpoints of the concourse.

6.3.2 Data predictability demonstrating reliability

Reliability was demonstrated by the stability of the data or process over time (Howell 2013). In the case of the reliability of data and data collection methods within this study, erroneous data or incorrect operating procedures would not have produced what would be expected. Q methodology does have certain parameters around expectations of the data, for example how many factors might be relevant. These operations were measured statistically to identify what is significant as well as being 'sense checked' about what logically seems right. For this study, Watts and Stenner's *Q Methodology* (2012) provided a comprehensive guide to all data management and processes including the management of sorts, data handling and interpretation. In summary, along with knowledge gained from within the Q methodology community and via the Q methodology discussion forum, aspects of the process have been checked with literature, with the statistical packages of QSortWare and PQ Method and sense checked.

6.3.3 Data corroboration demonstrating reliability

Reliability of the data collected from the sort was also enhanced by the second set of data collected via the post-sort interviews. The post-sort interview data was used to corroborate or challenge understanding of the viewpoints extrapolated from the factor analysis. This process added depth, rigour and reliability of the to the final viewpoints reached.

6.3.4 Use of the 'crib sheet' method to demonstrate transparency and reliability

Reliability and transparency of the interpretation was demonstrated by using the 'Crib sheet' method (Watts and Stenner 2012). This method grouped together the relevant data that needs to be considered when undertaking the analysis. Again, the analysis was corroborated with the information gained during the participant interviews, the data within the viewpoints, the literature review and additional literature that supported the findings that relate to counselling, harm, and individual experiences of second harm. Robust processes and demonstrable reliability makes this research study credible, in other words believable and authentic. This includes a transparency with regard to limitations, errors and lack of results. These aspects are discussed in future chapters.

6.3.5 Recognition of the impact of the researcher on the data as a means to demonstrate transparency.

As well as a sound methodology and indeed as part of it, the researcher needs to be clear about her own part in the construction of the data, and her own processes that shaped the research and the interpretation. Reflexivity is required in order to ensure that personal opinions are not assimilated into the research in a way that biases the findings. Malterud, (2001) recognises that the researcher themselves will impact the process of the research and that this cannot be avoided. A recognition of the input of the researcher, their experiences and even their ideas and how this influences the process, findings and discussion needs to be evident. This study is a complex one and as a researcher, a counsellor and a nurse, I anticipated that these perspectives impacted upon engagement with the data. The anticipation was that the aspects of the study that were most challenging would be those which were unfamiliar, such as the use of the two software programmes and the ethical approval process. However, while these were indeed challenging, the most significant impact on the process was the reading of the concourse.

6.4 Summary of the chapter

Within this chapter the process and principles of the data analysis for this study has been presented. The analysis of the Q sort data followed a well recognised method and log of procedures. Even so these processes relied on the understanding of the researcher to make key decisions, such as the number of factors to extract, in order to make the numerical data both useful and coherent. Clear steps were set out in the analytical process and having analysed the data, the next chapter, goes on to present Stage 4 of Q methodology; findings and the interpretation of data.

7 Chapter Seven - Findings and interpretation

7.1 Overview of the chapter

This important chapter sits as a means by which the findings and a coherent interpretation are presented prior to the main discussion in Chapter Eight. Section 7.2 begins with the development of the descriptive statement names given to the viewpoints. Section 7.3 goes on to review the findings from the viewpoints and interpretation of the Q sort data with direct quotes from the post-sort interviews which deepen understanding of the viewpoints. In section 7.4 the process by which needs were identified from the viewpoints is discussed. This process is one that is consistent with Q methodology processes but does require a short explanation. The chapter is summarised in section 7.5

7.2 Stage Four – Data Interpretation

7.2.1 Descriptive statement names

In the early stages of the Q methodology process factors were identified numerically i.e. 1 and 2. As the process moved on these were assigned descriptive names that illustrated what the factor was about. The factors became viewpoints through a process of assigning appropriate descriptive names indicative of their meaning and interpretation. Watts and Stenner (2012) suggest that this is a means of giving the viewpoints an identity that readers can remember. The names captured the thrust of what is encapsulated in the viewpoints and were not too long or complex. The names for the viewpoints in this study were certainly challenging but there seemed little point in naming the viewpoints too early prior to the process of reflection and analysis of the interview transcripts. Following the gathering of all the data the following names were decided:
Viewpoint 1 - Needs that are both past and present focused: being understood.
Viewpoint 2 – Needs that are both present and recovery focused: making me well.
These seemed to best capture the essence of each viewpoint.

7.2.2 Interpretation of the viewpoints

Interpretation of the viewpoints, including the naming of them, is perhaps one of the most challenging parts of the study. The difference in the two viewpoints in relation to time focus was striking and this aspect of the viewpoints heavily influenced the needs discussed. This aspect of the study, more than any other, related to the real experience of individuals and felt more qualitative in nature than some aspects of data analysis. The interpretative process was a complex one and took several sessions of reading and considering possibilities that involved fitting together all the pieces from each interview, considering the Q sorts and the rationale for each placing of a statement as well as the integration of the two sets of data for a holistic perspective.

7.3 Findings from the viewpoints.

The viewpoints are described below with the statement number and the place in which the statement was ranked in each factor array. For example (30: +3) means that statement 30 (see Appendix 3) was sorted in the +3 position, 'most important' position. However, it is important to recognise, when considering viewpoints, that the ranked importance of a statement by one individual or even within a viewpoint, is often relative to the ranking of that statement within the other viewpoint. For example, one statement ranked at -1 may not be important per se but may be more important than the same statement in another viewpoint that was ranked at -2. Section 7.3.1 onwards cites direct quotes and refers to participants by number (i.e. P1). A page number is also provided denoting the page of interview transcript in which the quote originates.

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

Viewpoint 1 had an eigenvalue of 2.12 and explained 21% of the study variance. Three participants were significantly associated with this viewpoint. Two of those were female, one male. During the initial telephone call these participants indicated that the time period ranged from 20 to five years ago. All have suffered varying degrees of distress, anger and psychological disturbances, as a result of the response of healthcare settings to the harm and the issues raised. Settings include one mental health setting, and two acute settings.

A sense of wanting to know and understand about the possibilities of what happened to them comes across from this viewpoint as a specific need (30: +3). Additionally, a need for a two-way honest and particularly respectful communication and dialogue in the exploration of those possibilities with a counsellor is clearly articulated as a need for these participants.

In the process of making sense it was recognised that the client would have to be honest about what had happened to them as a means to help the recovery journey move along, and to 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'* (P2 Page 1).

The need to be listened to and to be heard (33: +3), to ‘talk out’ their experiences without feeling that they were judged (28: +2) is articulated as part of the need for respectful and honest communication in the viewpoint. Participants were less worried about the counsellor understanding the enormity of what happened to them. Aspects of the sense of enormity about what happened are articulated in statement 41 (-1), statement 32 (-1), and 24 (-2), and these are not ranked highly. Participants were clear that they saw the ability to be heard and for what they had said to be valued by somebody who was kind and encouraging (34: +2) equated with being treated as a human being (5: +2) and this was more important to them than the counsellor understanding the enormity of their experience. This further explanation from the participants interviews deepened understanding of the need for respectful and honest communication.

Core values, such as honesty in the counselling relationship, were identified as a specific need by participants and were seen as adding to the relationship with the counsellor (17: + 2**).** Three participants on viewpoint 1 suggested that there was already an assumption of core values and ethical working. As this assumption was also held by one participant whose sort loaded on to viewpoint 2 and one onto neither viewpoint, this suggests that this assumption was not viewpoint specific. Participants were not necessarily aware of ethical frameworks, policies and procedures but held an underlying assumption that counsellors would behave in a particular manner or that if ethical practices were not adhered to then it would be particularly surprising. 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, a sense that this is how counsellors worked.

> *I do get why that’s important……Didn’t know they had policies really. …in my brief experience of counsellors, they don’t tend to, you know, wield an unnecessary amount of power. This is just something I wouldn’t expect to be an issue.* (P2 Page 2).
>
> ‘*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?’* (P5 page 2).

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'* (P7 page 1).

Although across both viewpoints no participant felt it was important for the counsellor to have legal knowledge or expertise the statement that asked about the need for a client to feel that they could be emotionally supported through the legal process was always ranking higher. However, participants were clear that they needed counsellors who support those going through an experience of harm and second harm to have an understanding of the trauma of the process and impact of going through the legal process Individuals that choose the route of undergoing a complaint or a litigation process often do refer to the situation as a 'fight' that is difficult, or as participant 5 called it:

> *'harrowing and traumatising'* (P5, page 1).

Often, this *'fight'* constitutes a search for answers as a means to understanding of what happened and may not really be focused on actual litigation, but may be an attempt, albeit acrimonious to have some sort of dialogue with a care provider that has disengaged with discussion about what happened.

The counselling relationship is expected to be one that is characterised predominantly by care, compassion, and empathy (22: +1). Other aspects of the relationship were seen as less important including perceived intrinsic value that the counsellor holds toward the client (4: 0), transparency (18: 0) empowerment (21: 0), lack of threat (36: 0) or deception (16: 0), all of which rank relatively low. Also ranked as low are the negative aspects of counselling; the sense of the ability of the client to challenge the counsellor (25: -1), a sense that they are just one more 'case' (26: -1), or that the counselling relationship is more important than demonstrating an outcome (39: -1).

As well as recognising the values that clients need to see demonstrated in the room, there is also a recognition of clear boundaries and understanding about what participants are happy to trust counsellors with.

> *'all of those things are about confidence in your counsellor. It's about trust really'* (P2 page 1).

Participants did not feel the need to be concerned about feeling of equal value to counsellors (35: -3), being part of decision-making about their psychological care (38: -3), or having any sense that the counsellor needs to understand the legal system (9: -1), or indeed the legal process (8: -3). Participants do not feel particularly concerned that counsellors need to be accountable for their actions (19: -1), or that they need reassurance that policies and procedures will be adhered to (23: -2).

> *'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'* (P2 Page 1).

Neither do participants feel uncomfortable about talking with counsellors about strong and difficult feelings (11: -2), or about being judged in relation to those feelings (31: -2). They do not feel that they need to be concerned about having any 'no go areas' (14: 0) or about experience being believed and validated (37: 0). This articulates a need for participants to feel that the counsellor can be with them and their feelings comfortably enabling a safe space for their relationship.

> *'Number one was to feel physically and emotionally safe, which just means that I could feel happy to say anything I needed to say* '(P2 page 1).

Given this sense of feeling comfortable with counsellors and that feeling physically and emotionally safe with the counsellor is relatively important (1: +2), it is surprising therefore that support in general ranks lower than one might expect (2: +1) as does how the counsellor can support an individual to have a different relationship with the healthcare system in the future (13: +1), (10: +1).For this viewpoint there is a sense of needing to start the journey by gaining some understanding if possible or to be understood. Once participant referred to recovery as being something that you '*just have to get on with'* (P7 page 2) was very much evident in this viewpoint. However, there is also a sense of looking back into the past for understanding.

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

Viewpoint 2 has an eigenvalue of 0.99 and explains 10% of the study variance. Four participants are significantly associated with this viewpoint. All are female. During the initial telephone call these participants indicated that the time period ranged from a decade ago to four years ago. All had suffered life changing psychological impacts as result of the response of healthcare settings to a complaint, and in one case a death, in an acute setting.

This viewpoint most highly placed items denote a need for participants to be safe (1: +3), supported (2: +3), believed, and validated (37: +3). 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 any counsellors 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'* (P10 Page 1)

Participants did not want to be engaged with as if they were a problem (26: +2), but they did want their experience of harm validated (41: +2) rather than merely an opportunity to 'talk it out', and wanted the counsellor to understand the enormity of what happened to them (32: +2).

In this viewpoint participants wanted to explore the difficult terrain of emotions but were willing to go further than in viewpoint 1 (14: +2) both in depth of exploration of their own emotions and the impact of what happened (27: +1) although they were not at all concerned about being seen as betraying the NHS or wanting blame or retribution. The participants that loaded significantly on to this viewpoint had life changing events happen and seems 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 (33: +2) and have a counsellor that is kind, encouraging, values what they had to say (34: +1) and treats them with humanity (5: 0) but there is a sense that participants who had this viewpoint are less concerned about what the counsellor thought of them (28: +1), (6: 0), (17: 0), and (22: 0) (4: -1), (20: -1) were more focused on validation, recognition and working towards recovery.

Two participants identified having a sense of powerlessness yet being in a good place to challenge as a result of what had happened to them in the past, having gained confidence but also in some sense, not allowing the situation to happen again. This emerged as a set of statements that participants did not rate highly, predominantly because they would be happy to challenge now.

> '*I had to challenge quite a bit because doctors, high profile consultants would meet with us and we would think we would get a chance to ask then them questions and they would say 'We will be asking the questions. They just told us what happened, they didn't expect us to ask anything and their response was that the questions were theirs to ask not ours. But how would they know what we needed and what questions to ask. So we have to challenge them'* (P9 Page 2).

Viewpoint 2 participants seemed to want to take some control over the counselling process, more so than in viewpoint 1 (25: +1), (38: +1) (39: 0). This viewpoint also wanted counselling to be more contextualised: for example, at a need for some recognition of the impact for clients going through a legal process (8: 0) and a need to recognise that the client may be going through existential issues that emerged in the counselling room (24: -1). Within that, there was a sense of disengagement that ranks engagement and consideration of future choices in health as being low in priority (10: 0) (13: 0).

The participants ranked the working practices of the counsellor not particularly highly, for example the issues of counsellors following policies and procedures (23: -3).

One participant on viewpoint 2 suggested that there was already the assumption of core values and ethical working in relation to their narrative of what happened being believed. The participant cited negative experiences with others as a reason for this need for fundamental values and a sense of 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* (P6 page 2).

Similarly, participants with this viewpoint did not value a non-threatening relationship with a counsellor highly (36: -1) or the need for the counsellor to be honest if something went wrong (16: -1), use constructive feedback usefully (18: -1) or to be accountable for their actions (19: -2). However, neither did participants expect a counsellor to help then feel empowered (21: -2), understand aspects of the law (9: -2) or, perhaps rather surprisingly, did not feel that there is a need to explore the possibilities about what happened to them, which is in stark contrast to viewpoint 1 (30: -2).

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 helps people keep going until they can '*fall apar*t' when it feels safe for them to do so (P3 page 3),

> *'I had to try to hang on so that I looked as though I was managing and coping with my work… I've made so much more progress in counselling in the last couple of years because I have been able to fall to bits during my time off'* (P3 page 3).

The specific need to know about counselling, accessing services and coming to counselling was identified by four participants in viewpoint 2 who felt that counselling helped them move forward in a number of ways. However, one participant whose sort loaded on to neither viewpoint also mentioned this theme in their interview. 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.

> '*The most important thing to me in counselling was it was delayed, {..}.and that there was the funding issue between regions, as well as the fact there were no counsellors in the centre in {region} which I think is absolutely disgusting. Every {specific disability} would need to have access to a counsellor and that doesn't help because it means that the way you feel is more entrenched'* (P3 Page 2).

> '*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*' (P10 Page 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 is again not viewpoint specific. All those that referred to the process agreed that it was long, exhausting and often hindered the process of recovery. For those who complain, the process may involve considerable energy and focus at a time when they have neither, but for those who turn to litigation, the process is viewed as being designed to demoralise, deter people from undertaking the process or to 'wear down' potential claimants. The impact of consistent and constant adversarial processes impact upon the lives of clients in a negative manner. One participant whose sort loaded on the viewpoint 2 summed up how this was for her, a common experience among those who take this route.

