DOCTORAL THESIS

From Hell to Utopia: How clinical psychologists who don't believe in free will experience delivering therapy.

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Sometimes people come into your life for a moment, a day, or a lifetime. It matters not the time they spent with you, but how they impacted your life in that time. No one comes into your life by accident. Everyone that crosses your path serves a purpose.

- Unknown

Thanks

CONTENTS

1. ABSTRACT

Background: Both Freud (1921) and Skinner (1971) were regarded as 'hard determinists' who saw human thought and action as determined by prior events, and the idea of free will as simply an illusion. While this belief system clearly impacted on the models of therapy they developed, whether such beliefs also had an impact on their ability to develop qualities of effective therapy, such as empathic and genuine therapeutic relationships, is not known. Furthermore, whether there is something about holding this belief system that could affect therapists' abilities to attain and nurture such qualities, remains unclear.

Research Question: The research study reported here sought to gain some insight into the above question, and into what it is like to deliver therapy from a hard determinist philosophical frame, by asking how clinical psychologists who hold a hard determinist philosophy, experience delivering therapy.

Method: The study made use of a qualitative design methodology. Semi-structured interviews were conducted with seven hard determinist clinical psychologists, and interview transcripts were analysed using Interpretative Phenomenological Analysis (IPA).

Results: Four super-ordinate themes emerged from the analysis: 'From Hell to Utopia: How it feels to be a hard determinist therapist', 'Hating the sin, loving the sinner: Enhancing the therapeutic relationship', 'Free will: A felt vs reflective understanding', and 'Therapist as thinker'.

Implications: The themes to emerge from the data gave rise to a number of implications and recommendations for practice and further research. In particular, it was recommended that the link between hard determinist beliefs and a perceived enhancement of the therapeutic relationship warrants further research. Furthermore, since the philosophy was linked to ideas about power, self-control, therapeutic models, science, and research, discussions of the philosophy may add valuable contributions to clinical psychology's understanding of these issues. In addition, a replication or development of this study with a broader range of therapists is recommended, to establish whether the findings reported here can be generalised to therapists from fields outside clinical psychology.

2. INTRODUCTION

According to the British Psychological Society (BPS; 2010, p.2), "clinical psychology aims to reduce psychological distress and to enhance and promote psychological well-being by the systematic application of knowledge derived from psychological theory and data". Clinical psychologists are thus considered to be scientist-practitioners; integrating theory, research and practice, and applying "psychological science to help solve human problems" (BPS, 2010, p. 3). This means that clinical psychologists within the UK are employed in a wide range of roles, across a wide range of settings, and they are considered to be "more than psychological therapists" (BPS, 2010, p.2). Nevertheless, the delivery of psychological therapy remains a large and important part of many clinical psychologists' job roles, and according to Kuipers (2001), they are sought after in many teams specifically for their expertise in psychological therapies.

But what exactly is psychological therapy and how can it aid the psychologist in meeting their aim of reducing psychological distress and enhancing psychological well-being?

This chapter will begin by attempting to answer the above question. It will start by offering a full definition of psychological therapy, and will then move to discuss the literature around how such therapy can work to produce positive outcomes for clients. It will be suggested that an empathic and genuine relationship, working alliance, therapist self-reflection and therapist allegiance to model, are all important factors in therapy outcome, and that a therapist's beliefs can impact on these factors. Some time will then be spent on considering the impact of beliefs on therapy outcome, arguing that metaphysical belief in free will and determinism should be considered alongside epistemological and ontological beliefs in impacting and guiding therapy. The research literature on free will/deterministic beliefs will then be discussed, before the research focus and research question posed in this thesis is stated.

2.1 Defining 'Psychological Therapy'

At first sight, 'psychological therapy', or 'psychotherapy' as it is often called, may appear an easy concept to define. However, a search of the literature reveals a different story, with psychotherapy being described in several different ways across a range of contexts.

The reason for this seems to be the multi-faceted nature of psychotherapy, and the fact that different elements or aspects of therapy are considered important by different people, at different times. According to the British Psychological Society (BPS), for example, psychotherapy can be defined as "the practice of alleviating psychological distress through discussion between client and therapist…" (BPS, 2015, para.8). This method of defining psychotherapy by its aim and by a relationship between client and therapist appears a common one, and emphasises the therapeutic relationship as a central component of psychotherapy. However, there appears to be more to psychotherapy than this central relationship, and others have included different aspects of therapy more explicitly into their definition of the term. The Oxford English Dictionary (2015, "psychotherapy, n.") for example, defines psychotherapy as "The treatment of disorders of the mind or personality by psychological methods", placing less emphasis on the therapeutic relationship, and more on the actual "methods" or work of therapy.

In 2012, the American Psychological Association (APA) approved a definition of psychotherapy that incorporated both the aspects above, suggesting that

> [P]sychotherapy is the informed and intentional application of clinical methods and interpersonal stances derived from established psychological principles for the purpose of assisting people to modify their behaviours, cognitions, emotions, and/or other personal characteristics in directions that the participants deem desirable (APA, 2012, para 6).

This definition seems to explicitly acknowledge clinical methods and an interpersonal relationship as central in defining psychotherapy. However, these two key components still do not seem to encapsulate the entire notion of psychotherapy, or sum up exactly what psychotherapy is. Others have thus included at least two further aspects as core in defining the concept. The first is the existence of a relationship between the therapist and at least one other professional. By requirement for clinical psychologists, this is likely to be a supervisory relationship, but in many contexts (including the NHS for example) therapists are also likely to have relationships with other colleagues, many of whom are professionals from different disciplines. As well as a necessary existence of a relationship between a therapist and another professional, the process of therapy also seems to require therapists to reflect on themselves, and use this reflection to enhance practice. The

Psychotherapy and Counselling Federation of Australia (PACFA), for example, state "…self-awareness, self-development, self-monitoring and self-examination as central to effective and ethical practice" (PACFA, 2015). PACFA also incorporate the other three aspects of therapy into their definition of psychotherapy, emphasising regard for "ongoing clinical supervision" as well as highlighting the interpersonal relationship between client and therapist, and utilisation of skills and theories within the therapeutic intervention.

In drawing all this together, it could be argued that psychological therapy can be defined as a practice which aims to "alleviate … psychological distress" (BPS, 2015, para. 8) and which is comprised of four interrelated elements; a relationship between a therapist(s) and client(s), a relationship between a therapist(s) and other(s) (colleagues/supervisors/ mentors or others), a therapist's engagement in professional self-reflection, and the actual 'work' of therapy (the model(s) and techniques applied). Each of these elements will now be further explored, with particular attention paid to how, and whether, each of these elements contributes to meeting the aims of clinical psychology described above.

It is important to note that I have so far used the terms 'psychological therapy', 'psychotherapy', and 'therapy' interchangeably to mean 'psychological therapy', as defined above. For the remainder of this thesis, I will talk simply of 'therapy' or 'psychotherapy' for ease of clarity. The reader should note that in so doing, I am referring to 'psychological therapy', as defined and described above.

2.2. Exploring what works in psychotherapy

2.2.1 The great debate

In 1977, Smith and Glass published a now well-known meta-analysis looking at nearly 400 controlled evaluations of psychotherapies. This analysis was pivotal in finding psychotherapy to be efficacious, and more recent studies continue to support this finding (e.g., Hofmann et al., 2012; Shedler, 2012). However, Smith and Glass' (1977) meta-analysis also found no significant differences in the outcomes of behavioural vs non-behavioural therapies. This finding was in line with the musings of Saul Rosenzweig, who writing in 1936 noted his belief that all psychotherapies appeared to yield similar outcomes. Rosenzweig likened this to a line from *Alice's Adventures in Wonderland* by

Lewis Carol (1865, p.34), which read, "… at last the Dodo bird said, "Everybody has won and all must have prizes". This idea, that the benefits of different psychotherapies are generally equivalent, has thus come to be known as the "Dodo bird effect" (Wampold & Imel, 2015; p.33). However, while there is much support for the "Dodo bird effect" (e.g., Stiles, Shapiro & Elliot, 1986; Duncan et al., 2010), there are those who argue that some psychotherapeutic models and orientations really *do* provide better outcomes than others, particularly when different mental health problems or disorders are categorised into specific diagnoses. For example, Roth and Fonagy (2005) conducted a large systematic review of the research literature, and as a result identified specific psychotherapeutic models which they proposed work best for specific disorders. In particular, they found evidence to suggest cognitive behavioural therapy was particularly efficacious for a number of disorders.

Norcross (2011, p.16) suggests, like Roth and Fonagy (2005), that the treatment model can make a difference to therapy outcome. However, Norcross (2011, p.12) points out that it "remains a matter of judgement and methodology how much [it] contributes". In making this comment, Norcross (2011, p.12) notes "in considering decades of research", when one looks at the explained variance in psychotherapy outcome, "treatment factors specific to the prescribed therapy" (often called "specific factors") can account for around 15% of the variance. When looking at the unexplained variance, Norcross (2011) states this figure falls to around 8%, and still others note the contribution of "specific factors" to therapy outcome to be more around 1% (Wampold & Imel, 2015).

2.2.2 Reconciling the great debate: the importance of allegiance to model

So, how does one reconcile these different findings and conclude the debate between those who believe in the importance of the theoretical model in therapy outcome, and those who believe no one model to be better than another? Wampold and Imel (2015) suggest psychological models are important for outcome, but that what is important about the different psychological models and approaches used in therapy is not the specific factors of the treatment approach but rather the degree to which the therapist and client buy into the approach. Wampold and Imel (2015) suggest that therapist's allegiance to the therapy delivered (i.e., the degree to which they believe that the therapy is efficacious) is crucial for therapy outcome, since clients expect their therapist to explain their disorder and come

up with a treatment strategy consistent with that explanation. If a therapist does not believe in the treatment approach, Wampold and Imel (2015) suggest it is harder for the client to trust in the therapy and expect positive change. Wampold and Imel's (2015) allegiance effect has been supported by several studies and meta-analyses which have found allegiance effect sizes up to .65 (e.g., Dush, Hirt and Schroeder, 1983; Falkenstrom et al., 2013; Dragioti et al., 2015).

In terms of the above it seems that a therapist's own beliefs are crucial in shaping therapy, since the degree to which a therapist buys into a specific therapeutic approach is likely to affect outcome. It could be argued too, that therapist self-reflection on beliefs in this context is also important, since it may enable the recognition and monitoring of beliefs related to treatment approach, and empower the therapist to modify their approach (or perhaps more challenging, their beliefs) in order to maximise allegiance and thus outcome.

2.2.3 The therapeutic relationship

In discussing the therapeutic relationship (or the relationship between therapist and client), Wampold and Imel (2015, p.56) suggest, in line with others (such as Rogers, 1951; Kolden et al., 2011) that the stronger the 'real relationship' (marked by empathy and genuineness) between therapist and client, the better the outcome of therapy. This suggestion has been supported by studies which consistently find empathy to be a strong predictor of psychotherapy outcome (e.g., Norcross & Wampold, 2011; Elliot et al., 2011). In terms of genuiness /congruence, Kolden et al. (2011, p.69) suggests that this can be both a personal characteristic of the therapist, but also a "mutual, experiential quality of the relationship". They suggest, based on the results of meta-analysis, that the current evidence supports the contribution of congruence to patient outcome, but recommend more research to solidify and clarify this finding.