> '*I couldn't deal with getting statements back and all that stuff it was just so difficult to do. 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{..}You got this constant reminder, that you really were having to go back over and over again. It's so negative, you have to go over all the negative stuff that you can't do any more, you know, it was incredibly difficult. {..} I felt so awful{..}you very quickly become tired in the process and are not are able to fight, and I was surprised how quickly I felt like that. I didn't want to fight much more (*P3 page 2).

This common experience of a 'fight' came through in the interviews, informing the viewpoints and in the statement pack drawn from the many stories within the concourse. 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 within their lives and indeed to seek change as a means to recovery and to come to terms what happened to them.

7.4 Identification of needs from the viewpoints

The 42 statements that derived from the concourse material demonstrated what clients might perceived their needs to be when coming to counselling for second harm. Eleven needs were specifically identified from within viewpoints. These can be seen in Table 17.
These needs were identified by using two particular methods common to Q methodology.
First, by utilising the crib sheet method suggested by Watts and Stenner (2012) which clearly demonstrates the statement ranking, in this case the identified need, within each viewpoint (Appendices 15 and 16).
Secondly, the needs were identified by utilising the factor arrays compiled from the factors which show the exemplars of each factor and where each statement would be ranked in a sort that demonstrates the actual viewpoint (Appendix 14).
Additionally, as is sometime common in Q methodology, the needs were discussed in the interview data, which provided more information as to why these needs were important to participants and thus allowing for a more in depth understanding of the viewpoints and confirming

the importance of the needs identified within them. This data also provided some important contextual information.

Table 17 An overview of the needs

1. A need for respect
2. A need for the counsellor to sit with them in their experience and not feel alone
3. The need for ethical working practices
4. The need to make sense of what happened
5. The need to understand, be understood and helped cope with change and impact
6. The need to use counselling as a means to recover
7. The need to regain control, power autonomy
8. The need for access to appropriate counselling
9. The need to develop competency in accessing and engaging with counselling
10. A need for participants to not be blamed for what happened
11. A need to have the counsellor understand the impact of the harm and the complaints and litigation system including issues of control, power, and autonomy

7.5 Summary of chapter

This chapter discussed the findings of the study which were; two distinct viewpoints identified from the Q sorts.

The viewpoints were described in the traditional Q methodology manner utilising a narrative description taken from the crib sheet. The interview data was used to elucidate the description with examples to help the reader understand more fully the descriptions of the themes. The interview data added to the data from the Q sort allows the understanding of the viewpoints to be more nuanced and to enable a rationale for points of view began to emerge and a sense of human experience come from the viewpoints. From within the viewpoints 11 needs were identified as being pertinent to this study. This chapter leads into the discussion in Chapter Eight.

8 Chapter Eight - Discussion

8.1 Overview the chapter

The chapter draws together the findings of this study, the context of second harm as defined from the concourse review and the wider context of counselling needs as discussed in Chapter Two, the literature review. This chapter will do two things to enable the study objectives to be met. First, it will make judgements about what has been learnt from the study, and secondly, explain the relevance, impact and meaning of the study. In doing so, the findings will be interpreted in a meaningful way for the reader prior to the conclusion. This chapter commences in section 8.2 and introduction to the discussion. Section 8.3 presents the discussion of the findings with respect to the perceived needs that are common to individuals coming to counselling while section 8.4 discusses the findings with respect to the perceived needs unique to those coming to counselling for second harm. Section 8.5 considers the context of harmed patient needs by exploring the beliefs and assumptions expressed within the study by participants. Section 8.6 goes on to consider the potential gap in knowledge about second harm that counsellors may have and that has been identified within the study as being key to what participants needed to be confident in a sound therapeutic relationship. Section 8.7 considers the limitations of the study and in section 8.8 a critique of the study is offered. A review of the original and new knowledge contributed by this study is undertaken in section 8.9. The dissemination strategy and potential outputs are discussed in section 8.10 which includes my self-development towards being an independent researcher. A summary concludes this chapter in section 8.11.

8.2 Introduction to the discussion

The study identified two viewpoints relating to what clients said they needed coming to counselling following an experience of second harm; ‘Needs that are both past and present focused: being understood’ and ‘Needs that are both present and recovery focused: making me well’. From within these viewpoints 11 needs were identified as perceived as being important for clients coming to counselling for second harm (table 17).

Participants identified needs within the two viewpoints but given that there is at present no academic literature that discusses counselling for second harm these findings cannot be contextualised in wider academic literature around second harm. However, setting these findings within the wider counselling literature on the needs of clients coming to counselling for issues other than second harm provides a context within which these needs can be explored, and similarities and differences identified.

While most of the needs from this study are discussed in the wider counselling literature, this literature does not illuminate all the needs identified and yet data in this study identified the importance of additional needs in people who attend counselling for second harm. This distinction suggests there are needs that are generic and needs which are specific. These needs are considered under this distinction providing the opportunity to address the objectives of the study.

8.3 Needs that are common to individuals coming to counselling

To address the first objective of the study consideration should be given to how this Q methodology study has advanced understanding of needs that are common, or generic, that are shared with the wider client base accessing counselling for other reasons than second harm. The wider counselling literature reviewed in in Chapter Two of this study identified eight broad needs as themes including autonomy, relatedness, outcomes for recovery: competence, self-actualisation, safety, direction and self-esteem of those coming to counselling generally.

Considering the needs identified in the data for this study for those coming to counselling for second harm, there are many needs that are held in common with those expressed in the counselling literature in Chapter Two. 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 person-centred therapeutic environment where the needs of their clients can be met (BACP 2019). 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 are discussed in the wider counselling literature as demonstrated in Chapter Two. The expectation therefore is that for these needs to be met, clients could access any trained counsellor to work with.

The needs identified as common had three foci; the need for core values in the counselling work, needs for the journey to recovery and needs in accessing and coming to counselling.

8.3.1 The need for core values in counselling work

The needs that focused on core values were the most evident from the two viewpoints and were complex in how participants articulated these, being different within the two viewpoints. These differences underpinned the different perspectives of the two viewpoints and shed some light on the perspectives of participants and their views on their needs when coming to counselling. There were three consensus statements that related to core values and ethics that participants agreed upon and were articulated in the statements and interviews as: a need for respect, a need for the counsellor to sit with them in their experience and not feel alone and a need for ethical working practices.

8.3.1.1 A need for respect

For many individuals, a lack of respect from their health care providers was a recurring theme from the concourse and from the data an important need from the counselling relationship.
This need for respect extended to the need for respect both from others and for themselves. Clients who come to counselling after second harm exhibit, as many clients who have experienced a traumatic event do, have a sense of guilt and self-blame often questioning whether they could have done more to avert the situation. A lack of self-compassion and self-respect is often evident as well as a plethora of difficult and sometimes destructive feelings. Those who experience trauma often had a loss of identity, and a significant change in their beliefs about the world, including a loss of a sense of safety (Brewin, 2003). It is the repair of this sense of self and connection with others and a new self that is the basis for the need for respect. These difficult feelings inevitably impacted on how they felt about themselves and how they believed others saw them, including those close to them. The work of therapy is so often about finding new sense of self with which to face the present and future. This complex work requires significant support and a trusting relationship. In viewpoint 1 support was ranked significantly lower than viewpoint 2 but the relational aspects of needs in viewpoint 1 was articulated in the top two most highly ranked statements, which again links with the need for respect in seeking honest and respectful communication, being listened to and being heard.

8.3.1.2 A need for the counsellor to sit with them in their experience and not feel alone

Those participants that loaded on to viewpoint 1, also ranked aspects such as kindness, encouragement and being treated as a human being as being important. It becomes evident that those participants needed to be related to as a human being and it was the ability of the counsellor to ‘sit’ with a client and to value their human experience that would help clients to feel as though they are not alone and have some human connection where there had been disconnection.

Every modality trains counsellors to be able to acknowledge and cope with the feelings that emerge during sessions with clients, to develop a sense of when to speak and when to use silence as well as other techniques often depending on the modality employed. This sense of being with a client and sharing a deep connection, even in silence, is referred to by counsellors as relational depth was what participants mean when talking about the counsellor sitting ‘with’ a client, connecting with their difficult feelings and not being alone (Knox *et al.*, 2013).

This was supported in the data from interviews that talks about the importance of the additional core values of compassion and empathy as well as an expectation that was implicit within most modalities that demonstrates the ‘organismic valuing’ of the client; the valuing of an individual as worthy and valued for their true selves with all their faults and flaws (Rogers, 1951).

This sense that organismic valuing should be demonstrated by the counsellor seemed to contradict the fact that in viewpoint 1 participants did not rate highly the perceived intrinsic value that the counsellor might hold towards the client, the ability of the counsellor to facilitate empowerment and, despite rating safety highly, participants felt that they were unconcerned about ensuring a lack of threat or deception. Participants did not rate some aspects of how they related to the counsellor as being important. These aspects were predominantly connected to the personal relationship between client and counsellor, such as the ability to challenge the counsellor, whether the counsellor saw them as a case, the importance of the counselling relationship over the outcome of the process, being of equal value to the counsellor or part of the decision-making process about care. This sense of almost having a depersonalised relationship gave some cautious distance between the counsellor and the client, almost as if they had gone past the stage of needing that from the counsellor but required other things as discussed above. This cautious distance might be accounted for by what Herman calls ‘backing away’ when a client is uncertain about how the counsellor will respond to details of their experience and is navigating between the need to share the details to enable exploration and relational depth, and the concern of voyeurism and distressing the counsellor (Herman 2015). The initial negotiation of the relationship in relation to what can be shared and how, the response of the therapist and the congruence of the process is therefore important in establishing a sound and safe relationship.

In viewpoint 2, as well as participants having highly ranked being '*believed and validated'*, which was relevant to relatedness and being isolated, participants also highly ranked '*the need for the counsellor to understanding the enormity of what happened'* and '*the need for support'*. There was a clear indication that support was a distinct need identified by these participants. However, different kinds of support are indicated to the support required by the participants whose sorts loaded on to viewpoint 1. From the interviews the data suggests that the support required in viewpoint 2 was to 'keep going' (P 3), to manage complexity and loss (P6). This support was to maintain functionality, and for getting through life, not just for managing difficult emotions, but all aspects of the initial harm and second harm. This links well with Herman's stages of remembrance and mourning and reconnection (Herman 2015) Being supported to look back and remember, to be accompanied in those difficult emotions by a counsellor, and to have a safe place to process emotion, mourn if necessary and make moves to reconnect sits well with the experiences of keeping going and managing complexity and loss talked about by participants.

These were seen as being core values, not just because that is what is expected of counsellors but also, for these participants these values were not displayed to participants during the initial harm and subsequent interaction with healthcare providers. Fundamentally, it was these core values that helped clients establish trust and therefore develop a safe relationship from which the second harm was viewed, whereby the individual was heard and not judged. Once a relationship of this nature had been established, clients felt it would be safe to explore their other needs.

8.3.1.3 The need for ethical working practices

Similar to the need for counsellors to have core values was the need for counsellors to be ethical. Between the two viewpoints there were significant differences and this included some of the values that counsellors traditionally believe promotes an ethical counselling environment. For example, viewpoint 1 participants and viewpoint 2 participants did not rate highly the need for sound working practices of counsellors for example; following policies and procedures. Similarly, both viewpoints did not rate ethical values as being important. From the analysis of the data, this lack of emphasis on ethical values that is so highly regarded by counsellors themselves and was a recurring theme in for example the work of Rogers (1951), might seem an anomaly. However, from the interview data it appeared that participants had an expectation that counsellors already behaved ethically towards the client, had the ability to provide a constructive and encouraging place and encourage their client to be themselves holding their client in a safe relationship. It seems that participants did not rank these things highly because they made an assumption that they existed already despite having experienced unprofessional behaviors and attitudes from other professionals. In the interviews one participant expressed surprise that these values were even included as she was very clear that this was an assumption. This was also supported by other participants.

The low ranking of features which might be described as ‘ethical’ or ‘values based’ across both viewpoints such as demonstrating worth, empowerment and transparency at first appeared surprising for a counselling relationship given that, for example in the literature review, counselling ethics and values were seen as being important. The interview data clearly added some context to this with participants saying that the ethical and values base of counsellors was for them a ‘given’.

8.3.2 Needs for the journey to recovery

Recovery is deeply personal and individuals who comes to counselling may hope for this as a specific outcome as seen in the wider counselling literature in Chapter Two. The need for counsellors to support what is needed for the journey to recovery came through in both viewpoints with participants needing support to: make sense of what had happened to them, understand and cope with change and impact and utilise counselling as a means towards recovery.

8.3.2.1 The need to make sense of what happened

The opportunity to start the journey with someone who can ‘hear’ what is said comes through strongly in the data, whether the harm was relatively recent or was a while ago. However, the opportunity to be heard seems to have a different purpose for participants whose Q sorts loaded on to the two viewpoints. For viewpoint 1 participants the purpose of being heard was to be listened to. The data suggests that this might be important in beginning to explore what happened to them, whereas in viewpoint 2, the data suggests that the purpose was validation and being believed. It was at this level that differences become evident in the viewpoints that suggest that process might be similar but purpose may be different between the two viewpoints. From the data we already know that viewpoint 1 participants want the counsellor to display some empathy and humanity, but that viewpoint 2 participants were less concerned about those qualities wanting the counsellor to understand the enormity of what had happened to them, and the data suggests that these needs have a purpose in the journey to recovery. All participants whose Q sorts loaded on to viewpoint 2 had significant life changing events. The need to have the enormity understood by the counsellor is therefore understandable and clearly relevant for these participants. These participants also did not want to be seen as a ‘problem’ an issue not highlighted as a concern for viewpoint 1 participants. For viewpoint 2 participants engagement with others in relation to their harm has led, according to the interview data to not being believed or taken seriously, with a sense of frustration being evident. Early on in the journey to recovery it seems as though exploration was enough, but as the journey progresses validation and recognition become important. Similarly, it did not seem to make any difference whether the second harm was experienced by a participant themselves, a relative or a close friend. Both viewpoints included significant Q sorts from those who were relatives, patients themselves or close friends and both viewpoints allude to the impact and long-term damage of the second harm.

8.3.2.2 The need to understand, be understood and helped cope with change and impact

The need to understand impact came from one consensus statement; ‘To know that the counsellor understands and takes account of the impact of second harm on partners and other family members. This also arose from the interview data when participants talked about personal relationships with family members, with the person who was harmed (if they are a friend or relative) and the challenges that are there for them in managing these relationships as well as the impact of the complaints and litigation process. The recognition of the changes to and challenges of personal relationships was recognised in that this statement was one that was added to the final sort following the two ‘expert’ participants’ review of the statements. Both agreed to this addition in recognition of the issues around friends and family impact. However, the expectations on the counsellor seems to be that they would help individuals manage these relationships, possibly even give advice, help clients manage how they feel about others and have some input into the management of responses to difficult relationships. The counsellor is unlikely to be seeing both the client and their family member(s), this is recognised as not good practice, unless they are a couples counsellor (BACP, 2018). Therefore, the need for direction may be, depending on the counsellor, one that may not be met, given that many forms of counselling are in fact non-directive. Usually, the purpose of counselling is to allow the individual to explore the possibilities that they want to see happen and to facilitate their strengths to be able to take any changes forward. Traditionally, counselling is non-directive to enable the solutions to the issues identified in counselling to come from the client and thus allow them to recognise the significant strengths that they have (Rogers, 1957). The participants appeared to in some sense to want advice and perhaps some direction to enable them to move forward. Careful and skillful counselling can do this without being directive but by helping client to consider a range of options which are generated from themselves, in this case with regard to how they might manage relationships. This can empower and focus the client on their own personal strengths rather than the opinions of the counsellor (Jones-Smith, 2013; Sparks and Duncan, 2016).

8.3.2.3 The need to use counselling as a means to recovery

The consensus statement ‘That the relationship is focused on me and my needs, experiences and feelings’ demonstrated the need for the work to be focused on the client and not the therapist, recognising the need for the development of a stronger self-esteem and personal qualities to move toward recovery. In recognising in themselves that clients have needs and that another person, particularly a professional, should be prioritizing these enables the client to begin to learn to respect themselves, to care for themselves again, to recognise their own needs and respond to them appropriately, particularly in the context of the needs of others. This need drives the movement towards recovery, in Herman’s (2015) suggestion that an initial task should be about taking control. As well as beginning to take control of caring for oneself, this need also begins to reconstruct fragile self -esteem damaged by the second harm.

8.3.2.4 The need to regain control, power autonomy

In viewpoint 1 meaning was sought to enable some kind of understanding that opened the possibility of growth and some element of autonomy to be regained. In viewpoint 2 a sense of autonomy was still a need but is articulated differently. Participants whose sorts loaded on to viewpoint 2 sought their autonomy though validation. The statement ‘That my experience be believed and accepted as a valid experience’ was sorted as most important. While the statement on exploring the possibilities of what happened was ranked by participants whose sorts loaded on viewpoint 2 as significantly lower that viewpoint 1, it was interesting to note that being believed and having their experience validated emerged from the interview data as being very important to these viewpoint 2 participants.

The nature of autonomy discussed by these two groups is significantly different, with viewpoint 1 seeking meaning for autonomy and viewpoint 2 seeking validation. The difference in these groups may be explained by considering the context of these two groups of participants.

Participants whose sort loaded on to viewpoint 1, of whom there were three, predominantly spoke about what had happened to them in the past and the present was ostensibly manageable. However, there was still a sense from them that they did not know or understand to the level of detail they would have liked what had happened to them. This left them with a period of time when they could not make sense of what happened. While making sense is important in itself, it is particularly relevant when one does not understand that happened in one's own body. Herman (2015) talks about the need to regain bodily control as part of beginning to feel safe again. Some participants did not always have a full explanation from professionals about what happened, choosing to withhold information about the nature of the error and the circumstances of the harm from the patient. The impact of this is that a sense of helplessness develops and a sense of lack of power, especially for those hoping to gain further information.

Participants whose sort loaded on to viewpoint 2, of whom there were four, predominantly spoke about the second harm as still happening and a need not for understanding but for validation to be able to cope on a day-to-day basis with the impact of the first harm and the second harm in order to remain on a recovery pathway. They also had an evident need for an element of control over the counselling process which was less visible in viewpoint 1. Participants felt as though it was important to be able to challenge, to be part of the decision-making process and to ensure that the importance of the counselling relationship was recognised as being above targets and outcomes.

8.3.3 Needs in accessing and coming to counselling

In relation to accessing counselling, there was one consensus statement that participants agreed upon in relation to the need for access to information about counselling. That statement was 'That information about counselling is available to me'. Participants from both viewpoints mentioned access to counselling and for one participant this has been a particularly difficult issue with access to a counsellor that they felt was appropriate for the kind of harm that they had experienced being challenging and not timely. Additionally, issues of competency emerged within the viewpoints with respect to using and engaging with counselling to contextualise the harm and begin the recovery journey.

8.3.3.1 The need for access to appropriate counselling

In the case of the individual who referred to a preference for a specific kind of counselling that was not available to her, she was not offered the kind of support that she herself felt she needed. This limited choice is an issue for many clients and is highlighted by Perfect *et al.,* (2016). Access to information about counselling and making a decision about what help and assistance to ask for seems to be connected in both viewpoint to the ability to make decisions and to be able to manage one's life, to function effectively and facilitate change.

8.3.3.2 The need to develop competency in accessing and engaging with counselling

This management of one's own life links well with the competence aspect of self-determination theory (Deci and Ryan, 2015). Competence may also be connected to the ability to seek counselling as this is not an easy step for clients. Work by Elliott *et al.*, (2015) confirms previous work that suggests that the step that takes the longest in therapy is getting to the point of accessing therapy. The suggestion that even if therapy is available then admitting it is required, considering how it may be useful and actually initiating an appointment may be challenging and may take a significant amount of time. Accessing counselling does require a level of competence as does engaging fully with the counselling process.

For participants the need for the counsellor to help develop competence in life management is strongly connected to the ability of the counsellor to contextualise the second harm, to visualize it, to take perspectives and to recognise it as being a legitimate source of harm and distress. In the literature review carried out in Chapter Two, being directed/managed was found to be useful for clients, at times when they simply cannot move in their processing of the therapeutic work towards their ultimate needs without some gentle direction.

In viewpoint 1 participants did not expect the counsellor to contextualise the second harm to the same extent as those participants whose sorts loaded on to viewpoint 2, the focus being on getting the story out to someone, perhaps as a means to begin the mental processing of it, as suggested by Herman (2015). Even though they may have talked to many people, the possibility of discussing this with a professional and getting it heard comes out within some of the interview of participants who were involved in 1 and neither viewpoint.

The wider context of second harm was important to participants who loaded on to both viewpoints. Again, considering the example of the counsellor needing to understand the legal process, participants did recognise that some context was important and that an understanding of the impact on day to day life, and in some incidences the trauma of the legal process, added to the counsellors' understanding of the clients' perspective and to how second harm might be exacerbated using legitimate means (Pyo, Ock and Han, 2019) A clear sense of past and some present helplessness was communicated in the interviews for viewpoint 1. However, for participants whose sorts loaded on to viewpoint 2, the focus on contextualizing the harm as a means to competence seems to be less. These participants focused on the processes within themselves, maintaining and facilitating relationship but also having less regard to being seen as betraying the NHS, apportioning blame, wanting retribution, expressing dissatisfaction or requiring support for future engagement with the NHS. Their focus is more an internal process than external recognition, with less fear of judgement than those whose sorts loaded on to viewpoint 1. Within the participants that loaded on to this viewpoint were those that had litigated, those that had a public profile as a result of the harm and second harm and those that had been subject to continuous and repeated harm and second harm. For these individuals the embarrassment of the initial harm and the shock of the second harm had waned and were in some senses part of life for them.

8.4 Needs unique to individuals coming to counselling for second harm

To address the second objective of this thesis an in-depth understanding and defense is required of what needs were deemed specific to those clients who seek counselling after second harm in order to advance this field. While the needs identified in the academic literature on counselling resonated with many of the perceived needs of participants in this study this wider literature does not reflect specific needs; 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 including issues of control, power, and autonomy. Both needs were clearly evident in the viewpoints and the post-sort data

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

Within this study participants identified their own concern that the apportioning of blame might get in the way of a respectful counselling relationship and that one of their needs would be to not experience blame within that relationships. 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 as discussed in Self Directed Theory (Deci and Ryan, 2015) and was about a need to be connected to others, to be understood and to have relationships with self and others repaired. This includes the counsellor modelling the 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 the 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 and Adcock ,2019; Titcombe, 2015; Steane 2017 and Ryan 2017). It is not uncommon, as in the concourse for patients to be ascribed elements of blame when care goes wrong. Indeed, Vincent and Coulter noted this trend in patient safety as far back as 2002.

Ascribing blame to patients where there is none in an attempt to detract from errors made in healthcare, especially in the death of child further exacerbates second harm and hinders the grieving process as well as causing significant distress to families (Adcock and Adcock 2019). Being blamed by those who may have contributed to the harm yet fail to acknowledge or apologise for this again cuts across the perceived expectations of what healthcare professionals should do and how they should 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 describe 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.

All participants in the study wanted the relationship to have a level of kindness, encouragement, personal value and physical and emotional safety that means that their experience be accepted by another and blame not attributed. Participants rate this highly in both viewpoints.

Differences in viewpoints begin to emerge when looking at where safety was ranked, as most important in viewpoint 2, but slightly less so in viewpoint 1, and where some of the statements regarding ethical behaviour and core values were ranked. In relation to the counsellor providing a level of safety that includes psychological and physical safety the consensus statement that participants agreed upon and ranked the same in both viewpoints in relation to needing safety was 'To be helped to trust people and to try to mitigate the negative impact of what happened'. This pertained predominantly to psychological safety in not being vulnerable and having to defend ones position or make a client feel uncomfortable, to say anything that the client wanted to say, trusting the counsellor to go further, being believed and acknowledged, being heard and being safe to explore possibilities. This need for safety is according to Maslow a basic one, and he suggests that 'practically everything looks less important than safety' (Maslow, 1943 p4).

The findings in this study make clear that clients who have experienced second harm come to counselling not just with different purposes, but also wanting and expecting a different relationship between themselves and the counsellor than perhaps other clients might seek. However, all clients need an element of safety and security that is clearly set out as an expectation by all counselling professional bodies in their ethical frameworks, for example the BACP (2018).

8.4.1.1 A need to have the counsellor understand the impact of the harm and the complaints and litigation system including issues of control, power, and autonomy

Four participants across the two viewpoints mentioned the need for the counsellor to understand the impact of the second harm especially the complaints and litigation and that the process exacerbates second harm. Within accounts of harm, the long process in which barriers seemingly are put in the way of progress towards resolution in the eyes of harmed patients, causes additional distress with the perceived purpose of dissuading individuals from the litigation route (Steane, 2007; Titcombe, 2015; 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, (Keat, Heavin and Sparrow, 2017; Hickling, Blanchard and 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 (General Medical Council 2020; Nursing and Midwifery Council 2020). When these explanations and apologies fail to happen then this exacerbates the sense of wrong and causes additional second harm (Adcock and Adcock ,2019; Titcombe, 2015; Steane 2017 and Ryan 2017). Frequently, those that are harmed go through extensive and intrusive scrutiny during litigation, (Keat, Heavin and Sparrow, 2017; Hickling, Blanchard and 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). In the case of one family, where a popular doctor was removed from the GMC register, the family wrote an open letter to the British Medical Journal requesting assistance from the Journal as 'trolling' was being perpetrated by those within the medical profession itself.

Generally, the unique relationship of trust that a patient has with their healthcare provider is the basis for many competent, life-enhancing and effective interventions, however when that relationship deteriorates it can become particularly devastating.

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 *et al.*, 2017). An imbalance of power often leaves harmed patients feeling vulnerable and so the perceived inequality and sense of unfairness at the system is almost inevitably something that will emerge in the counselling room. Participants believed this imbalance of power should be understood for the impact it has.

8.5 Contextualising the needs of patients who have experienced second harm.

To understand the needs articulated within the viewpoints it is important to note within both the statement pack and the viewpoints some implicit beliefs about the experience of patients subject to second harm, how they view their treatment by the healthcare system and what they expect and believe they will gain from counselling in the hope of having their needs met. It is important then to consider the context and the beliefs to further understand the client perspective and their hopes for recovery from second harm.

One of the defining perspectives of clients that came out of both the narratives within the concourse, the statement pack and the viewpoints was the view of the health care system as being dehumanising for these clients. This was particularly noticeable with regards to the way that clients felt they were treated. With information about what happened to them being controlled by the healthcare professionals there was often a sense that those that were harmed did not have basic information about what had happened and therefore the ability to explore these experiences was limited. For participants counselling was viewed as being an opportunity to explore possibilities about what had happened and to use that exploration as a possible opportunity as a means of growth in order to regain function and normality. Participants and those whose stories contributed to the concourse and statement pack recognised that the experience of second harm contributed to the development of personal wisdom and knowledge gained through adversity and that this personal knowledge was valuable, not just in making sense of what happened but also in navigating their life challenges.

There was also a recognition of the integration of the past and present that was required in order for those that were harmed to move forward which required a necessary desire to embark on the exploration of emotions, which could be particularly challenging for some. This deep exploration of the context, nature and impact of second harm did, for some, allow for a recognition of a wider existential meaning.

These references to context ran through the concourse, the statement pack and the viewpoints. The interviews further illuminated these beliefs and therefore it is pertinent to consider the contextual information provided as a means to set the needs into that wider context of the lived experience of patients that have experienced second harm.

8.5.1 The view of the health care system as being dehumanising

Some participants did not understand the specifics of their first harm even after several years. This left some with a real sense of dehumanization. This sense of being dehumanised by second harm links to the current discourse in health about the humanisation of health care.

In her book ‘Humanising Healthcare’ Margaret Hannah (2014) discusses the issues that have made our healthcare system unable to connect with the humanity of those that utilise the system. These issues are multifactorial, and include the manner in which doctors have been trained, a system that is built for scale, is increasingly technical and has limited resources. Recognition of the importance of the need to humanise care came from organisations such as the Point of Care programme at The King’s Fund which ran between 2007-2013 with the purpose of improving care for individuals following the Francis Report, and the wider professionals community of nurses (Scammell and Tait, 2014) and doctors (Youngson and Blennerhassett 2016).

A recent systematic review by Busch *et al.* (2019), included 14 studies on the humanisation of healthcare and themes emerged that suggested that the challenges in ensuring that healthcare was humanised were threefold; relational, organisational and structural. In patient accounts of harm these three themes can be identified, and seen to contribute to patients feeling dehumanised by, for example being ignored, not being included in discussions and organisations not acknowledging their harm. A considerable amount or research effort is now given to ensure that healthcare is humanised and that the basic values of humanistic person-centred care are demonstrated to patients.

Todres, Galvin and Holloway, (2009) argue that humanising healthcare goes beyond merely the delivery of person-centred care, and instead is relational. On the basis of their research and on that of others, they suggest the adoption of a framework for humanising healthcare that is based on eight dimensions of humanization, each one on a continuum (Figure 14).

Figure 14 Eight dimensions of the humanization of healthcare

Forms of humanization	Forms of dehumanization
Insiderness	Objectification
Agency	Passivity
Uniqueness	Homogenization
Togetherness	Isolation
Sense making	Loss of meaning
Personal journey	Loss of personal journey
Sense of place	Dislocation
Embodiment	Reductionist body

(Todres, Galvin and Holloway, 2009 p70)

It is noticeable within the eight dimensions, that the forms of dehumanisation resonate with the words that are familiar from the description of second harm within both the concourse material, the statements constructed from the concourse, and with the language used in the post-sort interview. This study, and others by Todres and Galvin, (2010) focus on the need to understand wellbeing and the individual sense of being as a key to humanising healthcare and support the findings of this study that when care goes wrong, it often results in sense of diminished value as a person and lack of autonomy felt by the participants as can be demonstrated in the statement sorting and subsequent post-sort interviews.

Humanising healthcare is challenging. Systems are set up for scale and pressures and lack of resources frequently mean human interaction may be minimal for healthcare staff.

Generally, counsellors have more opportunity to interact and make their intervention more human purely because they have a one-on-one relationship that is so very different to that of healthcare professionals.

For harmed patients, exemplified in both the concourse material and the participants responses, being seen as human with a valid need to be part of conversations about what happened to them links strongly to being able to progress on to talking about what happened to them and why.

8.5.2 The view of counselling as being an opportunity to explore possibilities

Participants clearly wanted to explore what had happened to them through the lens of both the past and the present. Southwick, Cranley and Hallisy (2015), note the reluctance of providers to engage in dialogue that might support harmed patients to explore the possibilities of what happened to them, preferring to '*deny and defend*' (p627). This sense of seeking some understanding, not by finding out from the healthcare providers, but by working through what happened with the counsellor and finding some personal meaning might seem in some sense perhaps futile given that participants are unlikely to find answers to what has happened. However, this part of the journey to understanding as part of recovery is important for clients to enable some meaning to be made and is not about a factual account.