Related to, and potentially made possible by the therapeutic relationship, is the notion of therapeutic "alliance" (Horvarth, et al., 2011, p.10). This concept, which currently appears to have no universally agreed definition, may be approximately taken to refer to the working collaboration between therapist and client. It is often taken to refer to the idea of a working bond between client and therapist, which enables collaborative goal setting and for the tasks of therapy to be conducted (Bordin, 1979). The therapeutic alliance has

consistently been found to correlate with therapy outcome (Norcross & Wampold, 2011), and therapists "non-defensive response to client negativity is critical for maintaining a good alliance" (Horvarth et al., 2011, p.15). Wampold and Imel (2015) suggest that therapeutic alliance is related to the work and models of therapy, in that the collaboratively developed goals and tasks of therapy induce the client to engage in activities which are designed to promote well-being and reduce symptomology. Further support for the benefits of client–therapist collaboration on client outcome, comes from Tyron and Winograd (2011), whose meta-analysis of 19 studies, totalling 2260 clients, found a medium effect between psychotherapy outcome and collaboration.

It seems then that the method of therapy, the therapeutic relationship, and therapist self-reflection are not only linked, but have a role to play in the outcome of therapy. In particular, the research literature suggests that an empathic and genuine relationship, working alliance, and therapist allegiance to model are all important factors in therapy outcome. Furthermore, Norcross and Wampold (2011) point out that other qualities relevant to the therapeutic relationship also positively effect therapy outcome, including positive regard (which some may believe is entailed by empathy and/or congruence), and the ability of the therapist to tailor therapy to the needs of the client (again, this is arguably entailed by empathy). However, there remains a question of how these elements are attained and nurtured. How does a therapist achieve genuineness and empathy for example, or ensure a solid allegiance to model? A consideration of therapist self-reflection may begin to shed some light on this, and a brief discussion of the research in this area is addressed now. However, it is also important to note that consideration of therapists beliefs, a discussion raised in Section 2.3 of this report, may also begin to address this question.

2.2.4 Professional self-reflection

According to Boud et al. (1985, p.19), reflection is "a generic term for those intellectual and affective activities in which individuals engage to explore their experiences in order to lead to new understandings" and it "encompasses the observation, interpretation and evaluation of one's own thoughts, emotions and actions, and their outcomes" (Bennett-Levy, 2006; p.60). The importance of therapist self-reflection to therapy outcome has already been briefly touched upon in the above sections, and will again be revisited in

relation to therapist beliefs in section 2.3 of this report. However, it is perhaps worth noting at this point that a number of research studies have found an association between therapist self-reflection and therapist expertise (e.g., Binder, 1999; Bennett-Levy et al., 2003) indicating that "continuous professional reflection is what distinguishes expert therapists from average therapists" (Bennett-Levy, 2006). Furthermore, in a recent meta-synthesis of qualitative research by Gale and Schröder (2014), self-reflection among cognitive behavioural therapists was found to be associated with a sense of increased empathy for clients, deeper understanding and appreciation for the tools of therapy (such as formulating and note-taking), a better understanding and ability to communicate the therapeutic model, an enhanced appreciation of the therapeutic relationship, and an increased sense of competency among therapists. Such findings would seem to imply a positive association between professional self-reflection and therapy outcome. Furthermore, it seems to provide one method of enhancing empathy – a quality that has been indicated in the above sections, to positively impact therapy outcome. Exactly how reflection can lead to increased empathy however, is not known. Section 2.3 will begin to address this question, but for now attention will turn to considering the impact of supervision and colleague relationships on therapy outcome.

2.2.5 Supervision and colleague relationships

According to Bambling et al. (2006), and Wampold and Imel (2015), the effects of supervision and the supervisor-supervisee relationship on therapy outcomes are relatively unknown. According to Wampold and Imel (2015), there has only been one published study investigating supervision effects. This study (Bambling et al., 2006) found that clients who received supervised therapy for major depression showed less symptoms of depression following therapy than clients in unsupervised therapy, rated their satisfaction with therapy as greater than the unsupervised clients, indicated a greater working alliance, and were less likely to drop out of therapy. The reasons for these findings are not known, and as there has only been one study, the replicability of these findings is also not known. However, it appears in this study at least, that supervision could enhance therapy outcomes, and it would be interesting to investigate further the mechanisms behind this.

In terms of the impact of the therapist's relationship with their supervisor, wider colleagues or other professionals within a team, on client outcome, I have been unable to

find any studies[1]. It is important to note that my search of the literature in this area was brief as it is not the main focus of this research project. Nevertheless, if such studies do exist, given their failure to be returned in the search conducted, I would suspect they are limited in number. This is perhaps surprising given that the majority, if not all therapists, work in a context which involves other professionals. Even those therapists engaged in lone private practice are likely to engage in at least a supervision or peer-supervisor relationship. Given the importance of therapist allegiance to model earlier described, it seems that understanding the impact of a shared or divided allegiance to model between therapist and supervisor, or therapist and team, may also be important in understanding client outcomes. If therapist and supervisor/team share allegiance, would this enhance therapeutic outcome for example? How and why? It is clear that more research is needed in this area. However, this is not the focus of the current research project, so for now attention will turn summing up the 'what works' research literature so far discussed.

2.2.6 A summary of what works

This section of the report has been concerned with exploring the following four elements of therapy: a relationship between a therapist(s) and client(s), a relationship between a therapist(s) and other(s) (colleagues/supervisors or others), a therapist's engagement in professional self-reflection, and the actual 'work' of therapy (the model(s) and techniques applied). To this extent, close attention has been paid to whether, and how, each of these four elements contributes to effective therapy outcome.

In exploring the above, it has been found that the following aspects of therapy, which will be labelled as the 'qualities' of therapy for the remainder of this report, all appear to some degree interrelated and to influence therapy outcome: an empathic and genuine therapeutic relationship, therapist allegiance to model, therapeutic alliance, and self-reflection. Supervision has also been shown in one study to influence client outcome, however more research is needed in understanding this aspect of therapy, and the mechanisms behind why supervision may contribute to positive therapy outcome.

[1] PsychInfo was searched using the following search criteria, "("MDT relationships" OR "MDT" OR "Multidisciplinary Team" OR "colleagues" OR "supervisor*") AND ("therapy outcome" OR "effects of therapy" OR "therapy effects" OR "Psychotherap* outcome" OR "Psychotherap* effects")"

While there has been much research conducted into establishing the qualities of effective therapy described above, there appears to have been little research conducted into how these qualities are actualised. That is, how therapists can attain and nurture their allegiance to model, a solid and effective working alliance, an empathic and genuine therapeutic relationship, and a reflective professional self.

2.3 The impact of beliefs

According to Anderson (1997, p.94), the beliefs, "values and biases we hold…influence the way we position ourselves with, or the stance we assume with, other people". And this idea is congruent with many different psychological models of therapy, which recognise a link between beliefs or constructs of some form, and subsequent behaviours. It follows from Anderson's (1997) assertion that therapists' beliefs may have the potential to influence their behaviour, and therefore, their ability to attain and nurture the qualities of effective therapy (such as empathy, congruence, allegiance, alliance and self-reflection) outlined above. But what sort of beliefs could influence these qualities of effective therapy? And how?

2.3.1. Philosophical beliefs

Anderson (2007, p.48) argues that some epistemological positions, such as the position of "not knowing" can enhance the therapeutic process through enabling collaborative practice and encouraging therapists to get 'alongside' their clients. In this instance, a therapist taking on a non-realist position, and being aware of that, is hypothesised to be advantages to the therapeutic process, and may be useful in enabling the positive qualities of therapy described in section 2.2 of this report. The non-realist, "not knowing" stance is an epistemological position most often connected with family therapy, and to thinkers such as Gregory Bateson (1972) who contributed to the postmodern advancement of social constructionist thinking. However, while consideration of epistemological beliefs is considered hugely relevant to family therapy, even within apparently individualistic therapies there are important epistemological questions to grapple with. Beck (1979) for example, linked cognitive therapy to stoicism: the idea that knowledge can be attained through reason, and that it is the mind's job to determine if our mental impressions are true or false representations of reality. In a cognitive behavioural framework then, it might

be seen as advantageous for a therapist to align themselves with a more realist (rather than "not knowing") philosophy; helping the client to challenge thoughts that misrepresent reality.

So it seems the philosophical stance assumed by therapists could affect, and even be advantageous, to the therapy delivered. Furthermore, given the allegiance literature earlier discussed, one could argue that a therapist's philosophical beliefs could impact significantly on their allegiance to the model employed, depending on the fit between model and beliefs. In fact, there is a small but growing body of research suggesting that therapist's epistemological beliefs are related to their preferences for different therapeutic models (e.g., Arthur, 2000). Furthermore, according to Niemeyer et al. (2005, p.92) the research so far in this area "provides strong evidence for the interdependence of epistemological commitments and psychotherapeutic preferences".

Despite some promising research within the philosophical realm, such as that linking psychotherapeutic preference with epistemological stance as mentioned above, philosophical discussions of epistemology and ontology (philosophical fields concerned with knowledge and reality) have tended to dominate the literature linking philosophical theory to therapy. This is perhaps since theories of knowledge and reality are intricately bound to, and made explicit within the family therapy tradition, as well as within the more constructivist therapies (such as personal construct psychology; Kelly, 1955), where the majority of philosophical discussion related to therapeutic practice appears to have taken place. Given Anderson's (1997) comments on the relation between beliefs and the stance we assume with others though, it would seem that consideration of wider philosophical beliefs may also be relevant to psychotherapy. The focus of this particular research project is on the philosophical ideas of determinism and free will. Before discussing how consideration of these concepts may be relevant to therapeutic practice though, I first wish to spend some time defining and explaining the concepts.

2.4 Determinism and free will

As noted briefly in the previous section, epistemology is the field of philosophy concerned with the study of knowledge, and ontology (a related discipline) is generally accepted to be the field of philosophy concerned with the study of being, existence and reality. Both

fields fall under the wider philosophical umbrella of 'metaphysics', which also includes the study of the will, and asks questions such as, "Are human beings free agents?"

For years philosophers have debated the existence of free will, and many (e.g., Skinner, 1974; Pereboom, 2006) have argued in determinism as a viable alternative belief system. Determinists believe that all human thought and action are caused by prior events, which are themselves caused by prior events, and so on all the way back to the start of the universe. Or put more succinctly, that "every event is necessitated by antecedent events and conditions, together with the laws of nature" (Hoefer, 2010, para. 1). 'Hard' determinism (James, 1956) sees this belief as incompatible with a belief in free will, and thus rejects free will. Interestingly, while the concepts of free will and determinism are not often considered by clinical psychologists (or taught on every clinical psychology training programme), at least two of the major therapeutic traditions (psychoanalytic and behaviourist) were founded in a deterministic philosophical frame, by theorists considered to be hard determinists (Freud, 1921 and Skinner, 1971).

Sigmund Freud (1921, p.242) noted that a belief in "freedom and volition" is "absolutely unscientific", and that it is "determinism" that "controls even the psychic life". In referring to the feeling of freedom, Freud (1921, p.97-98), like many current day determinists, noted this feeling to be an "illusion". However, Freud (1949, p.72) clearly recognised the importance of this feeling, stating that rather than denying the feeling, psychoanalysis actually sets out "to give the patients ego freedom to choose one way or the other". It seems then, that from this psychoanalytic, hard determinist perspective at least, the goal of psychotherapy may be viewed as "to create or restore an illusion" (Gatch, 1963; p.6).

While the psychoanalytic tradition views human events as caused by 'internal' processes, radical behaviourism (Skinner, 1971), a contrasting therapeutic orientation also founded on the principals of hard determinism, views human events as caused by 'external' factors. According to Skinner (1971), behaviour is determined by external reinforcers, or "environmental contingencies" (Skinner, 1971, p. 210). Such environmental contingencies take "over functions once attributed to autonomous man" (Skinner, 1971, p.210). In making explicit the hard determinist connection to human behaviour, Skinner (1971, p. 16) notes his belief that "a person's genetic endowment, a product of the

evolution of the species, is said to explain part of the workings of his mind and his personal history the rest". For Skinner, this 'scientific' view of humanity offered "exciting possibilities" (Skinner, 1971, p.210), and laid the foundation for his radical behaviourist model of psychotherapy which utilises methods of reinforcement to change human behaviour.