Whilst healthcare providers focus on fact and the 'evidence' of what happened they lose an opportunity to engage with harmed patients, once again as human beings but as individuals that can be helped to make some meaning out of the experience. This meaning also seems to be linked to the ability to gain some kind of autonomy in the making meaning process.

In her seminal work *Trauma and Recovery* (2015) Judith Herman makes clear that '*recovery can take place only within the context of relationships; it cannot occur in isolation'* (p133*)*. Her assertion is primarily due to the experiences of trauma as being disconnection and disempowerment and her belief that recovery is focused on connection and empowerment. The making of meaning in therapy becomes a means for establishing connection, initially in a safe place and for developing empowerment.

In his book, *Mans' Search for Meaning,* a classic text by the founder of Logotherapy Viktor Frankl, he describes his observations of his fellow inmates of Theresienstadt and Auschwitz and what enabled them to survive (Frankl, 1985). His observations took him to found the Third Viennese School of Psychotherapy and become an inspiration to humanistic and existential psychotherapists. He was a controversial figure for his apparent 'accommodation' of Nazi methods in that he believed that adding meaning to life allowed individuals to tolerate almost unbearable conditions. Despite the controversy, Frankl's work and his recognition of meaning as an important aspect of life and the added value of meaning to life continues among his students.

Furthermore, in his work on motivation and needs Maslow (1943) acknowledges the 'desire to know and understand' (p 8); in other words the search for meaning as, in part a technique for the acquisition of the basic needs that he recognised in his hierarchy. This search for meaning then becomes purposeful, to enable autonomy. More recently the work of Costin and Vignoles, (2019) found that meaning could be broken down into three key aspects: purpose, coherence and existential mattering (otherwise known as significance) and say that of the three, it was significance that was a precursor to individuals making a judgment about how meaningful their life was.

Judging that one's life has meaning has been linked to significant good health and wellbeing and this connection has been well researched over the years (Steger *et al.*, 2006) with recent more nuanced research comparing and contrasting elements of well-being connected with meaning and purpose such as Costin and Vignoles' work. While meaning might be relevant to clients, the experiences that they had, continues to be significant in their lives, but negatively so. With a sense that these events or the initial event (in some cases) were a defining moment in life after which things were never the same, it may be difficult to see how such a negative moment might be assimilated into an existential judgment on the meaning of life that might allow some positive benefits, which it seems the participants are seeking in their search for meaning. The work of Vohs, Aaker and Catapano (2019) explores the meaning that individuals ascribe to negative experiences and comes to some interesting and relevant conclusions. Their work suggests that the negative experience may stimulate individuals to seek more meaning in their lives and to engage in what they call 'counterfactual' thinking, which is a sophisticated form of reflection from which to learn about what happened. This form of reflection is a 'what if' thinking and reflecting style and explores possibilities to make and heighten meaning from events. Contemporary healthcare and medicine often struggle to recognise 'what ifs' or subjective phemonological thinking that is about lived experience (Greenhalgh, 2016). Therefore, for clients to meet healthcare providers in a space where personal experiences and the meaning derived from these experiences, including psychological impact that is anything other than a diagnosed, textbook PTSD or anxiety disorder is a challenge.

Counsellors are able to meet this need, especially those that have some understanding of the difference in approaches between a medical model of care and a person-centered one.

This need for meaning and the thought process that helps individuals to explore the events and interactions that were harmful are well known, and recognised as being usual and beneficial if these processes allow individuals to regain and maintain the ability to function normally, promoting the possibility of personal growth

8.5.3 The view that post-traumatic growth is possible to regaining function and normality

The phenomenon of post traumatic growth is well known and was coined by psychologists Tedeschi and Calhoun (2004) who define the struggle with the affective-cognitive processing and adjustment to life following a traumatic experience (Murphy and Joseph, 2013) but also a significant growth in positive aspects of life as a result of a reappraisal of beliefs about self, others and the wider world. The exact nature of post traumatic growth within the research literature is contested, with early research, summarised by Janoff-Bulman, (2004) suggested as one of three theories: the shattered assumptions theories, personality-based accounts, and growth as coping-based accounts. However, more recent theories suggest that growth is more of a positive personality change (Jayawickreme and Blackie, 2014). Regardless of which stance one takes about the rationale for why and how growth happens, all theories agree that there is the possibility of positive growth following a traumatic event (Janoff-Bulman, 2004). Therefore, it is this need to search and draw meaning from trauma that may present some opportunity for personal growth. Elements of growth were evidenced within the post-sort interviews with participants reflecting on, for example, the fact that they felt they would be in a better position to challenge and expect respect from those that they engaged with, including healthcare professionals.

Being in a position to undertake a challenge may well see harmed patients subjected to further psychological harm, but they may often feel that they have no option. This cycle was evidenced in a number of books that narrated the stories of those who have lost family members and had been subjected to very serious second harm (Steane, 2007; Titcombe, 2015; Ryan, 2017).

Therefore, the possibility of post-traumatic growth must be balanced with what was clearly evident in the study as a devastating impact upon the life of the individual that has been subject to first and second harm and a potential consideration of continued second harm should the individual chose to challenge or indeed even to share wisdom and knowledge that they have developed as a result of the first and second harm.

8.5.4 A recognition of the personal wisdom and knowledge through adversity

Plews-Ogan, Ardelt and Owens (2018) suggest that there is a process of development of personal wisdom, as a result of adversity. Their tested models of personal wisdom development suggest a relationship between wisdom and three characteristics: forgiveness, gratitude and spirituality. In their research they fail to establish the exact relationship between wisdom and these three characteristics; whether the wisdom came first, and from that came the other characteristics, or vice versa which leave a number of questions in relation to learnt wisdom following second harm. These include for example, whether fostering forgiveness, gratitude or spirituality helps wisdom develop. Research does suggest that fostering, for example gratitude does help enhance general well-being even in traumatic circumstances (Vieselmeyer, Holguin and Mezulis, 2017). What is clear and what is also recognised, is that post adversity and trauma, an integration of the brokenness, a re- assimilation of beliefs about self and others, and a fresh view of the world and ones' place within it occurs for those that successfully navigate trauma and adversity (Brewin, 2003). This assimilation of learning manifests as new wisdom but may also be utilised as a means towards post traumatic growth.

This growth can be for personal development and navigating a different life but can sometimes be the means and motivation for action, as in the case of a number of high-profile patient safety activists.

It is not uncommon for individuals to want to share their wisdom and have that acknowledged following an experience of first harm, often as an action to ensure that an error or an experience of poor care does not happen to other families. Patients often exhibit frustration when that wisdom is not valued or heard. Indeed, the recent publication from the patient safety charity Patient Safety Learning (2019) acknowledges the need to capture this knowledge and wisdom to enhance leaning from incidents and to include patients in all aspects of safety as a means of also helping patients to heal from their harming experiences. The frustration that clients feel in not being listened to may leave a feeling that the meaning they have found, their wisdom and indeed themselves are being devalued and not recognised, their experienced being once again unacknowledged. In some scenarios the tokenistic involvement of harmed patients in work has also led to a further sense of offence and contempt (Ocloo, O'Shea and Fulop, 2013; Ocloo and Fulop, 2012).

This need to make meaning by sharing wisdom and learning or being involved in patients safety leads again to the work of Trew Nettleton and Flemons, (2013) on partnering with harmed patients. Trew and colleagues suggest that patients' readiness and 'fitness' to contribute should be assessed or be able to be part of this work. This is understandable given the vulnerability of harmed patients and sensitivity of 'never events' and patient harm is to any organization (Langer *et al.*, 2016). However, the nature of the assessment discussed by Trew was not clear and seems to involve a wholly subjective assessment by healthcare professionals of the personal qualities and motivations of possible participants rather than using any validated instruments. The suggestion by the researchers '*readiness* (to be involved*) is at least in part indicated by the act of putting oneself forward as a volunteer'* (p12) demonstrates the naivety of staff to harmed patients although the researchers do acknowledge this complexity. One wonders about the feelings of potential participants who are rejected as not being ready and the impact of that on an already harmed individual. Patient involvement in healthcare is complex, but there is increased recognition of the value of involvement of patients per se in the co-production of systems and delivery of healthcare as evidenced by Patient Safety Learning (2019) and in healthcare education by Heath Education England (2019) among others. This recognition has come from an acknowledgment of the benefit of the unique knowledge that harmed patients have from their counterfactual thinking process along with a recognition that excluding patients from discussions following incidents causes more harm and fractures relationships.

8.5.5 A recognition of the integration of the past and present to move forward

In addition to the sense of meaning and growth, the context of the harm and subsequent assimilation of this event into the lives of participants noted that they have become in some sense familiar with their own narrative of what happened to them and that their lives have changed as a result of that narrative as well as simply the event itself.

Knowing their own story is not the same as knowing the details of the error or how underlying poor care led to a negative outcome. For some, especially those that mapped on to viewpoint 2, the day-to-day struggle of living with what happened is no longer obscured by the lack of detail but more about a strategic view of the story. They seem to have found a way to move from that past orientation to one of present, managing the issues, their future, how will things be for them. As discussed previously whilst the theory of post traumatic growth includes the integration of wisdom and learning from adversity, it is clear from the interviews that there remain some specific psychological needs for some, if not all of the participants. These participants accessed counselling for different reasons that were more contextualised, for example asking for some support going through a legal process or to access support to manage the wider and more existential issues that emerged in the counselling room. Even so, these contextual reasons that were brought to the fore in counselling also appeared to help clients in their integration of what had happened to them and allowed them to move through periods that were problematic towards recovery and growth.

It is clear then that all harmed patients are not the same. One approach then does not fit all therefore approaches, must be flexible and person centred and should support any modality.

8.5.6 The desire to embark on exploring emotions

For all participants there is an expectation that counselling will be about exploring emotions at a variety of different levels and being comfortable with talking about any topic including their anger and frustration at situations that have not had a satisfactory outcome.

All participants alluded to or explicitly mentioned difficult emotions and all recognised the usefulness of processing emotional issues although the purpose for which these difficult emotions were processed differed among participants. For some the goal was self actualisation and they were clear that the need for that was important to them, despite being a challenge. For others it was simply to help manage the emotions and move toward recovery. Again, the overall picture of the exploration of emotions in counselling is one that is not simple or straightforward. Individuals who have been through experiences of second harm want to explore emotions at different times, at different levels and for different purposes.

Within the interviews there was a sense of being stoic to almost ‘push through’ these emotions to get to a place that was different. For some, the loss had been all encompassing, devastating and life changing. They may have become accustomed to the change as the norm for their life now, but it did not feel normal in comparison to their life before their experience of second harm. It was this new ‘normal’ that participants often struggled to come to terms with. There was also a sense that there was some growth and change that was positive.

Along with any enforced change often comes a sense of loss and, as discussed previously a search for meaning. This meaning may be personal, in relation to the event, and may involve a reappraisal of the wider meaning of life for that individual and possibly the meaning of death. This is particularly true of those who experienced a loss or who came very close to death themselves of which there were a number.

8.5.7 The recognition of existential meaning

The more general existential issues raised by participants about life, is linked to the discussion on meaning. Existential issues in this context are not about the meaning connected with the event or even about the subsequent events, but again are more contextualised with the meaning about life per se rather than the meaning of a specific event. Wong (2015) introduces his Meaning Therapy, that is derived from the work of Frankl, and focuses on the search for the existential meaning of life as a positive value that enhances life in its search for meaning as both a process and a product. Existential therapy is a modality on its own and is growing in popularity as a therapy with a resurgence in the seeking of meaning through philosophy, the growth of Buddhism through mindfulness and the seeking of new means for individuals to manage a stressful lifestyle (Loewenthal, 2018). It is also incumbent upon all counsellors to have some understanding of existential meaning and the underlying development of philosophies on meaning (Vos, 2017). Developing this understanding helps counsellors explore meaning with their clients and consider perspectives on meaning and how these shape decisions.

8.6 Recognising the knowledge gap in counsellors

The viewpoints of participants demonstrate that an understanding of what second harm is, the impact of second harm on the lives of individuals and the challenges of living with second harm including the difficult process of pursuing litigation, is perceived as being essential knowledge for the counsellor being able to work effectively with the client. As it would be inconceivable that a client would go to a counsellor for support following a bereavement or a period of depression without confidence that the counsellor had some knowledge of the grief process or an understanding of depression, then perhaps this need is not surprising.

As no definition previously existed as to the nature of second harm or indeed recognition of second harm and its impact, then cousellors are unlikely to have this knowledge, or indeed know where to go to get this. Some will certainly have worked with clients that have had this experience, may have had this experience themselves, but will have had no training on what second harm is or the evidence as to the impact on the lives of individuals and families. For this study it is evident that there remains a gap in practice around the understanding of second harm, the nature of the experience of second harm and its impact.

8.7 Limitations of this work

8.7.1 Lack of research on second harm

The research was clearly hampered by the fact that the subject of second harm has previously had no evidence base, no research and is discussed within the academic and even practice literature. Second harm is clearly 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. Second harm is often discussed as something else, as in some of the work discussed within this and previous chapters, therefore in conducting a literature review it was a challenge to decide on an approach in considering whether to define second harm from the concourse or to accept the definitions that exist currently such as disrespect (Sokol-Hessner, Folcarelli and Sands, 2015), or grief (Trew, Nettleton and Flemons, 2013). The review of the concourse in respect of being able to define second harm was essential and further supported the exploration of the term and the experience of clients who have been subject to second harm.

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). However, the review undertaken in the literature review chapter of the needs of clients coming for counselling generally gives the study a comparative with which to consider the needs of clients coming to counselling with second harm.

8.7.2 The participants

The number of participants was disappointing and the reason for the reduction in initial interest from individuals is discussed within the Chapter Five. Clearly, a larger number of participants may have allowed for more viewpoints to be identified. However, as previously explained this may not necessarily have changed the extraction of the factors as viewpoints and thus final findings of this study.

The participants came from across the UK included a good range of ages, 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.

8.8 Critical analysis of the study and method

Criticisms of Q methodology tend to focus on the perceived lack of robust methods for gathering data and subjecting this data to rigorous analysis. To counter this, Watts and Stenner (2012) make a good defense of Q methodology, suggesting that lack of correct process that does not follow the original method as set out by Stephenson, tends to allow for errors and poor analysis of results (Stenner, Watts and Worrell*.,* 2008). Within this study a systematic and rigorous approach was taken in carefully following the method set out by Stenner, Watts and Worrell, (2008). A number of checks and balances were observed to ensure that the data was appropriate and that the data outputs were as expected. For example, the factor extraction was re-run requesting three rather than two factors to be considered. This resulted in the data for any third factor emerging as not being statistically significant enough to warrant having three factors. The analysis phase, the phase that took the longest, was also undertaken as recommended using the crib sheet method. The possible viewpoint interpretations were considered from different perspectives and were significantly enhanced by the interview data.

Thomas and Baas, (1992) challenge the generalisability of Q methodology to other populations. This is an understandable critique in that the attitude or view of an individual could not possibly be extrapolated to others. However, this fails to recognise that for Q methodology, the measure of a robust study is about replicability. Suggesting that the same condition of instruction might lead to similar results that represent the range of views across the topic, even when Q samples are different and when administered to different sets of persons, might seem unlikely. According to Brown (1980), a key tenet of Q methodology is that a limited number of viewpoints exists on any given topic and that these can be captured by any robust method that sufficiently represents the viewpoints of any similar representative group. Generalisability within Q methodology is always an issue in relation to how far these findings can be extrapolated. What can be stated with respect to this research is that the viewpoints extracted demonstrate what is important for these participants. Having used robust methods, achieved a systematic and in-depth concourse, the data has demonstrated a thorough and in depth understanding of the counselling needs of those coming to counselling following second harm. While this may not be generalisable in a traditional sense, this work has demonstrated the complexity of the human response to second harm and how to help people in the future.

One particular issue that is frequently raised with respect to the sorting process is that of a forced vs free distribution. While utilising a forced distribution may be uncomfortable and possibly frustrating, as evidenced by participants in their post sort interviews and as acknowledged by Watts and Stenner (2012) that this does allow for real thought about what is important to an individual and where they had no particular thoughts one way or another. The issue of a free versus a forced distribution is discussed by Brown (1971) in his classic paper, and by Watts and Stenner in their book (2012). Whilst Brown is clear that the distribution is technically not likely to influence the final generation of viewpoints, according to Watts and Stenner a forced distribution actually may help individuals to make the finer decisions on where to place a statement. Watts and Stenner, also comment on the range and scope of the distribution, in other words how many points of value, (in the case of this study a steep distribution of -3 through 0 to +3), and the number of items attributed to each category. The steep distribution and relatively small number of value points, a seven-point distribution, was used to again make participants distinguish between the statements that were really important to them.

In the interviews following the sorting activity it was evident that participants were significantly challenged to put the statements into the distribution as forced. The issue appeared to be that most participants felt that most statements should be in the positive part of the distribution as being important. Therefore, in constructing the distribution as it was, this did avoid the possibility that most of the statements were important or very important to participants.

It might appear to be a limitation of Q methodology, that having reviewed the concourse for all the things that are relevant, the participants then have to allocate some things as least relevant. Least relevant is not 'not relevant' and should be considered as a continuum of relevance where each is compared to the other, not merely by itself. Most participants will have strong ideas about relatively few of the statements given that the topic is a particularly emotive one and elicits strong feelings including anger among those that have been subject to harm. The use of a forced distribution might seem in some sense incongruent with the critical theory perspective of allowing the voice of the participant to come through in the research. When looking specifically for viewpoints in a Q methodology study, there has to be both the opportunity for participants to speak through the study and for what is most important to participants to be evident. The design of the distribution allowed individuals to express strong feelings at both the - and + ends of the distribution (Watts and Stenner 2012 and participants did acknowledge that the process made them choose what was really important.

More participants are likely to have elicited more viewpoints. However, whether these viewpoints would be significant is the bigger issue. Remembering that significance is calculated with respect to the level of significance for the number of participants, then any further viewpoints might not be significant and the viewpoints already extracted would be unlikely to change in their significance. Considering that the key point with Q methodology is that appropriate coverage of the concourse gives the greatest likelihood of variability rather than the number of participants, there may not necessarily be a difference. The question of how far we can say this study demonstrates what is the case for every person who has experience second harm is relevant. What can be said is that, given the strong concourse material, the viewpoints that are articulated in the two factors would be likely to be identifiable. What can also be said is that there would be likely to be participants that would not load on to any viewpoint in a study and that, if the number of participants were increased, then there may be additional factors. What would be difficult to predict is how significant these additional viewpoints would be given, that the concourse material may not provide us with any greater participant views. It is usual and expected that however many participants were involved, some would not load on to any sort (Watts and Stenner 2012).

The lack of knowledge around Q methodology generally has been a significant issue in this study including articulating the proposal to the ethics committees. This could be an issue for new researchers considering Q methodology for their research. The lack of knowledge of the wider research community has been a disadvantage in that explanations have had to be simple yet robust enough to capture both the exciting possibilities of the method and the complexity of it. Notwithstanding issues of challenge in Q methodology, the choice of Q methodology did meet the needs of the study.

8.9 Original contribution and implications from the study

8.9.1 Original contribution to knowledge

This study has produced new and original knowledge. This includes a recognition of second harm as an emerging phenomenon, that has come to the fore in the numerous reports identified in the contextual discussion in Chapter One. This recognition has not been articulated anywhere else within the academic literature with specific regard to second harm.
A new and original definition of second harm was presented in Chapter Four 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*'.

This definition helps clients to recognise that their experience of second harm is one that can be acknowledged as being a genuine one and that this experience is not commensurate with professional behaviour expected by the health care regulatory bodies in their codes of conduct. This definition does not merely indicate impact, but also action, that this impact of as a result of an action by healthcare professionals. This can also help healthcare professionals consider their responses to complaints and concerns about care helping them to explore why they feel as they do and giving them strategies to manage their responses professionally.
New and original knowledge on the specific needs that individuals coming to counselling with second harm identified as being both similar and different to those coming to counselling with other issues. The needs that are similar predominantly are related to needing a sense of safety and confidence in the relationship, with these needs tending to be generic. However, what is also evident is that clients who have experienced second harm have some different needs, specifically; 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. This requires counsellors to educate themselves about the causes and consequences of second harm.

These new contributions have the potential to impact significantly on both practice and research with far reaching possibilities for practitioners and for patients/clients.

8.9.1 Implications and recommendations for practice

The third objective of this thesis was to establish clear recommendations for counselling that can be used by those working with clients that have experienced second harm. These recommendations offer some originality int eh therapeutic approach adopted by counsellors regardless of modality.

First, this thesis offers counsellors a definition of second harm which, will support them in helping those who have experienced this to be identified, and to recognise themselves that their responses are a normal response to what happened to them. The definition will also help counsellors, begin to develop their knowledge of second harm and ensure that people can be appropriately supported taking account of their individual needs.

Secondly, the needs identified in this thesis 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.

Thirdly, 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.

The recognition of second harm as a phenomenon is now able to be acknowledged. Having a definition can help second harm to be identified in patients/clients as a negative impact of the attitude of some professional in some circumstances. This is important is two aspects; first that professionals are no longer able to display an attitude of contempt without being held account for it; and secondly, that the attitude does have an impact on patients and that impact is harmful. Healthcare regulators should ensure that any attitudinal expectations of their practitioners does include the expectation that contemptuous relationships have no place in healthcare relationships both toward patients and towards fellow practitioners.

8.9.2 Implications for future research

These findings must be a starting point for further research and understanding of second harm and the needs of clients in the counselling relationship. The definition of second harm should be tested over time to ensure it remains relevant and accurate. Additionally, there remains a need for further research as to what counsellors feel they need in terms of training, knowledge, or resources on second harm, to enable them to meet the needs of their clients. In the future study evaluating the difference that knowledge of second harm, its nature, and impact makes to clients seeking counselling for second harm should also be carried out. An initial step towards this might be establishing the detailed nature of the knowledge that clients feel would be beneficial. The needs identified in this study would benefit from further exploration in future research projects on second harm to establish further knowledge and allow for both patients and practitioners to be confident in the applicability of the findings.

Peer reviewed publications on this topic as well as further research will help to advance understanding and conversations around second harm. The work done within this study will be presented for discussion among communities of practice in both healthcare and counselling.

My own research on this topic will be life-long and section 8.10 gives an outline of the short-term plans for research, dissemination and outputs.

8.10 Dissemination strategy and outputs

In order to facilitate a greater awareness of second harm an outward facing strategy to disseminate this work is required. In the short to medium term there are plans to disseminate this research via presentations at conference, although the specifics of which appropriate conferences still need to be identified. This will enable targeted audiences to be identified and it is hoped to include healthcare professionals, patients' organisations and patients themselves. Additionally, dissemination of the research findings will occur within my teaching and into the new curriculum for the BSc (Nursing) at the University of Cumbria.

I will continue to disseminate the findings and enable the research to inform future work and to build on the work already done on this topic, as well as developing my understanding of Q methodology and championing this as a credible method for research.

Six papers have been identified as potential publications from this study within appropriate peer-reviewed academic journals.

Two publications have come about as a result of this work already:

> Kenward, L., Whiffin, C. and Spalek, B., (2017). Feeling unsafe in the healthcare setting: patients' perspectives. *British Journal of Nursing*, *26*(3), pp.143-149.

Kenward, L., (2019). A literature review to guide novice researchers using Q methodology in the development of a framework for concourse management. *Nurse researcher* 27(1), 17-21.

The initial article in 2017 was a first attempt at writing for anything other than a professional journal and therefore I was delighted to be able to begin the public conversion about the perspectives of patients as to what constitutes safety for them. The second article in 2019 concerned the use of Q methodology for novices and this had generated some discussion in the Q methodology community.

The impact of this work has been recognized at a national level by personal invitation to work with the national investigation Panel into the East Kent Maternity Services. These findings of this study are relevant to the work of this Panel and will inform its strategic direction.

Additionally, the research findings, lessons learnt, and the experiences gained will be used to inform future research and dissemination.

8.10.1 Personal development towards becoming and independent researcher

Current research projects with which I am involved includes being a PPI lead for successful research bid (Oxford University with Professor Peter McCulloch) and advising on improvements in the rescue systems of deteriorating patients. This came about from my reputation as having knowledge on patient harm and patient involvement.

For the future, considering my own research, I have some initial plans in being involved with the Law School at University of Cumbria, looking at the impact of litigation on the recovery from second harm. One student has expressed an interest in working with me on this. Additionally, I have interest from the Acute and Critical Care team at University of Cumbria on how nurses recognise contempt.

My practice as a counsellor will continue to develop. In summer 2021 I will be applying for senior accreditation with the BACP and this work will form the basis for part of that application.

In the longer term I will be working with Patient Safety Learning, a charity that seeks to implement into healthcare learning that is gleaned from errors or harm. It is expected that I will be implementing the findings into the development of a harmed patient pathway (this has been agreed with the CEO already). This will specifically utilise the needs of clients and service to test and evaluate the findings of this study. Alongside that I will continue working with other charities to highlight the impact of second harm and the needs of those who have experienced second harm to ensure that these are recognised, with other charities including Action against Medical Accidents.

Having researched this topic for over five years, I am mindful that this is an emerging area and that I am one of few academics that have studied this in any way. It is therefore an ethical responsibility to disseminate the findings, contribute to greater knowledge and practice and to ultimately make the lives of harmed patients a little better.

8.11 Summary of chapter

This chapter has discussed the findings of this study and has set the study findings in a wider context. The identified needs that are similar for those coming to counselling with second harm have been identified as how those that are unique to second harm. This has enabled new knowledge to be identified. The significance of the findings has been explained and critique of the research itself has been explored. Additionally, this chapter looks at the outputs and impact of the work, including the implementation of the findings into a national investigation. This chapter also includes consideration of possible future research that will be done.

9 Chapter Nine - Conclusion

9.1 Overview of the chapter

In this short chapter the thesis is drawn together as a conclusion from the study. This includes summarising the key points of the study and identifying what is important in counselling after second harm as well as providing recommendations for practice and research.

9.2 Summary of findings

The findings of the Q methodology study identified two viewpoints. that resulted from the participants Q sorts; 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 common to 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. A need to not be blamed for what happened as well as an understanding of the impact of harm, complaints and litigation may be seen by counsellors in other contexts. However, 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. The interview data that added to the viewpoints suggest that these might include such issues as anxiety, depression, existential crises or relationships issues. The context and the needs identified in the viewpoints were largely relational and involved the need to relate to others, to be

related to and to relate to oneself in a particular way that is traditionally met by coming to counselling.

The viewpoints also gave a view of how clients who come to counselling following second harm view what happened to them and what coming to counselling meant to them. This included the wider context where participants felt that their experience in healthcare felt dehumanising, where counselling was seen as an opportunity to explore possibilities about what happened and that they recognise that there is a possibility of post traumatic growth to regaining function and normality. It also became evident through the viewpoints, especially from the interview data that participants felt that they have developed personal wisdom and knowledge as a result of second harm and that they understand that they need to integrate the past into the present to move toward recovery.

There was for participants an expectation within both viewpoints that counselling would be about exploring emotions, however, the viewpoints differed in the depth at which these emotions might be explored and whether this would include, for example having an opportunity to explore existential meaning.

In addition to the needs identified, the study 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'.*

9.3 Impact

This study has taken five years during which the sector is already discussing second harm, a significant move forward from when this study started. The study is the first to consider what counselling is required for those that have experienced second harm and to offer a definition of second harm. The work advances understanding of the topic and will enable a more focused discussion within the sector.

These findings advance our understanding of second harm and the counselling needs of those who have experienced this, but also add something to counselling 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.

9.4 Focus on the future

Invitations to share my work and to contribute to further work have begun to be received. Significantly I have been asked to contribute, on the basis of this work, to the Inquiry into East Kent Maternity Services which reports in 2021. The work carried out with this Inquiry will be written up and disseminated and is likely to generate significant interest and further advance what is known about supporting those who have experienced second harm.

Work with continue with Action Against Medical Accidents to promote counselling for second harm and this, again is likely to generate interest as will work on a harmed patient pathway with the Harmed Patient Alliance.

Future research should now concentrate on the advancing the understanding of second harm, establishing what resources, knowledge or education counsellors need to enable them to feel that they are able to be confident in their understanding of second harm. This 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. In additions scholars and practitioners are invited to critically debate the definition of second harm proposed in this thesis in order to refine this definition for other setting and to provide different and perhaps alternative perspectives. It is only through robust and critical debate that an evidence base for practice is established.

9.5 Summary of this chapter

In this chapter the thesis has been summarised briefly and conclusions drawn from the findings. The components of this study have been summarised and the needs identified in the study as well as an original and new definition of second harm makes for a new, innovative and original contribution to theory and a springboard for the development of new responses in practice to second harm. Additionally, the chapter reiterates the need for the further development of new knowledge that can inform counsellors and counselling about the nature, impact and experiences of second harm. Added together these components will open up the opportunities for robust and evidence-based support for those who have experienced second harm and a recognition that the impact of this specific type of harm is a unique experience.

10 References

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Appendices

Appendix 1. Data extraction table

	Year	Setting (kind of counselling)	Country	N=	How data was gathered method/ tool	Data gathering tool (if any)	Findings	Relevance to topic
Keleher *et al* -	2017	University counselling services	Canada	87	Semi Structured Interviews	RWAI-S***	Clients that felt they had their needs met (as indicated by measure) had planned endings.	Needs explicitly discussed as a factor
Klassen *et al* -	2017	Bereavement Centre	Australia	36	Semi Structured Interviews	None	The meeting of expressed need correlated to client recognition of positive outcomes	Salient needs within a PCC context for bereavement
Walls *et al*	2016	Alcohol counselling agency	UK	5	Semi Structured Interviews	None	Clients are able to articulate their preferences when offered	Preferences were based on some identified client needs.
Dew and Bickman	2005	36 articles on expectancies	USA	36	Systematic lit review	None	Expectancies are related to outcomes but not correlated to attrition.	Some client needs identified but not in all papers
Bachelor	2013	University clinic Private clinic & community setting	Canada	125	Survey then Factor analysis (Using PCA)	WAI-RS*/ HAQ[XX] & CPAS[xxx]	Clients favour helpfulness, joint participation in the work and notice negative aspect of the WA	Some client needs identified
Patterson *et al*	2008	Outpatients clinic at Psychology Dept university setting	USA	57	Clients completed survey	WAI-RS* and the EAC-BF**	Client expectation for personal commitment predict dimension of the WA. Expectations for facilitative conditions and expertise do not.	Expectations that were articulated were based on some identified client needs
Manthei	2006	'walk in' counselling centre	NZ	20	Semi Structured Interviews plus questionnaire	CVCPQ[x] questionnaire	Clients active participation in counselling discussed	Needs were discussed in relation to whether these were met.
Frankl *et al*	2014	Substance dependence unit	Sweden	41	Survey	WAI-RS* & PEX-S[xxxx]	Expectations characterised by defensiveness predicts poor outcomes.	Needs discussed around client expectations of outcome.

Explanation of instruments used.