2.5 Relevance of the determinism / free will debate to therapy

Both Freud (1921) and Skinner (1971) were considered determinists who rejected the existence of free will, viewing this intuitive human feeling as an 'illusion'. Their hard determinist beliefs appear bound to the models of therapy they developed and utilised, and likely enhanced their allegiance to these models (or vice versa). An interesting question though, is whether a hard determinist belief system also had an impact on their ability to attain and nurture empathic and genuine relationships with clients, a positive working alliance, and an ability to engage in professional self-reflection. Moreover, the question remains as to whether there is something about holding this belief system, even when working with other therapeutic models, which could affect a therapist's ability to actualise these qualities of therapy and effect therapy outcome.

2.6 Systematic review of the literature

In order to ascertain whether any research has attempted to answer this question, a thorough systematic review of the literature was conducted, looking specifically at deterministic / free will beliefs and their relation to therapy. The results of this review are described and discussed below.

2.6.1 Search strategy

A thorough systematic review of the literature was conducted in order to ensure that as far as possible, any research which had been conducted related to therapy and therapist's beliefs in free will / determinism, could be found. From the researcher's prior reading around the topic, it was anticipated that very little research in this area may have already been conducted. It was thus decided to keep the initial search of the literature broad and not to refine it based on year of publication. Due to the researcher's geographical location,

and her resulting reader access rights to the University of Cambridge online resources, the initial literature search was conducted on the titles and abstracts of articles in the following databases, accessed via the University of Cambridge online resources: psycINFO, psycARTICLES and the Psychology and Behavioural Sciences Collections[2]. The latter is the world's largest full text psychology database, offering full text coverage for approximately 530 journals.

For this initial search of the literature, the following search terms were used, "(determinis* OR free will) AND (therap* OR psychologist or psychotherap*)". It was decided at this stage, not to include any "NOT" criteria, in order to ensure that no relevant articles would be missed. This initial search of the literature yielded 919 articles. After refining for exact duplicates, this was narrowed down to 777. The titles, and where ambiguous, the abstracts of these 777 articles were then screened by the researcher for relevance. Articles were excluded if the paper did not appear to make reference to therapist free will/determinism beliefs and therapy. In total, 663 articles were excluded by this initial screen, leaving 114 articles which appeared relevant. The majority of these articles appeared to be discussion papers. Abstracts of each of these articles were scrutinised in further detail, and discussion papers and articles which did not report the results of any research studies, were excluded. This left a total of four articles which appeared to report the results of research into therapist belief in free will / determinism and its relation to therapy.

In order for the researcher to be sure she had not missed any relevant articles, the search was repeated and narrowed to include only those articles which were deemed by the database search engine, to be "studies" not refined by methodology. This search yielded 128 results, narrowed by excluding for duplicates to 120. After a title and abstract screen for relevance by the researcher, this was narrowed to the same four articles as had been extracted from the first search. The researcher thus felt confident no relevant articles had been missed.

[2] The Psychology and Behavioural Sciences collection was available on trial at the University of Cambridge for the period during which the researcher conducted her literature search. I understand this database is not ordinarily available at the university, but is available via the British Psychological Society.

Given the limited number of relevant articles extracted, the researcher broadened her search to the following search terms, "("philosophical beliefs" or "philosophical orientation" or "philosophical stance") AND (therap* OR psychologist or psychotherap*)". This search yielded 109 articles, reduced to 108 after removing an exact duplicate, and narrowed to just two articles after titles and abstracts were screened for relevance by the researcher (the majority of excluded articles were discussion papers).

From the psychology databases utilised then, only six relevant articles were extracted. Again, in order to be sure that the researcher had not missed any relevant articles, a decision was made to repeat the searches on philosophically, rather than psychologically orientated databases. Two databases available via the University of Cambridge online resources were independently searched; the Philosophers Index, and Philpapers. The search terms used were "(determinis* OR free will) AND (therap* OR psychologist or psychotherap*)". The Philosphers Index search yielded 68 results, which when screened for relevance and the reporting of research findings, was narrowed to 0 relevant articles. Philpapaers returned 108 articles, which when screened for relevance and the reporting of research findings, was narrowed to 1 relevant article. This article (Fahrenberg & Cheetham, 2007) had already been extracted from the initial searches on the Psychology databases. The Philosophically orientated databases thus yielded no further relevant articles than had already been extracted. As a final precaution to ensure no relevant articles were missed, the reference sections of the final extracted articles were scanned. Again, this yielded no further relevant articles[3].

2.6.2 Search summary

Of the six articles extracted, the most relevant to the current study was a USA based dissertation thesis by Vera Gatch (1963). On investigation by the researcher, it was found that the findings of this thesis had subsequently been published in the *Review of Existential Psychology and Psychiatry* (see Gatch & Termerlin, 1965). While this journal appears to have ceased publication in the mid-1990's and I can find little information about it (e.g.,

[3] The reference list of the article written by Fahrenberg and Cheetham (2007) largely referred to titles written in German. As the researcher is not a fluent German speaker, it is acknowledged that relevant articles in this reference list may have been missed.

impact factor), it has been described (Hoeller, 1986, p.138) as having "published essays by nearly every major figure in the world including Viktor Frankl, Eugene Gendlin, Jacques Lacan, R.D. Laing, RolloMay, Maurice Merleau-Ponty, Jacob Needleman, Carl Rogers, and Jean-Paul Sartre".

Of the remaining five articles, three were published in peer reviewed journals. One of these articles (Kimble, 1984) was USA based and published in the *American Psychologist* (impact factor 6.5), one (Jackson & Patton, 1992) was USA based and published in *Counselling and Values* (impact factor 0), and the final article (Fahrenberg & Cheetham, 2007) was German based and published in *Philosophy, Psychiatry and Psychology* (impact factor 0). The two remaining articles are the only two British articles found in the literature search. Both were written by the same authors (Winter, Tschudi & Gilbert; 2006a & 2006b), and appear to report the results of the same study.

So it appears from the results yielded, that very little research has been conducted which considers determinist/free will beliefs and therapy. The implications of this for the current study will be discussed shortly. However, attention will now turn to discussing the six articles identified above.

2.6.3 Discussion of the literature

2.6.3.1 Therapist's deterministic beliefs

Winter, Tschudi, and Gilbert (2006a & 2006b) conducted a study making use of repertory grids, in which therapists were asked to rate 16 different therapeutic approaches (grid elements) in terms of 18 supplied constructs. In this study therapists rated psychoanalytic therapy as "deterministic", "impersonal", "potentially harmful" and "authoritarian", as well as being a therapy they would not feel comfortable using or being treated by. In contrast, therapists rated their "ideal treatment" as being "indeterministic", "unlikely to be harmful", "personal" and "democratic", as well as being a treatment they would feel comfortable to use and comfortable to be treated by. That psychoanalytic therapy was rated as deterministic is perhaps not surprising given the explicit deterministic roots of this therapy. However, it is interesting that few other therapies were rated as deterministic, and that most therapists rated their ideal treatment as "indeterministic". It

would be interesting to know why therapists are not keen on a deterministic approach. Perhaps it is because they link determinism with psychoanalytic therapy, which the participants viewed as "impersonal", "potentially harmful" and "authoritarian". Seeing a deterministic treatment in this negative light is unlikely to lead one to use it or desire it. However, there may be other reasons, such as a deterministic therapy not being in keeping with a therapist's own philosophical outlook, which would fit with the idea of "allegiance to model" earlier mentioned. Winter et al.'s (2006a & 2006b) research is clearly an important start in investigating philosophical beliefs and their relation to therapy. However, because the research investigated a wide range of constructs and elements, not just the deterministic-indeterministic construct, determinism was not the sole focus of the paper. As a result, many questions regarding determinism and therapy remain. In particular, the utility of holding deterministic beliefs on therapy outcome, and how determinist therapists themselves experience delivering therapy, remains unclear.

Interestingly, Winter et al.'s (2006a & 2006b) study looked at determinism in contrast to indeterminism, without mention of free will. Another researcher to consider the deterministic-indeterministic construct was Kimble (1984), who conducted a study looking at the deterministic beliefs (as well as other beliefs) of members of the American Psychological Society. In this study Kimble (1984) asked members of different divisions of the society (the experimental division, division for study of social issues, psychotherapy division and humanistic division) to rate their deterministic beliefs (among other beliefs) on a ten point scale, with '1' being deterministic and '10' being indeterministic. Kimble (1984) found that psychologists of all divisions generally rated their beliefs as deterministic – with the experimental division members holding this belief the strongest (rating an average of '1' on the scale) and the humanistic division members rating it the weakest (with an average of '4.1' on the scale). However, from Kimble's (1984) study it is not clear whether the determinism referred to was 'hard' determinism (i.e., a determinism incompatible with free will), or not. Furthermore, Kimble does not explain how he arrived at the definitions of 'deterministic' and 'indeterministic' which he gave to participants to enable them to rate their position. If one was to compare the definition of 'deterministic' given by Kimble (1984), to the understanding of that same term held by the participants in Winter et al.'s (2006a & 2006b) study, would they look the same? Or very different? Given that the participants in Kimble's study rated themselves overall as 'deterministic', one might assume the definition to have been perceived by participants

very differently to the 'impersonal', 'potentially harmful' and 'authoritarian' way this term was perceived by the participants in Winter et al.'s (2006a & 2006b) study. Some qualitative data in both studies may have helped enrich our understanding of how individuals' perceive these terms, and what they believe may be the impact of identifying with one or other term.

It appears that the objective of Kimble's (1984) study was to determine if two separate cultures existed in psychology; a humanistic culture vs a scientific culture. For Kimble (1984), deterministic beliefs were placed on the 'scientific' side of this divide, and 'indeterministic' beliefs were placed on the 'humanistic' side of the divide. That psychologists of all divisions rated their beliefs as deterministic, appears to have led Kimble to conclude that on this issue, the profession is not particularly divided. However, I wonder if this finding would be different if the definition of the term 'deterministic' made reference to lack of free will? I also wonder if this conclusion would have been different if the participants in the study had all been clinical psychologists, applied psychologists, and/or therapists?

Farhenberg and Cheetham (2008) conducted another, more recent quantitative study that this time looked specifically at the free will beliefs of individuals (alongside other philosophical beliefs). In their study, there was an explicit consideration of free will, and an attempt to assess participants' belief in free will. Farhenberg and Cheetham (2008) analysed the findings of questionnaires completed by 563 undergraduate psychology students. The relevant finding for the current paper was that at least 80% of these participants appeared to believe in free will, and to believe that free will is not merely an illusion. This is an interesting finding, and given that the participants were all psychology students, may indicate a similar dispersion of beliefs in psychologists, and even psychological therapists. However, this is speculative and further research is needed to reach any conclusions regarding the free will beliefs of psychological therapists.