*Working alliance inventory – Short Form	[xxx] California Psychotherapy Alliance Scales
**Expectations about counselling -Brief form	[xxxx]Psychotherapy Expectation Questionnaire – Short
[x] Clients view of Counselling Project Questionnaire	*** Revised Working Alliance Inventory-Short
[xx] Helping Alliance Questionnaire	

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Appendix 3. Final Statements (Amendments in red)

1. to feel physically and emotionally safe
2. to feel supported
3. to feel respected
4. to feel as though I am valued in the relationship
5. to be treated like a human being
6. to feel relaxed in our relationship and that I don't need to work hard in the counselling relationship
7. that the relationship is focused on me and my needs, experience and feelings
8. to feel confident that I can be emotionally supported through any legal process
9. that the counsellor understand aspects of the law about healthcare.
10. to be able to explore my fears about engaging with the healthcare system in the future and be supported to make my own choices.
11. to be able to feel angry with staff in a safe place, without blame or retribution
12. to be helped to trust people and to try to mitigate the negative impacts of what happened
13. to be treated as an equal from whom the healthcare system can learn.
14. to feel that I can be fully engaged with by the counsellor and not feel that anything that I want to share is a 'no go area'.
15. that information about counselling is available to me, and that information about me to be sensitively handled with respect and within the law.
16. that if something goes wrong in the counselling process or in our relationship I want to know immediately and to be able to discuss this openly.
17. that the counsellor be honest with me and that they value honestly in our relationship.
18. to be able to give constructive feedback to my counsellor and it be used to improve their service
19. that the counsellor to be accountable for their actions
20. to have honest and respectful communication
21. to feel empowered
22. that my counsellor care about me, to be compassionate and is able to empathise with my experience.
23. to be made aware of policies and procedures and know that these will be adhered to.
24. that a counsellor help with exploring the big questions about life and previous personal issues that might impact on my recovery if these do emerge in sessions.
25. to be able to challenge my counsellor if I don't think they understand what I’m trying to say or if they have got something wrong.
26. that I don’t feel as though I am a problem or a 'case'.

27 to explore the impact of no one saying sorry and to be able to be angry about this in a safe place.
28 To be able to explore and re-explore my experience without feeling that I am being a nuisance or being boring
29 to have a counsellor who can 'sit' with me in my experience and help me not to feel so alone.
30 to be able to explore the possibilities about what happened to me and why
31 to talk to someone who doesn't make me feel as though I have betrayed the NHS (removed let them down or)
32 to feel that my counsellor can deal with the enormity of what happened to me and its subsequent impact.
33 to be listened to and to be heard
34 that a counsellor be kind, encouraging and values what I have to say.
35 to feel of equal value to my counsellor
36 to feel that my relationship with a counsellor is a non-threatening relationship
37 that my experience be believed, and to be accepted as a valid experience.
38 to be part of all decision making about my psychological care - for example referrals
39 That the counselling relationship be the most important thing about the sessions rather than targets, outcomes or the reputation of the counsellor
40 that I am not blamed about what happened
41 that the counsellor acknowledges my experience of harm.
42 to know that the counsellor understands and takes account of the impact of 2nd harm on partners and other family relationships

Linda Kenward
Doctoral student

Kedleston Road, Derby
DE22 1GB, UK

Appendix 4. Letter for testers

IRAS ID: 236701

Dear xx

Re: Participation in research as a tester for Q statements
Working title -Help after harm: identifying the counselling needs of those who have experienced second harm in health and social care settings: A Q methodology study

I am writing to you because you have expressed an interest in the above research project

specifically being a 'tester'. Thank you for your interest in this project.

Before you decide whether or not you would like to participate as a tester, it is important for you to understand why we are doing this study, what the purpose of the statement testers is in relation to the main study, and what it would involve for you if you decide to participate. Please take time to read the enclosed information sheet carefully and to think about whether or not you would like to take part.

If you have any questions about the study then please do contact us. My phone number is 01228 161395 or you can contact me on linda.kenward@cumbria.ac.uk and I will be happy to discuss with you any questions you may have.
If, after consideration, you still feel that you would like to participate then please complete the reply slip at the bottom of this letter and return it to me at the above email or postal address. If you do not feel that you would like to be involved then you do not need to respond.
Thank you very much for reading this letter and considering your participation in this project.
Yours sincerely,
Linda Kenward,
Principal Investigator

………

Reply slip
I am interested in the possibility of being a participant in the above study and would be willing to talk to the researcher about participation. I understand that the researcher will contact me to book a time when she can telephone me to discuss the project and potential participation.
I understand that I can withdraw at any point up to the analysis of data (approximately one month from the collection of data) without prejudice or negative consequences and that should I choose to do so any personal data will be destroyed.
I will be happy to be contacted by the researcher (Linda Kenward) for a discussion about potential participation.
Name
Contact number
Preferred day(s) time(s)

Linda Kenward
Doctoral student

Kedleston Road, Derby
DE22 1GB, UK

Appendix 5. Information sheet for testers

IRAS ID: 236701

INFORMATION SHEET for Q Concourse testers - Version 3 February 2018

Name of Research: Working title - Help after harm: identifying the counselling needs of those who have experienced second harm in health and social care settings: A Q methodology study
Researcher: Linda Kenward

The aims of the study

To explore the range of perspectives on what clients say they need from counselling following experiences of second harm within the healthcare setting

The objectives of the study

To identify common needs of clients coming to counselling following second harm.

To identify key factors that are both common and novel in relation to counselling that clients believe would be most helpful following second harm.

To establish a clear framework for counselling that can be utlised by those working with harmed patients.

Research question

What would clients say they need from counselling following experiences of second harm within the healthcare setting

Background to the research

This study is looking at the counselling needs of clients who have experienced second harm in the healthcare system. First harm happens as a result of an error, mistake, neglect or mismanagement of treatment. The second harm may happen as a result of the poor response of the health care provider or professional to the first harm and may include; non-disclosure of information, denial of error, lack of empathy and recognition of the impact for the client, inability or reluctance of the organisation to learn from mistakes or implement findings of inquiries, dismissal of symptoms, fears and concerns relating to the what happened to the client and not communicating with the patients.

Can I participate in the testing?

You can be a tester if you have had an experience of second harm in the healthcare setting. You also need to be able to read English, have access to email and be able to use it to receive the list of statements. You must also be able to give informed consent.

What will be required of me as a tester?

If you agree to participate in this study you will be asked to look at a number of statements gathered from the literature about second harm. The literature includes books, academic journals, reports and patient stories. These statements will later, after your review, form the basis of the main study in which participants will be asked to sort the statements. The main study will ask participants to sort which statements are most or least important to them in having counselling following second harm. In order to make sure that this sorting process is of good quality the statements will be reviewed by you for the following:

- To ensure that statements are easy to understand, clear and the wording is not confusing.

- To ensure that there is nothing that you feel is missing from the statements - a particular theme that you feel is not covered, that should be there for example.

Following the review any changes, if there are any, will be made, additions will be confirmed with you by email and the final set of statements will be agreed between us. No data will be collected from you.

How will you protect my confidentiality and look after my data?

1. I will not use, or share any confidential information relating to or received from you. I am the only one that will see your data.

2. The use and sharing of all information about individuals that can be identified are governed by the General Data Protection Regulation and I have a legal duty to comply with this. I will not use or share any personal data received during this research work for any purpose other than that for this research. The research will also abide by the requirements of the University of Derby Good Scientific Practice http://www.derby.ac.uk/research/policy-and-strategy. Personal data will be stored on a computer that is password protected. Documents with personal data will be encrypted and stored on a password protected source kept in a locked safe. This mean that documents can only be access by a password that only I know. I am registered with the Information Commissioner with regards to storage of electronic data and will continue to comply with requirements of registration. This means that I have signed up to high standards of data protection and have agreed to abide by these. An online training package on data protection has been completed by me in May 2018 as part of my mandatory training so that I am fully aware of the data protection law.

3. I undertake to keep all confidential and personal data securely, and to follow all relevant data protection procedures in doing so. Data collected will be made up of numbers and some text. An ID number will be allocated to each person participating and used to identify the data from that individual. The details of the personal information relating to the ID number will be kept in a locked safe along with contact details only of the participants. This will include name, contact details and the consent form of each. Names will not be used during the study nor will information that could identify a person be included in the study.

4. All records provided or created for the purposes of this research, including any back-up records, will be deleted should you decide to withdraw from the research at any point. All data will be destroyed once the study has ended.

Is participation voluntary?

Participation in the **testing** is completely voluntary. Participants can withdraw at any point up to the analysis of data (approximately one month from the collection of data) without negative consequences. Should you choose to do so any personal data will be destroyed.

Are there any potential risks, harms and benefits to me and what are these?

It is not anticipated that there would be harm to you by participating in this research. However, it is important to note the following as potentially harmful.

Use of computers – participants are advised to have a break from the computer at least every hour.

Emotional distress as a result of considering the research question – participants will not be asked about their experiences of harm but about the counselling that they think would support their recovery from second harm. The research is designed to ensure that the minimal distressing questions are asked of participants. However, should participants be distressed or upset during the study they have the following mechanisms to manage their distress:

- Telephone follow-up call during which this can be discussed with the researcher to consider if a referral might be appropriate to local services including your GP. This is why your GP would need to be informed of your participation.
- Contact local services yourself.
- Contact the organisations indicated on the Support for Participants Sheet.

Potential benefits to participation include the following:
An opportunity to contribute to a greater understanding of second harm which will be shared within the academic, counselling and health professional communities. This will raise awareness of second harm and it is hoped that this, in turn will contribute to a better response to those who have been harmed in this way.
An opportunity to contribute to a framework developed for those counsellors working with those who have been harmed secondary to a medical or surgical error.
An opportunity to consider and reflect on your journey towards recovery.

Where can I go to get Independent advice about participation in this study?
Patient Advice and Liaison Service (PALS) - PALS will be able to offer advice on a range of queries including offering you independent advice that will help you think through whether you should be part of this research project. However, please direct any specific questions about this project to the researcher.
Can I see the final study?
All participants will have the opportunity to see a summary of the final thesis if they wish.
What are your contact details if I want further information?
The contact details of the investigators are below should you require further information. We welcome contact with our participants to ensure that you are fully informed of the details and implications of participation.
Principal investigator – Linda Kenward linda.kenward@cumbia.ac.uk 01228 616395
Supervisors –
Dr Charlotte Whiffin - C.Whiffin@derby.ac.uk
Dr Michael Townend - M.Townend@derby.ac.uk
How would I make a complaint?
The contact details of the Research Ethics Coordinator for the University of Derby Ethics Board are below should you wish to make a complaint on ethical grounds.
Chair: Lorraine Henshaw
Email: l.henshaw@derby.ac.uk

Linda Kenward
Doctoral student

Kedleston Road, Derby

DE22 1GB, UK

Appendix 6. Letter for participants main study

IRAS ID: 236701
Dear xx

Re: Participation in research - main study
Working title - Help after harm: identifying the counselling needs of those who have experienced second harm in health and social care settings: A Q methodology study

I am writing to you because you have expressed an interest in the above research project. Thank you for your interest in this project.

Before you decide whether or not you would like to participate in the study, it is important for you to understand why we are doing this study and what it would involve for you if you decide to participate. Please take time to read the enclosed information sheet carefully and to think about whether or not you would like to take part.

If you have any questions about the study then please do contact us. My phone number is 01228 161395 or you can contact me on linda.kenward@cumbria.ac.uk and I will be happy to discuss with you any questions you may have.
If, after consideration, you still feel that you would like to participate then please complete the reply slip at the bottom of this letter and return it to me at the above email or postal address. If you do not feel that you would like to be involved then you do not need to respond.
Thank you very much for reading this letter and considering your participation in this project.
Yours sincerely,
Linda Kenward,
Principal Investigator

……

Reply slip
I am interested in the possibility of being a participant in the above study and would be willing to talk to the researcher about participation. I understand that the researcher will contact me to book a time when she can telephone me to discuss the project and potential participation.
I understand that I can withdraw at any point up to the analysis of data (approximately one month from the collection of data) without prejudice or negative consequences and that should I choose to do so any personal data will be destroyed.
I will be happy to be contacted by the researcher (Linda Kenward) for a discussion about potential participation.
Name
Contact number
Preferred day(s) time(s)

Linda Kenward
Doctoral student

Kedleston Road, Derby
DE22 1GB, UK

Appendix 7. Information sheet for main study participants

IRAS ID: 236701

INFORMATION SHEET (Version 3) February 2018.
Title of Project:
Name of Research: Working title - Help after harm: identifying the counselling needs of those who have experienced second harm in health and social care settings: A Q methodology study
Name of researcher – Linda Kenward

The aims of the study
To explore the range of perspectives on what clients say they need from counselling following experiences of second harm within the healthcare setting

The objectives of the study
To identify common needs of clients coming to counselling following second harm.

To identify key factors that are both common and novel in relation to counselling that clients believe would be most helpful following second harm.

To establish a clear framework for counselling that can be utlised by those working with harmed patients.

Research question
What would clients say they need from counselling following experiences of second harm within the healthcare setting

Background to the research

This study is looking at the counselling needs of clients who have experienced second harm in the healthcare system. First harm happens as a result of an error, mistake, neglect or mismanagement of treatment. The second harm may happen as a result of the poor response of the health care provider or professional to the first harm and may include; not sharing information, denial of error, lack of care, not acknowledging the impact for the client, inability or reluctance of the organisation to learn from mistakes or implement findings of inquiries, dismissal of symptoms, fears and concerns relating to the what happened to the client and poor communication.

Can I participate in the study?

You can be a participant in this study if you have had an experience of second harm in the healthcare setting. To be part of the study you need to be able to read English and have access to a computer or laptop with Microsoft Word or a Mac computer. Internet browsers such as Firefox, Safari or Internet Explorer should also be installed. The use of IPads or SMART phones are not recommended with the software used in the sorting process. You will also need to have access to email and be able to use it. You must be able to give informed consent.

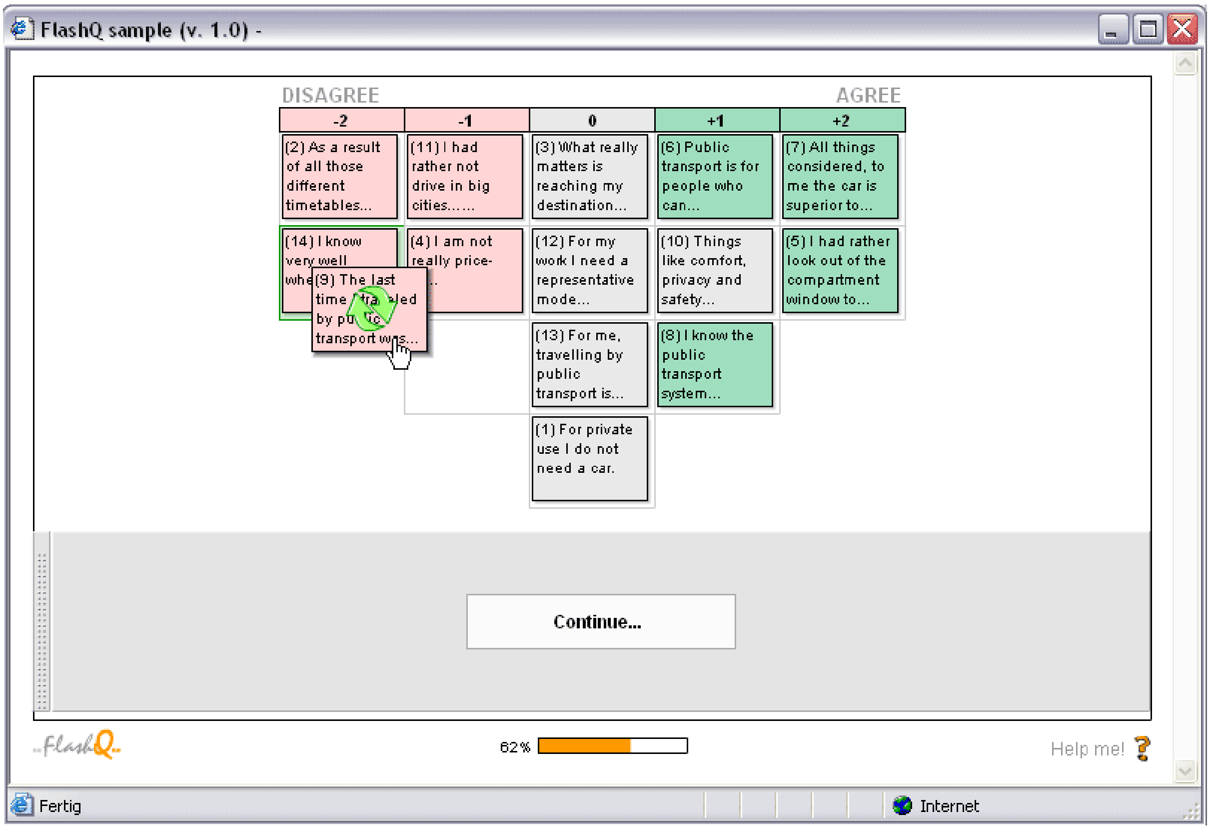
What will be required of me as a participant?