While Farhenberg and Cheetham (2008)'s study is incredibly important, as it considers free will beliefs not considered in Winter et al.'s (2006a & 2006b) or Kimble's (1984) studies, it lacks explicit discussion of participant's deterministic beliefs, and how these may or may not relate to and interact with their free will beliefs. In ascertaining free will beliefs, participants were asked to agree or disagree with three statements. The second

statement was worded as follows, "A conscious act of volition evolves from nonconscious brain functions which are completely interrelated causally. Thus the notion of free will is an illusion". This is a very complex statement. Furthermore, given that participants were not offered definitions for the terms used in this statement, and that they were all undergraduate psychology students, it is not clear that they would fully have understood this statement. It appears that the statement is hinting at a belief in determinism, due to the reference to complete causality within the statement, but this is not clear. It also seems the statement indicates conscious acts can co-exist with, and are evolved from material brain functions. This is an interesting idea, but is not a belief held by all determinists, or necessarily incompatible with a belief in free will. The statement also implies (via use of the word, "thus") that the second part of the statement follows logically from the first. However, some may buy into the first part of the statement, while disagreeing with the latter and vice versa. Unpicking this question, and gaining a fuller understanding of the nature of each participants determinist and free will beliefs, may have helped to illuminate the full extent of their free will/determinist beliefs, and potentially give an indication of why the result appears to some degree, to conflict with the findings of Kimble (1984). Furthermore, gaining some qualitative data alongside this research, may have helped shed light on why so many participants indicated a belief in free will, and what this belief meant to them in relation to their psychological studies. Moreover, despite the novel and interesting finding from this research, we are left wondering about the impact of the participants' free will beliefs on future psychological thinking and theories (which some of the student participants in the research may go on to become involved in), and on therapy (which again, may be a future vocation for some of the participants), and its outcome.

So it seems from discussion of the research so far, that some clarification is needed over the philosophical beliefs of therapists, since at first sight there seems to be a difference of opinion regarding whether most therapists are of hard determinist persuasion or not. It is likely that the different findings may reflect the different orientations of therapists, and that some of those studied have been students and not therapists. The different findings are also likely to be a reflection of an inconsistent definition and understanding of the philosophical notion of determinism, and in particular its relation to free will. Nevertheless, that research is being conducted into therapist beliefs regarding

determinism is encouraging, and leads to further questions regarding the impact of such beliefs on the qualities key to therapy outcome.

2.6.3.2 Therapist's beliefs and their relation to therapy

As noted previously, many believe Freud to have been a hard determinist. However, Gatch (1963) noticed that while many 'orthodox' psychoanalytic psychotherapists also shared this philosophy, there are psychoanalytic psychotherapists who believe in free will. Gatch (1963, 1965) became interested in whether there were differences in the therapy delivered between the two groups of psychoanalysts, and conducted research which analysed transcripts of sessions held by (hard) determinist psychoanalysts and those believing in free will. In total, Gatch (1963, 1965) analysed transcripts from ten determinist and ten free will psychoanalysts. She expected differences in behaviour between the two groups of therapists to be found. Specifically, she hypothesised that 1) the determinist therapists would make more statements during therapy referring to the patients history, than would the free will therapists, 2) determinist therapists and free will therapists would differ in terms of the number of interpretations phrased as hypothesised causal mechanisms, and 3) determinist therapists would make fewer references to issues of choice, decision and responsibility than would the free will therapists. Interestingly, Gatch (1963, 1965) found no significant differences between the two groups of therapists for the first two hypotheses. In particular, she noted that therapists on both sides tended to maintain a focus on discussion of the present or future and rarely phrased interpretations in causal terms. There was, however, a difference between the two groups in terms of hypothesis three; the free will "analysts evidenced significantly more interest in issues of choice, decision, and responsibility than did the determinists" (Gatch, 1963; p.55). Gatch's (1963) findings are useful in illustrating that similarities exist between the therapy delivered by determinist and free will therapists, and in highlighting that, in her study at least, determinist therapists talked of choice, decision and responsibility less than free will therapists. However, while this study is important as it is currently the only study to look at the differences in behaviour between the two sets of therapists, it is lacking in clinical implications. Gatch (1963, 1965) does not explain which style of therapy had better outcomes, or whether there was any difference in terms of outcome for clients. So it is difficult to know whether there is utility in holding one belief over the other. There was also little consideration of the impact that discussing choice/decision/responsibility had

on clients. Some more qualitative data may add to Gatch's research here, to see what therapists or clients felt were the drawbacks or benefits of their beliefs on the therapy, or how their beliefs impacted the therapy and the qualities of therapy key to effective outcome.

In another study considering the impact of beliefs on the behaviour of therapists, Jackson and Patton (1992) conducted a study looking at the language used by free will counsellors during counselling sessions. They noted that although the counsellors all stated their belief in free will, they used deterministic language frequently throughout their sessions. Jackson and Patton (1992) suggest that this points to an inconsistency in belief and behaviour. However, it may be simply that the participants were compatibilists – that is, held the belief that determinism is compatible with free will, in which case their behaviour would have been entirely consistent with their beliefs. It is also possible that the participants used language they felt was helpful for the client, rather than that fitted with their own philosophical assumptions. A further research project building on this one may therefore look to ask therapists about their philosophical beliefs and assumptions, how they experience therapy sessions in terms of their philosophical assumptions, and any impact they feel such assumptions may have on the outcome of the therapy they provide.

2.7 Rationale for the research question

The above literature search was conducted to discover the scope of the current research into deterministic / free will beliefs and therapy. As has been discussed, only six research papers were found, summarising the results of just five studies. While these five studies are useful in providing a start to the research literature on the topic of free will / determinism, they lack an answer to the question posed. That is, they do not give us any information regarding the utility of holding a (hard) determinist philosophy, or indeed whether or not there is something about holding a (hard) determinist philosophy that could affect a therapist's ability to attain and nurture the qualities of effective therapy earlier discussed (including allegiance to model, a working alliance, an empathic and genuine therapeutic relationship, and self-reflection). It seems that what is needed is research which directly tackles this question by hearing the voice of determinist therapists and how they experience therapy. By interviewing hard determinist therapists about their experiences, and how they perceive their beliefs impact (or not) the qualities of therapy

outlined, clinical psychologists and other therapists may begin to gain an understanding of the relevance of this philosophical belief system to therapy, and whether indeed there is any utility (or negative effect) in holding it. Furthermore, given that two major figures from the psychological/therapeutic world held this belief system, there seems a necessity to investigate this philosophical belief system further, to ascertain how this belief system could be advantageous or disadvantageous to the therapeutic work clinical psychologists do with clients.

2.8 The research question

Following from the above, the research question explored in this study was:

How do clinical psychologists who hold a hard determinist philosophy experience delivering therapy?

In asking this question, in line with the definition of therapy stated in section 2.1 of this report, particular consideration was given to exploring how clinical psychologists who hold a hard determinist philosophy experience the therapeutic relationship, relationships with colleagues, relationships with others, and their own self reflections.

3. METHODOLOGY

The following section outlines the methodological approach used in the study and the metaphysical stance of the researcher, inter-relating the two. It then goes on to introduce the participants recruited into the study, outlining in detail the sample demographics, participant recruitment and pathway through the research, and ethical considerations. An overview of the method of analysis is then discussed, before attention turns to summarising some of the strategies used to attain quality within this research study.

3.1. A qualitative approach

This study utilised a qualitative research design. A qualitative design was chosen primarily because the study aimed to hear from hard determinist clinical psychologists

about their experiences of delivering therapy. What clinical psychologists had to say about their experiences of delivering therapy was not known at the stage of developing the study as this voice had not previously been explicitly heard in the research literature. Thus, it seemed too early to form any firm, testable quantitative hypotheses, and it was decided that a qualitative study would enable space to hear from this sub-group of psychologists for the first time. Depending upon what the participants were to say, this qualitative research could then perhaps lay the foundation for further qualitative, or even quantitative research if this was indicated. According to Elliott et al. (1999, p. 216), "the aim of qualitative research is to understand and represent the experiences and actions of people as they encounter, engage, and live through situations". Thus the aims of this research methodology seemed to fit with the aim of the research question in this study, which was to focus on understanding how hard determinist clinical psychologists experience delivering therapy. Furthermore, given that Barker et al. (2002) recommend qualitative approaches for exploring topics that have been under-researched, a qualitative approach to this current study seemed appropriate.

3.2. My metaphysical position

In qualitative research it is often considered essential to state one's own metaphysical (and more particularly, one's epistemological and ontological position), as this is thought to underlie the entire research process and to govern the methodology and analysis used within the research (see for example, Alvesson & Sköldberg, 2009). Furthermore, given the discussion in section 2.3 of this thesis, on the impact of beliefs, I felt it important before discussing further the methods and results of the current study, to briefly outline my metaphysical position below. Given the philosophical nature of the current research project, and in order to enhance reflexivity (see section 3.8), I believe it is important to discuss my broader metaphysical position, rather than concentrating solely on my epistemological and ontological positions, and this is thus also outlined below. Due to the personal nature of this section, I have here moved in to referring to 'I' rather than 'the researcher'. This movement, between 'I' and 'researcher' will continue for the remainder of the report, with 'I' referred to during reflective/reflexive discussion.

It is my most fundamental belief that I cannot know anything[4] except that I think and (therefore) exist in some form. I am a constructivist in the sense that the rest of what I believe is essentially hypotheses (and I acknowledge therefore the fragility of my beliefs, and that my hypotheses may be 'wrong'). One of my hypotheses is that the physical universe exists. I am thus a realist in this sense. Another of my hypotheses is that I am a human being and that I (and others, if they exist) am made of the same stuff as the rest of the universe, and subject to the same laws of cause and effect. This means that I believe all my (and other's) thoughts and actions are caused by the events immediately preceding them, which are caused by those immediately preceding those, and so on back to the beginning of the universe. In this way then, I believe there is no room for freedom of the will since everything I do is 'caused' by an event(s) immediately prior to it, and that humans thus have no free will. In this sense then, I would define myself as a hard determinist[5].

Like many other hard determinists who have written about their beliefs (e.g., Freud, 1921; Harris, 2012), I believe that the intuitive sense humans have of free will exists as a useful illusion, and that it is almost impossible for humans to act other than as if they have free will much of the time. However, I am of the opinion that feeling free does not equal being free, and our sense of free will is nothing more than a clever trick.

While I am a hard determinist and believe, hypothetically, in the reality of a physical universe, I don't believe I can step outside of myself to see the world as it 'really' is. Since, as a hard determinist, I believe myself to be a product of my (biological and environmental among other) experiences and interactions, I can never see the world in a way that has not been shaped by these. According to Elliott et al. (1999, p. 216), "qualitative researchers accept that it is impossible to set aside one's own perspective totally (and do not claim to)". Thus, my own philosophical position seems compatible with that of a qualitative approach.

[4] In line with Descartes (1641/1996) and the skeptics, I believe I could be a brain in a vat, or dreaming, or subject to some other sceptical hypothesis. Thus, if any of these sceptical hypotheses could be the case, I cannot know anything at all. For example, I cannot know I am sitting at this computer now (since I might be dreaming).

[5] If hard determinism is "true" (as I hypothesise, but cannot know), then all of my beliefs (including that I cannot know anything), and all that is written here, has been determined. My "decision" to conduct this research is not free and is intricately, causally connected to my prior interactions and experiences.

Despite the belief that I cannot ever see the world as it 'really' is, and step out of my position, I do believe that from my position, I can look out on the world, and by looking out from my position, I can see and hear other's perspectives. In particular, I believe that if I can become aware of some of my own views and beliefs, I can then move these metaphorical curtains which might otherwise block or obscure my view of the world, aside. In so doing, I can gain a clearer, more accurate view of what others might see. However, the curtains (and my own eyes and windows through which I see) remain in my periphery so to speak, and cannot be completely removed, cleaned or taken down. In qualitative terms, becoming aware of these obscuring beliefs, and opening the metaphorical curtains, is known as 'bracketing'. Elliot et al. (1999, p.216) point out that qualitative researchers "believe that their self-reflective attempts to 'bracket' existing theory and their own values allow them to understand and represent their informants' experiences and actions". Thus, here again, my own philosophical views appear compatible with the qualitative approach to research.

3.3. Interpretative Phenomenological Analysis (IPA)

IPA was chosen as the most suitable method of qualitative inquiry for this research study. Given its phenomenological roots, IPA is "concerned with exploring experience in its own terms" (Smith et al., 2009, p.1), and since my research question focused on exploring the experiences of participants, IPA thus seemed a logical approach. Furthermore, as part of the phenomenological commitment of IPA, its researchers seek to "understand their participants' world, and to describe what it is like" (Larkin et al., 2006, p.104). It was thus felt that the IPA approach might enable the voice of hard determinist clinical psychologists to be heard, and for an understanding of their world, and specifically what it is like for them to deliver therapy, to be gleaned. However, although IPA is concerned with the lived experience of participants, and the meaning participants make of their lived experience, "the end result is always an account of how the analyst thinks the participant is thinking" (Smith et al., 2009, p.80). That is, IPA does not seek simply to describe experiences. It is interpretive and involves a "double hermeneutic" (Smith & Osborn, 2003, p.53). This means that in IPA research, "the researcher is trying to make sense of the participants trying to make sense of their world" (Smith & Osborn, 2003, p.53). The fact that IPA makes explicit the researcher's role as 'interpreter', also makes this approach

very compatible with my own philosophical stance. It is an approach which acknowledges that the researcher "only has access to the participant's experience through what the participant reports about it" (Smith et al., 2009), and crucially, "is also seeing this through the researcher's own, experientially-informed lens" (Smith et al., 2009). Thus, the process of reflexivity is central to the methodology of IPA. IPA researchers, like other qualitative researchers, see value in 'bracketing' their own beliefs and assumptions in so far as they are able, in order to get closer to participants' experiences.

As well as taking a phenomenological and hermeneutic approach, IPA is grounded in an idiographic understanding of human experience, in so much as it emphasises a detailed understanding of individual experience within context. In fulfilling its commitment to a detailed, contextual understanding of human experience, IPA utilises small, purposively-selected samples and endeavours to provide a rich and thorough account of the meaning of experience for the individual (Smith et al., 2009). Given that the hard determinist voice has barely been heard in the research literature on psychological therapy, this idiographic commitment to really hearing, and trying to gain a rich and detailed understanding of participants' experiences, seemed appropriate for this study. By allowing each individual participant to fully explore and explain their experience in context, it was hoped that the researcher would not miss any important aspects of the participants' experiences, something which may happen if the focus of research was too narrow and did not allow space for a detailed and rich understanding.

3.4 Participants

In this section, the participants who volunteered for and were interviewed as part of this study will be introduced to the reader. It is important to note that any names referred to in this, and subsequent sections of the report, are not the real names of the participants used in this study. Pseudonyms have been used for the purpose of protecting anonymity.

3.4.1 Recruitment

Purposive (also known as purposeful) sampling (Ravitch & Carl, 2016), was used as a recruitment method in this study. According to Ravitch and Carl (2016), this method of sampling is used in most qualitative research as it provides "context rich and detailed

accounts of specific populations …" (Ravitch & Carl, 2016). Two strategies of purposive sampling used by the researcher were homogeneous sampling (see section 3.4.2) and snowball/chain sampling (a strategy by which a participant or other individuals known to the researcher, recommends participants for recruitment to the study).

Initially, a call for participants was posted on the 'Psychology Network' discussion pages of the "LinkedIn" professional website (see appendix 1), as well as via hard copy advertisement in the British Psychological Society's (BPS) *Psychologist* magazine (see appendix 2). In order to maximise recruitment, clinical psychology training courses were also contacted via their course directors, who were asked for permission and assistance in forwarding an email request for participants to their staff (appendix 3).

Two participants (Anna and Andy) volunteered for the study as a result of the advertisement in the BPS magazine, three volunteered following emails to clinical psychology training courses (John, Tony and Graham), and no participants volunteered for the study as a result of the LinkedIn post. Two further participants were included in the study. Ethan was recruited via word of mouth. He was not known to the researcher and had never spoken to the researcher prior to the study. A clinical psychologist working in a learning disability service where the researcher was on placement (as part of her clinical psychology training) heard about the researcher's study in casual conversation and informed the researcher that Ethan, a friend of hers, may wish to take part. Ethan was contacted via this colleague in the first instance, and when he expressed his interest in taking part in the study to this colleague, the colleague put him in direct email contact with the researcher.

Justine, the final participant to be introduced to the reader, was initially interviewed as a second pilot interviewee (see section 3.6.2). Justine was known to the researcher prior to undertaking the pilot interview, and it is thus acknowledged that the relationship between Justine and the researcher may have impacted on the way in which Justine answered questions during the research interview. However, following the interview, the researcher did not feel that the relationship had had a negative impact on the quality of data that was obtained from Justine. The content of the interview was not related to the relationship between the researcher and Justine, and it was not felt that Justine was consciously altering

her answers during the interview as a result of the relationship between her and the researcher. Furthermore, Justine gave full and informed consent to take part in the interview under the impression that her data may be used in the final analysis, rather than being used only as pilot data. In addition, following the pilot interview with Justine, no changes were made to the interview schedule.

3.4.2 Participant pathway through the research

Once the participants had made initial contact with the researcher and indicated their interest in the project, they were sent a participant information sheet explaining the study (see appendix 4). After reading this information sheet, the participants were asked to contact the researcher, who then arranged with them a day and time to call to complete an eligibility screening questionnaire (see appendix 5), and a date to complete the semi structured interview (see appendix 6). While participants were offered the opportunity for a face to face interview, all participants chose to conduct the interviews via phone. Prior to the phone interview, participants were asked to complete and return to the researcher, a written consent form and demographic information sheet (see appendix 7 and 8 respectively). Following completion of the semi-structured interview, participants were emailed a copy of the participant debrief form (appendix 9).

3.4.3 Inclusion and exclusion criteria

In order to ensure homogeneity of the sample (Smith et al., 2009), participants were required to fulfil *all* of the following inclusion criteria, in order to be eligible for participation in the study:

- Be a qualified Clinical Psychologist
- Deliver therapy as part of their professional role
- Identify themself as a Determinist and/or hold the belief that every event is necessitated by antecedent events and conditions, together with the laws of nature.
- Hold the belief that human beings have no free will

There were no other restrictions on participation.

3.4.4 Sample size

In total, seven participants were recruited into the study, and each participant completed one telephone interview of between 42 and 96 minutes duration. This number of participants is in line with the "four to ten" (hour long) interviews recommended by Smith et al. (2009, p.52) for professional doctorate research projects. For the current study, the researcher felt that seven participants was enough to provide the different perspectives necessary for adequate perspectival triangulation (Ravitch & Carl, 2016), adding to the rigor and quality of the research (see section 3.8). However, this number was felt to be not too large so as to detract from the detailed case-by-case analysis inherent in the idiographic nature of IPA (Smith et al., 2009).

3.4.5 Demographic information

Table 1. Participant demographic information.

	Gender	**Age**	**Ethnicity**	**Length of time participant has been qualified as a clinical psychologist**
Justine	Female	30 to 35	African/Asian	< 4 years
Ethan	Male	30 to 35	White British	< 4 years
Anna	Female	40 to 45	White French	5 to 10 years
Andy	Male	50 to 55	White British	11 to 15 years
John	Male	Over 55	White British	Over 25 years
Tony	Male	35 to 40	White British	5 to 10 years
Graham	Male	Over 55	White British	Over 25 years

Table 1 above details the demographic information relating to each participant recruited into this study. The participants are ordered, from top to bottom in the table, in the order in which they were recruited into the study (with Justine having been recruited first). It is important to note that for the purpose of protecting anonymity, participants' ages, and the length of time they have been qualified, are specified in ranges, rather than as specific numbers.

As can be seen from the table, the participants represented a variety of ages from under 35 to over 55 years old. There was also a range of experience levels, with participants having been qualified from under four years to over 25 years. While five of the participants described their ethnicity as 'White British', one participant described her ethnicity as 'African/Asian', and another as 'White French'. Only two of the participants were female (interestingly, the non-White British participants), with the remainder being male. It is not known why there was not an equal balance of males and females, whether this is related in some way to an interplay between culture and gender, and whether this gender split is representative of hard determinist clinical psychologists more broadly. This will be considered further in the discussion section of this report.

In addition to the information provided in the table above, participants also gave information to the researcher relating to the area of the country where they had completed their clinical training, and the area of the country where they currently practice. It was felt by the researcher that including this information within the above table, and alongside other demographic information about the participants, may breach the anonymity of some of the participants. Thus, the researcher chose not to display this information within the above table. However, it can be noted that participants were currently practicing throughout England, from the south to the north of the country. They also noted having trained on a variety of different training courses, with one participant having trained outside the UK.

It is worth noting that during their interviews, both Graham and Tony mentioned that they knew John, and that they were aware he was a participant in the study and had completed his research interview prior to them completing it. Due to protecting the anonymity of all participants including John, I was not able to discuss John with Graham or Tony, confirm his participation in the study, or ask any questions about the relationships. Thus, I was not able to ascertain the length of the relationship or nature of the relationship (i.e. colleagues, friends) between Graham and John, and Tony and John. I was also not able to ascertain if Tony and Graham knew each other, or whether the relationships between any of these individuals impacted on the way in which they approached the study and the research interview. I was aware from their email signatures, that Tony and John worked for the same employer, and from the way in which Tony spoke of John, I believe they were colleagues.

Table 2. Models of alignment

	Models of psychological therapy used in therapeutic practice	**Models of psychological therapy participants felt most closely aligned to**	**Method used to ascertain model allegiance**
Justine	Schema therapy, CBT and 3rd wave CBT (ACT, CFT & Mindfulness)	Integrative	Email correspondence
Ethan	CBT	No dominant allegiance: cognitive, behavioural, existential, systemic, psychodynamic	Email correspondence
Anna	Systemic, CBT	Family therapy Gestalt Therapy / Yalom CBT	Email correspondence
Andy	Diadic Developmental Psychotherapy (DDP)	DDP, attachment models, and neurological models of trauma	Interview data
John	Behaviourism & CBT	Radical Behaviourism	Email correspondence
Tony	Behaviourism, ACT, CBT	Radical (Skinnerian) Behaviourism	Email correspondence
Graham	CBT	Behaviourism and CBT	Interview data

On the demographic form, participants were asked to indicate the models of therapy they use in clinical practice. These models are shown in table 2, above. Interestingly, while there was some variety in the models noted, all participants (with the exception of Andy) indicated the use of Cognitive Behavioural Therapy (CBT). This gave the impression that most of the participants were relatively similar in their therapeutic orientation. However, in speaking with the participants during the interviews, it quickly emerged that the way in which they used CBT was very different, and in fact some participants appeared much more aligned to other theoretical models, from radical behaviourism to systemic and gestalt approaches. So as not to misrepresent their model allegiances within this section

of the report, after all the interviews were complete, I emailed participants to ask them which models they felt most closely aligned to. Five participants (Justine, Anna, Tony, John and Ethan) responded to this email, and their responses (exactly as they were written in the emails), are shown in table 2 above. In order for the reader to gain an impression of the models the remaining participants felt aligned to, I have included in the table the models of psychological therapy the remaining participants appeared most aligned to according to their interview data.

3.5. Ethical considerations

Ethical approval for the study was granted by the University of Hertfordshire Ethics Committee. Relevant documentation is provided in appendix 10. The current study also complied with the British Psychological Society's (BPS; 2014) 'Code of Human Research Ethics'.

In order to ensure full ethical transparency, participants were provided with an official, independent university contact for reporting any queries or concerns about the study, and they were also given the protocol number of the study, relating to the ethical clearance received.