If you agree to be part of this study you will be sent an email from the researcher with a link to the study. Clicking on the link will enable you to log on and sort a number of statements on to a grid (similar to the one below) labelled 'most important/least important in response to the question:

‘Following the experience of second harm, what would be important to you in the relationship with your counsellor’.

A step-by-step instruction will be included in the email. The package is very simple and you don’t need to have done this before. You do not need any special knowledge but you should be able to answer an email and click on a link. You will see a grid similar to the one below, although the statements will be different. You can move the statements around to put them where you want to using the ‘drag and drop’ function on your computer. This is explained in the instructions. There will be about 40 statements and you will be asked to put all of them somewhere on the grid. If you experience problems undertaking the sorting process then you can contact the researcher for help about undertaking the activity. There is a tutorial that you can look at before you undertake the sorting process and it is recommended that you do look at that. The tutorial takes only a few minutes.

THE SORTING PROCESS WILL LOOK SOMETHING LIKE THE ONE BELOW BUT WITH DIFFERENT STATEMENTS.



DISAGREE … AGREE

-2	-1	0	+1	+2
(2) As a result of all those different timetables...	(11) I had rather not drive in big cities......	(3) What really matters is reaching my destination...	(6) Public transport is for people who can...	(7) All things considered, to me the car is superior to...
(14) I know very well whe	(4) I am not really price-	(12) For my work I need a representative mode...	(10) Things like comfort, privacy and safety...	(5) I had rather look out of the compartment window to...
		(13) For me, travelling by public transport is...	(8) I know the public transport system...	
		(1) For private use I do not need a car.		

(9) The last time ... transport w...s...

Following this process, you save your result and log off as the package will send the researcher the results by email. This activity will take approximately an hour.

You will be asked to complete the activity by a particular date and plenty of time will be allowed for you to do this after receipt of the email and link to the activity. Once you have completed the sort this will be automatically emailed to the researcher who will email you within 48 hours with a receipt and short ‘thank you’ email. In that email there will be a request for a short follow up phone call, at a time that is convenient to you, to discuss your experience of undertaking the sort and why you placed particular statements in the ‘most important’ or ‘least important’ part of the grid. I will also ask you about your experience of undertaking the activity.

How will you maintain confidentiality and look after my data?

5. I will not use, or share any confidential information relating to or received from you. I am the only one that will see your data.

6. The use and sharing of all information about individuals that can be identified are governed by the General Data Protection Regulations and I have a legal duty to abide by this. I will not use or share any personal data received during this research work for any purpose other than that for this research. The research will also abide by the requirements of the University of Derby Good Scientific Practice http://www.derby.ac.uk/research/policy-and-strategy. Personal data will be stored on a computer that is password protected. Documents with personal data will be encrypted and stored on a password protected source kept in a locked safe. This mean that documents can only be access by a password that only I know. I am registered with the Information Commissioner with regards to storage of electronic data and will continue to comply with requirements of registration. This means that I have signed up to high standards of data protection and have agreed to abide by these. An online training package on data protection has been completed by me in May 2018 to keep me up to date with data protection law.
7. I undertake to keep all confidential and personal data securely, and to follow all relevant data protection procedures in doing so. Data collected will be made up of numbers and some text. An ID number will be allocated to each person participating and used to identify the data from that individual. The details of the personal information relating to the ID number will be kept in a locked safe along with contact details only of the participants. This will include name, contact details and the consent form of each. Names will not be used during the study nor will information that could identify a person be included in the study.

8. All records provided or created for the purposes of this research, including any back-up records, will be deleted should you decide to withdraw from the research at any point. All data will be destroyed once the study has ended.

Is participation voluntary?

Participation in the **study** is completely voluntary. Participants can withdraw at any point up to the analysis of data (approximately one month from the collection of data) without negative consequences. Should you choose to do so any personal data will be destroyed.

Are there any potential risks, harms and benefits to me and if so, what are these?

It is not anticipated that there would be harm to you by participating in this research. However, it is important to note the following as potentially harmful.

Use of computers – participants are advised to have a break from the computer at least every hour.

Emotional distress as a result of considering the research question – participants will not be asked about their experiences of harm but about the counselling that they think would support their recovery from second harm. The research is designed to ensure that the minimal distressing questions are asked of participants. However, should participants be distressed or upset during the study they have the following mechanisms to manage their distress:

- Telephone follow-up call during which this can be discussed with the researcher and consider if a referral might be appropriate to local services, including your GP. This is why your GP would need to be informed of your participation.
- Contact local services yourself.
- Contact the organisations indicated on the Support for Participants Sheet.

Potential benefits to participation include the following:

An opportunity to contribute to a greater understanding of second harm which will be shared within the academic, counselling and health professional communities. This will raise awareness of second harm and it is hoped that this, in turn will contribute to a better response to those who have been harmed in this way.

An opportunity to contribute to a framework developed for those counsellors working with those who have been harmed secondary to a medical or surgical error.

An opportunity to consider and reflect on your journey towards recovery.

Where can I go to get Independent advice about participation in this study?

Patient Advice and Liaison Service (PALS) - PALS will be able to offer advice on a range of queries including offering you independent advice that will help you think through whether you should be part of this research project. However, please direct any specific questions about this project to the researcher.

Can I see the final study?

All participants will have the opportunity to see a summary of the final thesis if they wish.

What are your contact details for further information?

The contact details of the investigators are below should you require further information. We welcome contact with our participants to ensure that you are fully informed of the details and implications of participation.

Principal investigator – Linda Kenward linda.kenward@cumbia.ac.uk 01228 616395
Supervisors –
Dr Charlotte Whiffin - C.Whiffin@derby.ac.uk
Dr Michael Townend - M.Townend@derby.ac.uk

How would I make a complaint?

The contact details of the Research Ethics Coordinator for the University of Derby Ethics Board are below should you wish to make a complaint on ethical grounds.

Chair: Lorraine Henshaw
Email: l.henshaw@derby.ac.uk

Linda Kenward
Doctoral student

Kedleston Road, Derby
DE22 1GB, UK

Appendix 8. Consent form for testers

IRAS ID: 236701

CONSENT FORM – Q Concourse testers (Version 2)

Title of Project: Working title - Help after harm: identifying the counselling needs of those who have experienced second harm in health and social care settings: A Q methodology study
Name of Researcher: Linda Kenward
Please tick box

1. I confirm that I have read the information sheet dated February 2018 version 3 for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐

2. I understand that my participation as a tester is voluntary and that I am free to withdraw at any time up to the point of data analysis which is expected to be within one month of completing the statement testing. ☐

3. I understand that my personal details and all data gathered in this study will be treated confidentially and will only be used for the purposes explained in the information leaflet. ☐

4. I understand that my GP will be informed of my participation in this study. ☐

5. I agree to take part in the above study. ☐

Name of Participant	Date	Signature
Name of Person taking consent Linda Kenward	Date	Signature

You have a 7-day 'cooling off' period after giving verbal consent after which you will be sent the consent form to sign and return via a Stamped Addressed Envelope. This allows you to change your mind about commencing the study before the study begins. However, you can <u>change your mind and withdraw from the study at any point up to the commencement of data analysis which is expected to be up to one month of after completion of the Q sort testing.</u>
Due care will be taken to shred and recycle paper generated in the execution of the research. No travel will be required therefore lowering the carbon footprint. The researcher will make every effort to minimise the environmental impact and carbon footprint of this project.

Linda Kenward
Doctoral student

Kedleston Road, Derby
DE22 1GB, UK

Appendix 9. Consent form for main study

IRAS ID: 236701

CONSENT FORM – Main study participants (version 2)

Title of Project: Working title - Help after harm: identifying the counselling needs of those who have experienced second harm in health and social care settings: A Q methodology study

Name of Researcher: Linda Kenward

Please tick box

1. I confirm that I have read the information sheet dated February (version 3) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐

2. I understand that my participation in the study is voluntary and that I am free to withdraw at any time up to the point of commencement of data analysis which is expected to be within one month of completing the sorting activity. ☐

3. I understand that my personal details and all data gathered in this study will be treated confidentially and will only be used for the purposes explained in the information leaflet. ☐

4. I understand that my GP will be informed of my participation in this study. ☐

5. I agree to take part in the above study. ☐

____________________ Name of Participant	____________________ Date	____________________ Signature
____________________ Name of Person taking consent Linda Kenward	____________________ Date	____________________ Signature

You have a 7-day 'cooling off' period after giving verbal consent after which you will be sent the consent form to sign and return via a Stamped Addressed Envelope. This allows you to change your mind about commencing the study before the study begins. However, you can <u>change your mind and withdraw from the study at any point up to the commencement of data analysis which is expected to be within one month of completing the Q sort.</u>

Due care will be taken to shred and recycle paper generated in the execution of the research. No travel will be required therefore lowering the carbon footprint. The researcher will make every effort to minimise the environmental impact and carbon footprint of this project.

Linda Kenward
Doctoral student

Kedleston Road, Derby
DE22 1GB, UK

Appendix 10. GP Letter

IRAS ID: 236701
For information only.

Title of Project:
Name of Research: Working title - Help after harm: identifying the counselling needs of those who have experienced second harm in health and social care settings: A Q methodology study
Name of researcher
Linda Kenward

Dear Dr

I am obliged by the NHS Ethics Committee, under the terms of the approval for study IRAS ID: 236701, to inform you that your patient, xxx, is participating in the above study.

Kind regards,

Linda Kenward (Doctoral student) at University of Derby
RGN, BACP Registered Counsellor.
Principal Lecturer in Nursing
University of Cumbria
Contact details:
Linda.kenward@cumbria.ac.uk
01228 616395

Linda Kenward
Doctoral student

Kedleston Road, Derby
DE22 1GB, UK

Appendix 11. Post sort telephone interview questions

IRAS ID: 236701

Post sort telephone interview questions including participant reaction assessment as per ISTSS Guidelines. – Version 2 (02.06.2018)

Title of Project: Working title - Help after harm: identifying the counselling needs of those who have experienced second harm in health and social care settings: A Q methodology study

Name of Researcher: Linda Kenward

Thank you for undertaking the Q sort activity. I just want to ask you a few very basic questions about your experience of the sorting process so that I can better understand your choices, and your experience of undertaking the sort.

1. Can you please explain your reason for placing the statement xx (number of statement) in the most important section?
2. Can you please explain your reason for placing the statement xx (number of statement) in the least important section?
3. What statement did you find the most difficult to sort?
4. What statement did you find the easiest to sort?

These questions are for support purposes only and won't be recorded

1. Did you gain anything positive from participating?
2. Did you have any negative effects from participating?
3. Do you require any support following the sorting process?

Thank you for participating in the sorting activity.

Just to remind you that you can contact me at any time regarding queries, clarification or to discuss withdrawal from the project.

Linda Kenward
Doctoral student

Kedleston Road, Derby
DE22 1GB, UK

Appendix 12. Support for participants

IRAS ID: 236701

SUPPORT FOR PARTICIPANTS (Version 3)

Title of Project: Working title - Help after harm: identifying the counselling needs of those who have experienced second harm in health and social care settings: A Q methodology study

Whilst participating in this study you will not be asked about any experiences of hospital care. However, should you wish to access emotional support the following options are available to you.

- **Speak to the researcher who will offer you support during your post sort interview.**
- **Access emotional support and support for complaints from outside agencies that are experienced in supporting patients and managing complaints.**

Action Against Medical Accidents – a Charity offering health and advice in harm in the healthcare setting including support for complaints, compensation and inquests.

Further Information across the UK also includes

Patient Advice and Liaison Service (PALS) - PALS will be able to offer advice on a range of queries including offering you independent advice that will help you think through whether you should be part of this research project. However, please direct any specific questions about this project to the researcher.

England

Local NHS complaints advocacy services can support you to make a complaint about the NHS and may help compose letters and accompany you to meetings. They are commissioned by local authorities across England.

- For more information, visit the NHS Choices website

Scotland

The Patient Advice and Support Service (PASS) is part of Citizens Advice Scotland (CAS). The service is independent and provides free, confidential information, advice and support to anyone who uses the NHS in Scotland, including raising concerns or making a complaint about treatment and care.

- For more information, visit the Citizens Advice Scotland website

Wales

Independent help and advice with NHS complaints is available from your local Community Health Council.

- For more information, visit the NHS Wales website

Northern Ireland

The Patient and Client Council can help you make a complaint about NHS care and treatment in Northern Ireland.

- For more information, visit the Patient and Client Council website

Other support and advice

In addition to help from the services listed here you may benefit from support which other organisations offer. For a huge range of websites, services and information for patients and carers, visit the Patient support directory.

The Samaritans – offer a telephone or local drop in facility to those who need to talk to someone in confidence.

Linda Kenward
Doctoral student

Kedleston Road, Derby
DE22 1GB, UK

Appendix 13. Tester feedback questions.

Thank you for agreeing to 'test' the Q sort statements for me.

Please look at the list of 41 statements and comments as below:

1. Are the statements easy to understand? Please list any that you don't understand
2. Is the wording clear? Please list any that you don't understand
3. Do you feel that the statements cover every aspect of what individuals might want in response to the question: 'Following the experience of second harm, what would be important to you in the relationship with your counsellor?'
4. Do you have any further comments about the statements?

Following the review any changes, if there are any, will be made, additions will be confirmed with you by email and the final set of statements will be agreed between us.
No data will be collected from you.