3.5.1 Informed consent

As stated in section 3.4.2, informed consent was ensured by giving participants a written information sheet (appendix 4) about the study. This sheet outlined the research aims, what was involved in taking part in the study, issues of confidentiality, and any potential risks and benefits of participation. Participants were also offered the opportunity to ask questions about the study verbally, via email correspondence, or in writing. All participants were asked to sign a written consent form (appendix 7) prior to participation in the study, and they were reminded of their right to withdraw from the study at any time without consequence.

3.5.2 Confidentiality

Within the information sheet given to participants prior to the study, was information relating specifically to confidentiality. In particular, all participants were informed that

the information collected about them during the course of the research would be kept confidential, and their real names changed or withheld from any reports and publications. Participants were informed that any identifiable information would be kept securely and separately from their audio recordings and transcripts, and that an approved transcription service may be used to transcribe their interviews. Due to the time constraints of this research study, a transcription service was indeed used for 4 of the interviews. Participants were made aware that any audio recordings sent to the transcription service would be anonymised and the service was required to sign a non-disclosure, confidentiality agreement (see appendix 11). Participants were made aware that their audio recordings would be destroyed as soon as the researcher's degree has been conferred. Participants were also notified that any other anonymised data relating to their participation would be kept for five years post research project submission (June 2021), after which time it would be destroyed.

In order that participants could be made aware of who would have access to their data, they were informed within the information sheet provided, that the study was being conducted as part of the requirements of the degree of Doctor of Clinical Psychology. They were thus informed that it would be necessary for some of the data to be looked at by authorised persons from the University of Hertfordshire as well as, potentially, representatives from internal and external academic and professional assessment bodies.

Participants were made aware through the information sheet, that in addition to the findings of this research study being written up in a doctoral thesis, they may also be disseminated via academic publication and presentation. Participants were assured that they would not be identified in any report, publication or presentation, and that any quotes used would be fully anonymised.

Participants were informed that confidentiality would only be breached if they were to disclose to the researcher, something which would lead her to feel sufficiently concerned about their safety or the safety of others. In this case, participants were informed that the researcher would need to inform an appropriate third party.

3.5.3 Potential distress

The researcher felt that there was a small possibility that participants might find some aspects of the interview upsetting. Participants were therefore informed of this in the information sheet given prior to participation. Participants were also informed that if they found any question in the interview particularly upsetting, they did not have to answer it. As stated previously, participants were also notified that they could withdraw from the study at any time without consequence. Following the research interview, participants were given a debrief form (see appendix 9) and a list of contact details for national support services, should they feel distressed.

3.6 Data collection

Before detailing this section of the report, it is important to note that during this research study, the researcher had access to an IPA group. This group was facilitated by a Clinical Psychologist and Reader in Clinical Psychology Training, who was also an experienced IPA researcher, as well as being the researcher's second supervisor. The other six members of the group were colleagues who were conducting simultaneous IPA studies. The purpose of the group was for group members to learn specialist IPA knowledge from the facilitator, as well as to engage in dialogue and collaboration with others who might engage critically with the research, its design and analysis. According to Ravitch and Carl (2016, p.16), "dialogic engagement is a requirement of rigorous, reflexive research and constitutes an approach to qualitative research that engenders and supports criticality". Thus it was felt membership and participation in this group enhanced the rigor and quality of the current research project. Furthermore, dialogic engagement was also enhanced via the researcher engaging in email conversation with an external Professor of Psychology throughout the interview, analysis and write-up stage of this research study. This email correspondence was separate to the research, and was not intended to be used for the purpose of dialogic engagement for this study. However, on reflection the researcher acknowledges that the content of the correspondence concerned the researcher's philosophical beliefs in relation to free will/determinism. In several different emails, exchanged concurrently to the current research study, the external professor challenged and questioned the researcher's free will/determinism beliefs in different ways. Thus, the researcher feels that as a result of this email correspondence, she gained significantly more

insight into her beliefs. This enabled the development and enhancement of reflexivity, and furthered the researcher's awareness of her own beliefs and their changing nature (see appendix 13) over the course of the research and its write-up.

3.6.1 Interview design

A semi-structured interview schedule was constructed by the researcher. This was done in consultation with the above mentioned IPA group, the secondary supervisor, relevant literature, and specialist IPA guidance (Smith et al., 2009).

In constructing the semi-structured interview, the first few questions focused on gaining an understanding of the participants' beliefs. Due to homogeneity sampling and strict inclusion criteria, the participants were all considered to hold hard determinist beliefs. However, within the literature and common language, 'Hard' determinism is usually referred to simply as 'determinism' (which leads to much confusion as we have already established in section 2.6.3 of this report). Thus the researcher was unsure whether participants would be familiar with the term 'hard determinism', and/or whether they had considered their beliefs in relation to this label. In order to gain clarity over the participants' knowledge of the terms, and an understanding of their relationship to the terms, the first part of the interview thus included some closed questions. It is important to note however, that this section of the interview in particular, was used flexibly in order to be responsive to the language, understanding and background philosophical knowledge of the individual participants. According to Ravitch and Carl (2016, p.377), responsivity is an ethical approach to research, because it "pays careful and ongoing attention to participants and their realities and contexts".

In constructing the remainder of the interview, questions were designed to gain an understanding of participants' experiences of delivering therapy given their hard determinist philosophy. In particular, questions were designed to relate to the elements of psychological therapy encompassed by the definition of this term outlined in the introduction to the report. Thus questions included explicit reference to the therapeutic relationship, relationships with clients and the work of therapy. Questions also focused on professional identity and on gaining an understanding of how participants experienced their philosophy in relation to their professional identity. This, it was thought, may shed

light on the experiences of delivering therapy most important to the participants, thems*elves,* with their metaphorical professional hats on. As stated earlier, reflection is "a generic term for those intellectual and affective activities in which individuals engage to explore their experiences in order to lead to new understandings" (Boud et al., 1985; p.19). Thus, the whole process of the interview was considered to be a reflective pursuit, and it was thought that the way in which participants answered the questions may shed light on the way in which they experience self-reflection in the therapeutic context, given their hard determinist philosophy.

Since the voice of hard determinist clinical psychologists has not been explicitly heard in the research literature before, the researcher spent much time thinking about and considering a broad and open research question that would enable all experiences to be heard. Thus, in constructing the semi-structured interview, she was keen not to narrow down her research question by limiting the interview to only those questions specifically included in the semi-structured interview schedule. For this reason, and in line with guidance by Smith et al. (2009), the interview was used flexibly, to allow the individual voices of participants to emerge. Furthermore, towards the end of the interview schedule, participants were asked if they had further comments to add regarding their experiences of delivering therapy, which may not have been covered already in the interview.

3.6.2 Pilot interviews

Two pilot interviews were conducted, firstly with Holly[6] (in person) and then with Justine (via phone). Two pilot interviews (rather than one) were conducted to give the researcher opportunity to try out both face to face and telephone interviews, and to give the researcher breadth and variety of experience by hearing two voices rather than one.

Following the first interview, as a result of discussions with Holly, some minor changes were made to the order of questions in the interview schedule. Furthermore, Holly noted the researcher's interview style to be too 'therapeutic', and so the interviewer used this feedback to try and hold back on "certain common interactional habits (such as … exercising our therapeutic capacity)" (Smith et al., 2009, p.67). And, in its place,

[6] As with all the participants mentioned in this report, a pseudonym has been used for the purpose of protecting anonymity.

endeavoured to "do a lot of highly engaged listening and some well-timed, and sensitive, questioning" (Smith et al., 2009, p.67)

Following the interview with Justine, no further changes to the wording of the interview schedule, or interview style were made. Thus, and for the reasons outlined in section 3.4.1 above, Justine's interview data was used in the final analysis.

It is worth noting that in order to practice the full IPA process, not simply the interviews, Holly's interview was transcribed before being fully analysed by the researcher. This gave the researcher significant insight into the length of time required for data analysis, as well as practice in carrying out the steps of individual case analysis within IPA, outlined in section 3.7.1, below.

3.6.3 Interviews

All participants chose to be interviewed via phone, rather than face to face, due largely to busy work schedules and phone interviews being easier to slot in and rearrange. According to Irvine et al. (2013), telephone interviews can sometimes result in shorter interviews, and less rich data which is felt to be due to telephone interviews offering less opportunity for rapport building. However, Irvine et al. (2013) also point out that telephone interviewers tend to engage in less habits which might be detrimental to obtaining useful credible research data. For example, they note that telephone interviewers are less likely to complete an interviewee's utterances for them, or to re-phrase what an interviewee has said. Telephone interviews are also known to be useful in enabling lower travel and other costs for participants/researcher, and saving time when time is of the essence (Ravitch & Carl, 2016). Being mindful to work hard at ensuring rapport then, it was felt that telephone interviews could be used on this occasion, given the time and travel saving advantages for the busy participants.

All interviews were conducted in line with overall style, rhythm and content guidance by Smith et al. (2009, pp.63-69), and each interview was recorded using a digital audio recording device. The first four interviews (including both pilot interviews) were transcribed by a transcription service due to anticipated time constraints. However, due in part to the philosophical and psychological language used in the interviews, many errors

were found in the transcripts, and it was thus necessary for the researcher to listen through them, making several amendments before she considered them to accurately represent what was said in the interviews. Thus the researcher decided to transcribe the second four recordings herself.

3.7 Data analysis

Interviews were analysed using IPA, following guidelines laid out by Smith et al. (2009), and guidance regarding quality and rigor in qualitative research, specifically as laid out by Elliott et al. (1999), Yardley (2008) and Ravitch and Carl (2016).

3.7.1 Individual Case Analysis

Analysis of data began with individual case analysis. The first stage of this analysis involved reading and re-reading transcripts (at least two initial readings per transcript), in order for the researcher to begin immersing herself in the data. Audio recordings were also listened to in their entirety at least twice per transcript by the researcher during this stage, to allow for the researcher to imagine "the voice of the participant during subsequent readings of the transcript" (Smith et al., 2009, p.82). Following this initial immersion stage, the researcher began reading through the transcripts pen in hand, to make initial notes on the data. In the first instance this was done with paper copies of the transcripts, but later the transcripts were transferred to a word document table, with notes typed directly into this table. The table consisted of three columns (see appendix 12a), with separate columns for the transcript itself (the initial data), initial notes/comments, and emergent themes (to be discussed shortly). In making notes and comments on the transcript, Smith et al. (2009) suggest breaking these down into descriptive comments, linguistic comments and conceptual comments. Thus my notes and comments were guided by consideration of these three ideas. Once note-taking and commenting on the data was exhausted, emergent themes were drawn from the notes and comments, to summarise and capture their essence, while attempting to maintain the complexity, connections, interrelations and patterns found in and between the notes/comments (Smith et al., 2009).

Following the development of initial emergent themes, the researcher began the process of charting and mapping how the themes were considered to link together. Practically this was done by noting the emergent themes in a separate word document. Initially they were placed all in a column from the top to the bottom of the document (appendix 12b). Then, the themes were literally dragged using the mouse, into different positions on the screen. As anticipated by Smith et al. (2009, p.96), during this stage some of the themes appeared to "act as magnets, pulling other themes towards them". In terms of the mind guiding the mouse, the researcher attempted to move themes into different positions and groups on the page via a creative process involving the use of abstraction, subsumption, numeration, polarization, contextualisation and function. These processes were suggested by Smith et al. (2009), and in analysing each transcript, different weight was placed on the different processes, depending on the emergent themes and their apparent patterns and nature. In the process of charting and mapping the themes, emergent themes were clustered into groups of like-themes, and super-ordinate themes were generated to entail these 'like' subordinate themes (appendix 12c). These superordinate themes were given names which the researcher felt captured the meaning and quality of the cluster of subordinate themes. The clusters were then graphically represented (see appendix 12d) to give the researcher indication of their links and connections and an impression of the data as a whole.

The above process was repeated for each transcript, until seven maps of superordinate themes were developed. The use of pictorial maps enabled the researcher to visually capture the dominance of some superordinate themes, within the interviews. Although the idea of pictorial maps was not explicitly suggested by Smith et al. (2009), it was considered an appropriate technique. This is because Smith et al. (2009, p.99) suggest that at this stage of analysis, "the analyst should attempt a graphic representation of the structure of the emergent themes" and that "this may be done through the creation of a table or figure, or the researcher may find other devices helpful". Given that transcripts were analysed in succession, the researcher acknowledges the analysis of each subsequent transcript will have been influenced by those preceding it. However, through use of a reflective journal (see section 3.8) and the rigor of systematically following the above procedure, the researcher was able to allow space for new themes to emerge for each subsequent transcript analysis.

3.7.2 Cross-case analysis

This stage of analysis involved looking for recurrence of themes and patterns across cases. In order to ensure quality and credibility of themes, criteria of recurrence across themes was used (Smith et al., 2009), with themes being classed as recurrent if they were present in four or more of the participants' interviews. Super-ordinate and sub-ordinate themes were relabelled and reconfigured to represent group level themes in line with guidance from Smith et al. (2009), and then these themes were checked against the transcripts. At this point in the process, the researcher discussed the newly found list of group-level themes with her supervisor, and engaged in a bracketing interview to ensure rigor and quality of the final set of themes (see section 3.8 below for details). As a result of these dialogic encounters, the researcher felt that she had almost "over-bracketed" her own beliefs to the point of underplaying the significance of those transcripts most closely reflective of her own beliefs. As a result, she also felt she had magnified the importance of themes contrary to her beliefs, which had taken her interest. In particular, she felt over-emphasis had been placed on themes emerging from John, Tony and Graham's transcripts, while under-emphasis had been placed on the significance of themes related to the therapeutic relationship. Through revisiting the transcripts, the researcher was able to bracket-off this 'over-bracketing', seeing more clearly the significance of the therapeutic relationship to the participants, and allowing this super-ordinate group-level theme to emerge, despite it being closely related to the researchers own beliefs. The researcher also tried to bracket-off her interest in John, Tony and Graham's transcripts – ensuring that themes from their transcripts were not unduly magnified.

With the above in mind, themes were revisited, relabelled and reconfigured, until a final set of super-ordinate and sub-ordinate themes were developed which the researcher felt adequately and rigorously represented the voices and experiences of the participants in the study. Before these super-ordinate themes are introduced to the reader, and the results of the analyses described, attention will turn to briefly summarising quality and rigor as it related to the methodology of the current research study.

3.8 Quality and rigor in qualitative research

As has been noted, the IPA analysis conducted as part of this study was done in accordance with guidelines for conducting good quality, rigorous qualitative research (Elliott et al.,

1999; Yardley, 2008; Ravitch & Carl, 2016). Many methods to increase the rigor and quality of this current research study have already been outlined in the above sections. These include the use of perspectival triangulation (Ravitch & Carl, 2016), dialogic engagement (Ravitch & Carl, 2016), the use of pilot interviews, the following of a procedure for analysis (in line with Ravitch & Carl, 2016), the willingness of the researcher to offer transparent accounts of the recruitment and demographic information of participants (in line with Yardley, 2000), and the offering of a full transcript and its analyses (appendix 12) for independent audit (in line with Smith et al., 2009). Further discussion of the quality and rigor of the research methodology utilised within this study will be undertaken in the discussion section of this report. However, for present purposes, the researcher wishes to make a final point on the quality of this current research, by way of reference to the ideas of reflexivity.

According to Ravitch and Carl, (2016, p.14), 'reflexivity' is an "active and ongoing awareness and address of the researcher's role and influence in the construction of and relational contribution to meaning and interpretation throughout the research process". In line with this idea, Elliott et al. (1999, p.221) notes that researchers should "specify their theoretical orientations and personal anticipations". This specification of positions allows for two things. Firstly, specifying ones orientations, anticipations and beliefs serves to situate the research, offer transparency and allow the reader to reflect on possible interactions between the researcher's orientations, anticipations and beliefs, and the results of the research. Secondly, and as stated in section 3.2, reflexivity allows the researcher to attempt to 'bracket' existing theory and their own values in order to better "understand and represent their informants' experiences and actions" (Elliott, 1999; p.216).

Throughout this research, three main reflexive strategies were used. The first was the use of a reflective journal (as recommended by Smith et al., 2009) to record responses, thoughts and emotions which arose for the researcher during interviews, after interviews and in conducting the analysis. The second was the use of a bracketing interview (see section 3.7.2). This interview took place after an initial set of group-level themes had been developed, but before these were refined and a final set developed. The interview was facilitated by an experienced IPA researcher (also the researcher's second supervisor). The interviewers were all peers on clinical psychology training, conducting

their own (largely) IPA research. In total, six interviewers took part in the interview. This enabled breadth of perspectives on the research. The interviewers were given limited information about the study (the research question and sample demographics), and were asked to interview the researcher (for five to 10 minutes each, in succession) on her analyses and bracketing. In total, the interview lasted approximately fifty minutes and gave the researcher a valuable reflective space in which to think about, and be challenged on, her own beliefs and attitudes, and her role and positionality within the research. The final reflexive strategy used in the research was for the researcher to state her metaphysical position and her beliefs and attitudes in relation to the topic of the research question. The metaphysical position has been stated in section 3.2. I will thus now state my beliefs and attitudes in relation to the topic of the research question. (For a full discussion of the changing nature of these beliefs over the course of the research, please see appendix 13).

3.8.1 My position with relation to the topic of the research question

I am a 'White British', female, mid-30s, DClinPsy final year student. I have an interest in Philosophy, having studied it to degree level, and I have been interested in the free will/determinism debate from a philosophical angle for almost twenty years. In terms of clinical psychology, I have a particular interest in working with forensic clients. I do not consider myself aligned to any particular psychological model and do not believe in the 'truth' of any particular model. I believe models act as metaphors for understanding the contribution of a person's past to their current mental state, and for the intended influence of future change. It is my opinion that the model that best fits a client and therapist is rooted in the language, style, cultural, social, political and philosophical frame of that model that best suits these persons (particularly the therapist). Despite my lack of allegiance to a particular model, I am particularly drawn to PCP (Personal Construct Psychology), systemic, CBT and psychodynamic approaches, all of which inform my current clinical thinking.

My own experiences of delivering therapy from a hard determinist perspective have been largely positive. In particular, I feel the approach has enhanced my ability to empathise with clients (although this is not to say this is a trait exclusive to me as a determinist). Furthermore, I believe that discussion of free will/determinism is important in clinical psychology, not least because (as has been mentioned in the introduction to this thesis)

two major theoretical orientations are underpinned by the philosophy, but also because I believe beliefs can impact behaviour. Where one thus stands on the issue is likely, I believe, to impact on their behaviour in the therapy room. In addition to these points, it should be noted that I very much like and embrace the hard determinist philosophy, and prior to conducting this research, I had seen few downsides to holding it, with the exception perhaps of what I note in the paragraphs below.

I have held my belief in hard determinism for, as far as I'm aware, the majority of my life. In expressing my beliefs over the years I have been met with a variety of responses, the majority negative. It is my belief, in the language of PCP, that many people hold freedom of the will as (an often unquestioned) 'core' construct (Kelly, 1955). Thus it is likely that my vocalisation of the possibility of the non-existence of this concept may have seemed (very) threatening to some, which is likely to have contributed to the negative reactions I have received. Further, I have not always voiced my beliefs in the most helpful or well thought-out ways, which may also have played a part in the way my beliefs have been received, and reacted to, by others.

Perhaps in part in an attempt not to threaten others, and in part to avoid negative reactions from others, I have learnt to keep quiet about my beliefs. In expressing them, and hearing the negative responses that have often emerged, I felt a sense of shame, difference and invalidation. I suppose I hoped to avoid these feelings by keeping my beliefs quiet. However, in keeping them quiet this sense of shame and difference has not resolved, and I feel now that the silence probably only served to reinforce my belief that in holding a hard determinist philosophy, there was indeed something to be ashamed of. On this current doctorate course, I have for the first time found a space in which to make known my beliefs, without too much fear of negative response. That is not to say the negative responses haven't been forthcoming … because they certainly have! But, I have felt validated and safe enough in other respects to face those negative responses, and even to allow myself to speak openly enough about my beliefs to follow my passion and engage in this research project. Finding a supervisory team willing to take a risk on me, and allow this research to manifest, has been both validating, and an experience I am grateful for.

4. RESULTS

In the following section, the results of this research study are outlined. The superordinate themes and subordinate themes extracted are shown in table format (section 4.1), before a rich text description of each theme is then offered (section 4.2). It is important to acknowledge that the results shown here offer one account of how the researcher made sense of the participants making sense of their own experiences. The researchers' influence on the analysis and subsequent themes is thus acknowledged, in line with the philosophical frame outlined in the above methodology sections.

4.1 Tables of themes

The super-ordinate themes developed in the final group-level analysis are summarised in table 3, below.

Table 3. Table of superordinate and subordinate themes

Superordinate theme	Subordinate themes
From Hell to Utopia: How it feels to be a hard determinist therapist	• Swimming against the tide, floating on the water and leaping to utopia • Tied and oppressed vs liberalised
Hating the sin, loving the sinner: Enhancing the therapeutic relationship	• Empathy and understanding • Non-blaming / non-judgemental approach • Compassion and humanity
Free will: A felt vs a reflective understanding	• Illusion and the felt sense • Grappling with vocalising the belief • Responsibility and feeling autonomous
Therapist as thinker	• The reflector • Wanting and searching • Doubt

As was noted in the methodology section of this report, a well-established method of retaining quality in IPA research is to measure and note the recurrence of themes across

cases (Smith et al., 2009). Thus table 4 (below) illustrates the superordinate themes found in this study, and the recurrence of these themes (and their corresponding subthemes) across cases.

Table 4. Themes and recurrence across cases

Superordinate theme	**Subordinate theme**	**Justine**	**Ethan**	**Anna**	**Andy**	**John**	**Tony**	**Graham**
From hell to utopia: How it feels to be a hard determinist therapist	• Swimming against the tide, floating on the water and leaping to utopia	x	x	x	x	x	x	
	• Tied and oppressed vs liberalised	x		x	x	x	x	x
Hating the sin, loving the sinner: Enhancing the therapeutic relationship	• Empathy and understanding		x	x	x	x	x	
	• Non-blaming / non-judgemental approach		x	x	x	x	x	x
	• Compassion and humanity		x	x	x	x	x	
Free will: a felt vs reflective understanding	• Illusion and the felt sense	x	x	x	x	x	x	x
	• Grappling with vocalising the belief	x	x		x	x	x	x
	• Responsibility and feeling autonomous	x	x	x	x	x	x	
Therapist as thinker	• The reflector	x	x	x	x	x	x	x
	• Wanting and searching	x	x	x	x	x	x	x
	• Doubt	x	x	x	x	x	x	x

4.2 Text description of the data

4.2.1 From hell to utopia: How it feels to be a hard determinist therapist

This theme discusses the felt nature of holding a hard determinist philosophy, and how this related to the participants' experiences of delivering therapy. For some, the philosophy felt difficult at times, with John even describing it as "hell", whereas for others there was a sense of calm, liberalism, optimism and even utopia in holding the belief. These different feelings contributed to different ways of viewing therapy, including contrasting ideas on notions such as power and blame, and different ways of drawing on the philosophy to aid the therapeutic encounter.