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Appendix 14 Factor arrays (exemplars) for viewpoint 1 and 2

VIEWPOINT 1

-3	-2	-1	0	1	2	3
8 -To feel confident that I can be emotionally supported through any legal process	11-To be able to feel angry with staff in a safe place, without blame or retribution	9 -That the counsellor understands about aspects of the law	4 -To feel as though I am valued in the relationship	2 -To feel supported	1 - To feel physically and emotionally safe	20-To have honest and respectful communications
35-To feel of equal value to my counsellor	15-That information about counselling is available to me & that information about me is sensitively handled with respect & within the law	19-That the counsellor be accountable for their actions	12-To be helped to trust people and to try to mitigate the negative impacts of what happened	3 -To feel respected	5 -To be treated like a human being	30-To be able to explore the possibilities about what happened to me and why
38-To be part of all decision making about my psychological care-for example referrals	23-To be aware of policies and procedures and to know that these will be adhered to	25 -To be able to challenge my counsellor if I don't think they understand what I'm trying to say or if they get something wrong	14-To feel that I can be fully engaged with by the counsellor and not feel that anything I want to share is a 'no go' area	6 -To feel relaxed in our relationship and that I don't need to work hard in the counselling relationship	17-That the counsellor be honest with me and that they value honesty in our relationship	33-To be listened to and to be heard
	24-That a counsellor helps with exploring big questions about life & previous personal issues that might impact on my recovery if these do emerge in the session	26-That I don't feel as though I am a problem or a case	16-That if something goes wrong in the counselling process/in our relationship, I want to know immediately & to be able to discuss this openly	7-That the relationship is focussed on me and my needs, experiences and feelings	28-To be able to explore and re-explore my experience without feeling that I am being a nuisance or being boring	
	31-. To talk to someone that doesn't make me feel as though I have betrayed the NHS	29-To have a counsellor who can 'sit' with me in my experience and help me not to feel so alone	18-To be able to give constructive feedback to my counsellor and it be used to improve their service	10 -To be able to explore my fears about engaging with the HC system in the future & to be supported to make my own choices	34-That a counsellor be kind, encouraging and values what I have to say	
		32-To feel that my counsellor can deal with the enormity of what happened to me and its subsequent impact	21-To feel empowered	13-To be treated as an equal from whom the healthcare system can learn		
		39-That the counselling relationship be the most important things about the sessions rather than targets, outcomes or the reputation of the counsellor	27-To explore the impact of no one saying sorry and to be able to be angry about this in a safe place	22-That my counsellor cares about me, to be compassionate and is able to empathise with my experience		
		41-That the counsellor acknowledges my experience of harm	36-To feel that my relationship with the counsellor is a non-threatening relationship	42-To know that the counsellor understands and takes account of the 2nd harm on partners & other family relationships		
			37-That my experience be believed and accepted as a valid experience			
			40-That I am not blamed about what happened			

VIEWPOINT 2

-3	-2	-1	0	1	2	3
11-To be able to feel angry with staff in a safe place, without blame or retribution	9 -That the counsellor understands about aspects of the law	4 -To feel as though I am valued in the relationship	5 -To be treated like a human being	3 -To feel respected	14-To feel that I can be fully engaged with by the counsellor and not feel that anything I want to share is a ‘no go’ area	1 - To feel physically and emotionally safe
23-To be aware of policies and procedures and to know that these will be adhered to	15-That information about counselling is available to me & that information about me is sensitively handled with respect & within the law	16-That if something goes wrong in the counselling process/in our relationship, I want to know immediately & to be able to discuss this openly	6 -To feel relaxed in our relationship and that I don't need to work hard in the counselling relationship	7-That the relationship is focused on me and my needs, experiences and feelings	26-That I don't feel as though I am a problem or a case	2 -To feel supported
31-. To talk to someone that doesn't make me feel as though I have betrayed the NHS	19-That the counsellor be accountable for their actions	18-To be able to give constructive feedback to my counsellor and it be used to improve their service	8 -To feel confident that I can be emotionally supported through any legal process	25 -To be able to challenge my counsellor if I don't think they understand what I’m trying to say or if they get something wrong	32-To feel that my counsellor can deal with the enormity of what happened to me and its subsequent impact	37-That my experience be believed and accepted as a valid experience
	21-To feel empowered	20-To have honest and respectful communications	10 -To be able to explore my fears about engaging with the HC system in the future & to be supported to make my own choices	27-To explore the impact of no one saying sorry and to be able to be angry about this in a safe place	33-To be listened to and to be heard	
	30-To be able to explore the possibilities about what happened to me and why	24-That a counsellor helps with exploring the big questions about life and previous personal issues that might impact on my recovery if these do emerge in the session	12-To be helped to trust people and to try to mitigate the negative impacts of what happened	28-To be able to explore and re-explore my experience without feeling that I am being a nuisance or being boring	41-That the counsellor acknowledges my experience of harm	
		29-To have a counsellor who can 'sit' with me in my experience and help me not to feel so alone	13-To be treated as an equal from whom the healthcare system can learn	34-That a counsellor be kind, encouraging and values what I have to say		
		35-To feel of equal value to my counsellor	17-That the counsellor be honest with me and that they value honesty in our relationship	38-To be part of all decision making about my psychological care-for example referrals		
		36-To feel that my relationship with the counsellor is a non-threatening relationship	22-That my counsellor cares about me, to be compassionate and is able to empathise with my experience	42-To know that the counsellor understands and takes account of the 2nd harm on partners & other family relationships		
			39-That the counselling relationship be the most important things about the sessions rather than targets, outcomes or the reputation of the counsellor			
			40-That I am not blamed about what happened			

Appendix 15. Crib Sheet for Factor One

Factor 1 has an eigenvalue of 2.12 and explains 21% of the study variance. number of participants are significantly associated with this factor. They are

		Rank
	Statements ranked as most important in Factor 1 (ranked as 3)	
20	To have honest and respectful communication	3
30	To be able to explore the possibilities about what happened to me and why	3
33	To be listened to and to be heard	3
	Statements ranked higher in Factor 1 than in the factor 2 array	
30	To be able to explore the possibilities about what happened to me and why	3
20	To have honest and respectful communication	3
33	To be listened to and to be heard	3
34	That a counsellor be kind, encouraging and values what I have to say.	2
5	To be treated like a human being	2
17	That the counsellor be honest with me and that they value honesty in our relationship	2
28	To be able to explore and re explore my experience without feeling that I am being a nuisance or being boring	1
6	To feel relaxed in our relationship and that I don't need to work hard in the counselling relationship	1
13	To be treated as an equal from whom the healthcare system can learn	1
10	To be able to explore my fears about engaging with the healthcare system in the future and be supported to make my own choices	1
22	That my counsellor care about me, to be compassionate and is able to empathise with my experience.	1
4	To feel as though I am valued in the relationship	0
36	To feel that my relationship with a counsellor is a non-threatening relationship	0
16	That if something goes wrong in the counselling process or in our relationship I want to know immediately and to be able to discuss this openly	0
18	To be able to give constructive feedback to my counsellor and it be used to improve their service	0
21	To feel empowered	0
19	That the counsellor be accountable for their actions	-1
9	That the counsellor understands aspects of the law about healthcare	-1
11	To be able to feel angry with staff in a safe place, without blame or retribution	-2
23	To be made aware of policies and procedures and know that these will be adhered to.	-2
31	To talk to someone who doesn't make me feel as though I have betrayed the NHS	-2

Statements ranked lower in Factor 1 that in any other factor

1	To feel physically and emotionally safe	2
2	To feel supported	1
27	To explore the impact of no one saying sorry and to be able to be angry about this in a safe place.	0
14	To be treated as an equal from whom the healthcare system can learn.	0
37	That my experience be believed, and to be accepted as a valid experience.	0
25	To be able to challenge my counsellor if I don't think they understand what I'm trying to say or if they have got something wrong.	-1
26	That I don't feel as though I am a problem or a 'case'.	-1
39	That the counselling relationship be the most important thing about the sessions rather than targets, outcomes or the reputation of the counsellor	-1
41	That the counsellor acknowledge my experience of harm.	-1
32	To feel that my counsellor can deal with the enormity of what happened to me and its subsequent impact.	-1
24	That a counsellor help with exploring the big questions about life and previous personal issues that might impact on my recovery if these do emerge in sessions.	-2
8	To feel confident that I can be emotionally supported through any legal process	-3
35	To feel of equal value to my counsellor	-3
38	To be part of all decision making about my psychological care - for example, referrals	-3

Statements ranked as least important in Factor 1

35	To feel of equal value to my counsellor	-3
38	To be part of all decision making about my psychological care	-3
8	To be confident that I can be emotionally supported through any legal process	-3

Appendix 16. Crib Sheet for Factor Two

Factor 2 has an eigenvalue of 0.99 and explains 10% of the study variance. X number of participants are significantly associated with this factor. They are

	Statements ranked as most important in Factor 2	Rank
1	To feel physically and emotionally safe	3
2	to feel supported	3
37	That my experience be believed, and to be accepted as a valid experience.	3
	Statements ranked higher in Factor 2 than in other factor arrays	
1	To feel physically and emotionally safe	3
2	To feel supported	3
37	That my experience be believed, and to be accepted as a valid experience.	3
26	That I don't feel as though I am a problem or a 'case'.	2
41	That the counsellor acknowledge my experience of harm.	2
14	To feel that I can be fully engaged with by the counsellor and not feel that anything that I want to share is a 'no go area'.	2
27	To explore the impact of no one saying sorry and to be able to be angry about this in a safe place.	1
28	To be able to explore and re-explore my experience without feeling that I am being a nuisance or being boring	1
25	To be able to challenge my counsellor if I don't think they understand what I'm trying to say or if they have got something wrong.	1
38	To be part of all decision making about my psychological care - for example, referrals	1
39	That the counselling relationship be the most important thing about the sessions rather than targets, outcomes or the reputation of the counsellor	0
8	To feel confident that I can be emotionally supported through any legal process	0
24	That a counsellor help with exploring the big questions about life and previous personal issues that might impact on my recovery if these do emerge in sessions.	-1
35	To feel of equal value to my counsellor	-1
	Statements ranked lower in Factor 2 that in any other factor	
33	To be listened to and to be heard	2
34	That a counsellor be kind, encouraging and values what I have to say.	1
28	To be able to explore and re-explore my experience without feeling that I am being a nuisance or being boring	1
5	To be treated like a human being	0
6	To feel relaxed in our relationship and that I don't need to work hard in the counselling relationship	0

10	To be able to explore my fears about engaging with the healthcare system in the future and be supported to make my own choices.	0
13	To be treated as an equal from whom the healthcare system can learn.	0
17	That the counsellor be honest with me and that they value honestly in our relationship.	0
22	That my counsellor care about me, to be compassionate and is able to empathise with my experience.	0
4	To feel as though I am valued in the relationship	-1
20	To have honest and respectful communication	-1
36	To feel that my relationship with a counsellor is a non-threatening relationship	-1
16	That if something goes wrong in the counselling process or in our relationship I want to know immediately and to be able to discuss this openly.	-1
18	To be able to give constructive feedback to my counsellor and it be used to improve their service	-1
19	That the counsellor be accountable for their actions	-2
21	To feel empowered	-2
9	That the counsellor understand aspects of the law about healthcare.	-2
30	To be able to explore the possibilities about what happened to me and why	-2
23	To be made aware of policies and procedures and know that these will be adhered to.	-3
11	To be able to feel angry with staff in a safe place, without blame or retribution	-3
31	To talk to someone who doesn't make me feel as though I have betrayed the NHS	-3
	Statements ranked as least important in Factor 2	
11	To be able to feel angry with staff in a safe place, without blame or retribution	-3
31	To talk to someone who doesn't make me feel as though I have betrayed the NHS	-3
23	To be made aware of policies and procedures and know that these will be adhered to.	-3

Appendix 17. Participant 3 Interview transcript (example)

IRAS ID: 236702

Name of Researcher: Linda Kenward (LK)

Participant – 3

Hi, how are you xx

3- Very good

Lk – Fantastic. That will be lovely for you. As you know the purpose of this interview is to just ask you a few very basic questions about your experience of the sorting process so that I can better understand your choices, and your experience of undertaking the sort. Is that okay?

3 - Yes, of course.

LK- I just want to ask you how you got on doing the sorting exercise. Thanks for doing that by the way.

3- Oh yes, I got on fine.

Lk- Great. The one thing people sometimes struggle with is having to refine what they believe to be really the most important things. Was that something that you found difficult?

3. Yes, that was the most difficult thing.

LK - Was it?

3- Yes, it was difficult because you could only put three of the statements into the most important part. Yes, that was the most difficult part.

LK- Okay, but you didn't have any other problems with it?

3- No.

LK- I've got the data in front of me and basically the sorts of things that you are saying, it's about being safe and making sure that the relationship with the counsellor is a good one. So statements 14 (to feel that I can be fully engaged with by the counsellor and not feel that anything I want to share is a 'no go' area), 24 (That a counsellor help with exploring the big questions about life and previous personal issues that might impact upon my recovery if these do emerge in the sessions) and 28 (to be able to explore and re explore my experience without feeling that I am being a nuisance or being boring).

3- Yes, I felt these were absolutely crucial for counselling

LK- I also noticed the ones at the other end of the scale. Statements 9 (That the counsellor understands aspects of the law about health care) 19 (that the counsellor to be accountable for their actions) and 23 (to be made aware of policies and procedures and know that these will be adhered to). Can you tell me anymore about these?

3- Yes, I actually found the legal process very difficult

LK- Did you?

3- Oh yes.

LK- Right.

3- Yes, because my barrister was involving me a little bit more than he would normally, and more than a normal client.

LK- Yes

3- And I ended up saying, look, just contact me only when I absolutely have to do something…. I really couldn't deal with it.

LK- Right

3- I couldn't deal with getting statements back and all that stuff it was just so difficult to do. It's such a negative experience, as it's so concentrated

LK- Yes, of course, so that for you was something you didn't really want to be involved in

3- That's right

LK- Yes

3- It drags it out, and you know the other side drag you out to just before the trial. It's a very wearing process

LK -Yes of course

3- You hold that resolution because I couldn't make any progress in counselling until that process was over, really holding it up. You got this constant reminder, that you really were having to go back over and over again. It's so negative, you have to go over all the negative stuff that you can't do any more, you know, it was incredibly difficult…

I felt so awful because of the infection. You very quickly become tired in the process and are not are able to fight, and I was surprised how quickly I felt like that. I didn't want to fight much more. The most important thing to me in counselling was it was delayed, which didn't really help at all and that was the funding issue between regions, as well as the fact there were no counsellors in the centre in xx, which I think is absolutely disgusting. Every xx would need to have access to a counsellor and that doesn't help because it means that the way you feel is more entrenched. Then when I did start counselling, with the legal case going on it's very unhelpful to the process. The counsellor tried somehow to keep me going as I felt on the edge for a very long time. The other issue was being at work, because when I was at work It was really difficult to go to counselling. I had to try to hang on so that I looked as though I was managing and coping with my work. The thing that was really helpful for me was being able to have long periods of time off. I've made so much more progress in counselling in the last couple of years because I have been able to fall to bits during my time off.

LK- Yes, it is about having that space isn't it, to be able to do that.

3- Yes, that's it exactly. There's an awful lot of factors that affect the counselling really

LK- Yes, there are.

3- Including timing and everything like that, and the person has to be right as well. The benefits to me in having had all the counselling before was that I had a very, very good relationship with her and it means that I absolutely trust her to go further, you know, to be safe to be able to do that.

LK -Yes,

3- She never said, you know it's been 10 years. I don't know what you're making such a fuss about,

LK- Yes that's important, and that's coming out in what people are saying. Thank you very much xx, I really appreciate you doing this and what I'm going to do is to look at the data now. It's going to take me a while and when I start to get some interesting things, I'm going to let people know what I found.

3- That's interesting, how many people have you got to do it

LK- Well I've' got 10 at the moment, which is what I've aimed to get, which is what I was feeling pleased about. If I do get more than that great, but 10 was the initial amount I thought I would need to complete it.

3- I mean, if you want me to ask around. I will

LK- I'm happy for you to raise it with anyone that you think would be interested. I would be delighted if you gave them my email address. Yes, that will be great. Thank you xx. I've got a few more questions I want to ask you, but these have the support purposes only and won't be recorded. So I'm going to switch the recording device off now. Thank you

Appendix 18; Peer reviewed journal article

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Kenward, L. (2019) ‘A literature review to guide novice researchers using Q methodology in the development of a framework for concourse management.’, *Nurse Researcher*, 27(1), pp. 17–21.

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