4.2.1.1 Swimming against the tide, floating on the water, and leaping to utopia.

I'm swimming against the tide… (John)

The quote above sums up how holding a hard determinist philosophy felt for John. He clearly found the philosophy hard and effortful, as well as being a philosophy which he felt forced him to be "at odds" with the rest of society. For John, the two were also linked, with him feeling that the philosophy rendered him unable (or unjustified) to take what he considered the usual, culturally 'normal' stance of blaming clients for wrongdoings. This was particularly pertinent for John, who noted a long working career with forensic clients.

> *It's part of the hell of being a determinist isn't it? It puts you at odds with everything else you know doesn't it? … I mean if you look at everything from criminal responsibility, you know, the whole way society functions … religion, most things … generally free will wins out for most individuals.*
>
> *(John)*

> *I would much prefer for other people to have free will because then I could blame them for their sins … whereas I have to do analyses that take account of the lack of free will when relating to other people … which requires a degree of effort. (John)*

In contrast to the effort and hardship felt by John in holding the hard determinist stance, other participants described the stance in much less effortful, almost peaceful terms.

> *… I suppose I look at life as more of a process that is happening rather than something that I have to get through. (Ethan)*

For many of the participants, like Ethan above, there was a sense that holding a hard determinist philosophy enabled a calmness and acceptance of the process and difficulties of both life, and therapy. For Andy, this reflection on life as an unfolding process, appears to have enabled him to overcome challenges and obstacles in therapy, and helped him feel relief from worry in the moment.

> *It does sort of… kick-in a little bit when I find something particularly challenging, and it's…this idea that things will progress in the way that they have to progress. And that maybe we don't need to just worry about it quite so much. Relieve ourselves of the worry of the moment, and just allow things to evolve in a way. (Andy)*

For Tony, hard determinism was not only a useful philosophy to call upon when challenged, but a philosophy to be positively embraced and utilised proactively. In complete contrast to John's hellish feelings towards the philosophy, Tony attributed utopian status to hard determinism, believing it could be a philosophy capable of making the world a better place.

> *… I think if we embraced a deterministic philosophy, then, actually we could make the world a much better place … and everybody would be much happier. (Tony)*

For Tony, there was an enthusiasm, optimism and passion for the philosophy which not only came through in his tone of voice in interview, but which is also evident in the written data. In the extract below for example, Tony's own optimism seems to change the way he speaks from "would" to "will", almost as if he is so optimistic he has talked himself into believing the deterministic world he desires actually "will" happen.

> *If most of society held these beliefs it would be a good thing because there would be less stigma. People wouldn't be blamed for the experiences they have. … We could develop much better models. People could be much more open to the idea that behaviours are kind of determined … So, we'll develop better treatments. The treatments will be different. It will just be like lifestyle kind of changes and things like that. People will be able to adopt those lifestyle changes. Yeah, I think it would be Utopia. (Tony)*

4.2.1.2 Tied and oppressed vs liberalised

For some participants in the study, there was a sense that hard determinism was tying and oppressive. For Justine, this oppression appeared to come from above, with a sense that control and power were held by, and exercised by, those in authority.

> *We are ruled and governed, despite however much we think we're individuals and we want to be doing stuff, we're still ruled and governed by the bigger mass with those that are in power, either the religion, the government or whoever. (Justine)*

For Justine, there was a sense of authority figures pushing their views down onto her, and a belief that as a therapist, she would have no choice but to spread these views onto her clients. This power dynamic was something she clearly grappled with, as illustrated by the following two excerpts.

> *My behaviour as a therapist is determined by what my bosses want me to do or by my training that I have done … My beliefs are determined by my external factors and I'm sort of somehow either implicitly or subliminally presenting that to the clients. (Justine)*

> *So, I feel like…I feel a little bit bad about the fact that I am imposing my judgements onto someone else in an implicit way. (Justine)*

While Justine experienced a sense of views and beliefs being forced down on individuals from above, John appeared tied and entangled within a deterministic foundation, from

which he could not escape. For John, radical behaviourism was a model of therapy he embraced, used, and appeared very positively attached to. However, he also appeared to see this model as intricately bound to, and inseparable from, hard determinism, a philosophy he did not wish to hold.

> *I suppose I see myself as being primarily a Skinnerian, and therefore I am forced to be a determinist … I would much prefer to have free will …*
>
> *(John)*

While John felt behaviourism tied him to the philosophy of hard determinism, Graham appeared to feel that determinism was intricately tied and bound to science, and that the current neuro-scientific evidence was pointing to the accuracy of determinism. Graham also appeared to believe so highly in the value of research to clinical practice, that he himself seemed not only bound to the importance of research, but almost to embody its importance, citing well over twenty references during the course of the interview. This sense of embodiment of research, and the way in which it was bound to determinism and neuroscience, is perhaps most aptly illustrated by the below dialogue between myself and Graham.

> *Graham: Libet is retired, but he's looked at actually, to try and find evidence of changes in decision making.*
> *Interviewer: Okay.*
> *Graham: And he can identify... just prior to you making a decision when you're about to make the decision.*
> *Interviewer: Okay. Okay.*
> *Graham: And do you know Jeffrey Gray's book called Consciousness Creeping up on the Hard Problem?*
> *Interviewer: Yes.*
> *Graham: Yeah. He's trying to make it both ways and also Wegner's book Delusions of the Conscious Will.*
> *Interviewer: Okay.*
> *Graham: As far as I can see we like to think that we think and reflect on things and decide what to do and then act.*
> *Interviewer: Okay.*

Graham: It's my understanding that lower brain structures … and the rest gets started way before this conscious and executive.
Interviewer: Okay.
Graham: And so in fact our behaviours are...and also Demozio, I'm interested in Demozio's work as well. So as far as I can see our behaviours...and decisions are made prior to conscious awareness. It's not that the conscious awareness doesn't occur, it's just we're too slow.
Interviewer: Okay.
Graham: Depending whether you read the American or UK literature …

While Graham's belief in hard determinism appeared bound by research, and John and Justine found hard determinism tying an oppressive, others found the philosophy to be almost the polar opposite, with Tony describing it as "liberalising"

Determinism gives you a very kind of liberal, shall I say left leaning perspective in life. I suppose you're … I guess you're much less judgemental (Tony)

For Tony, the liberalising nature of the belief appears linked to his belief that the philosophy helps him (perhaps even frees him up to) suspend judgement of others, and take a more empathic approach. The below extract (in which Tony describes his deterministic beliefs as a child) illustrates this point.

I guess I was fairly liberal I suppose in understanding people's behaviour. I would still get annoyed like everybody else. But I could see why people behaved as they did, given their understanding of what was going on or whatever … at that time. (Tony)

For Andy too, there appeared a freeing and liberalising aspect to hard determinism. For him, hard determinism was about offering a stuck system an alternative way of being, and opening up new possibilities for people, that may not have been visible before therapy.

> *Being a psychologist is trying to influence people's lives. So … what you are doing is…you're actually, you're making everything possible that wouldn't have been possible before. (Andy)*

4.2.2 Hating the sin, loving the sinner: The therapeutic relationship

This theme centres on the idea of the therapeutic relationship, with most participants in this study commenting on the utility of hard determinism in enhancing non-judgementalism and a non-blaming approach to clients and others. In a similar vein, participants also raised a belief in hard determinism as positively impacting on empathy and understanding. Although many participants felt determinism was seen by others in a dehumanising or mechanistic way, most participants in the study rejected this idea, noting the philosophy to enhance compassion and be compatible with a 'human' approach.

4.2.2.1 Empathy and understanding

All participants expressed, in some way, the idea that determinism leads them to look deeper into the reasons for an individual's actions, to try and understand why that person did/thought/felt as they did. This, it was noted by some participants, could enhance empathy and understanding. Tony for example, noted the following

> *In most cases I think where people can find it difficult to create the rapport, actually, I think it can help in those difficult cases because you can look at cause and effect rather than good and evil or however else people understand. When you come down to what's gone on, you can usually understand it. (Tony)*

In this passage, Tony appears to be suggesting that looking at cause and effect helps one to better understand behaviour, and that notions of good and evil are less in keeping with this level of understanding. Anna also noted the desire to understand people, linking this to empathy and suggesting that understanding people is what the determinist framework is about, or means for her.

> *I am interested in people and what they have to say. I am very empathic. I always try to understand what people are saying. I am always trying to understand people. The determinist framework of therapy means you are always trying to understand them, understand people. (Anna)*

This sense of trying to understand people was echoed by Ethan, who noted the process of formulation as a hard deterministic method of gaining genuine empathy and understanding for the actions of others.

> *… that's the nature of formulation and validation … we constantly try to create a shared understanding where … I could look to the person opposite me and think, 'If I had your brain and I had your past experiences, I will be sitting opposite with exactly the same difficulties as you had.' So hopefully when I validate people's difficulties, I can do it … with genuine authenticity. I literally think that I would have their difficulties if I were born at their moment of time with their biology.*
>
> *(Ethan)*

In looking at Ethan's account, it feels as if his hard determinist philosophy in some ways adds nothing extra to what any other therapist might do when formulating a client. However, his belief that he would "literally" have "exactly" the same difficulties as another if he was "born at their moment of time with their biology", leaves no room for free will and seems to be what makes his determinist view of formulating different from perhaps a free will therapist. For Ethan, it seems that his hard determinist belief gives him "genuine authenticity" when validating his clients, because he literally believes if he had walked in their shoes he would have acted as they did. I wonder if this genuineness comes across to his clients in the therapy room, and what the effect of this may be on his relationship with his clients, and the subsequent therapy.

4.2.2.2 A non-blaming / non-judgemental approach

> *I think the non-judgemental kind of approach is clearly not just a determinist one. But I think it does kind of help with that. I think if you accept that the person in front of you couldn't possibly be anywhere else*

> *other than where they are right now, given the events and experiences … that they've experienced. Then, I don't think that leaves any room for blame. (Tony)*

In the above quote, while Tony recognises a non-judgemental approach not to be unique to determinism, he suggests that from this philosophical frame, blame is not actually possible. That is, there is "no room for it". John also appears to suggest a similar idea, although for him the language of this idea is couched within a behaviourist frame, illustrating again the inseparability he felt between behaviourism and determinism. The following dialogue between myself and John helps to illustrate this.

> *John: Maybe being a determinist helps you with that being non-judgemental thing.*
> *Interviewer: Can you tell me more about that?*
> *John: Well, I think you're more interested in context rather than blaming individuals. Looking at learning histories possibly, but certainly seeing someone in the immediate context and the reinforcers possibly – that may help. (John)*

Most participants in the study, like John and Tony, raised a belief in the use of determinism in reducing blame and judgement. Furthermore, all noted the particular usefulness of this philosophy when working with forensic or challenging populations. Andy for example, noted the following.

> *… it enables you to step into somebody's shoes, to be less judgemental about people, to empathise and to be more compassionate towards people … possibly even when people do horrendous and horrible things. If you have that view, then … in a way, if you truly believe it, then you really can't judge people. (Andy)*

In the above excerpt Andy notes, like Tony, a sense that if you hold a hard determinist philosophy, judgement is not possible. The philosophy then, seems to take away the autonomy to judge. For the participants, this felt like something positive, and something that enabled them to work with even the most difficult of clients. As Andy goes on to

state in the following passage, without the philosophy there exists a possibility that people can "choose" to do good or bad, whereas the philosophy of hard determinism does away with such notions. It does not, as Tony previously indicated, allow space for concepts such as "good or evil"

> *If determinism is wrong, then people really do choose to do things that are not good for them, not good for other people. So, immediately, that pathologises them as being different. Whereas in fact, I don't think they are. It's about walking in their shoes. (Andy)*

In this excerpt, Andy seems to imply that, under a hard determinist philosophy, all humans are in a sense equal – people who do "not good" things, being just the same as those who don't. He goes on to note however, in the following extract, his belief that non-determinists may fear this position, or misunderstand it, which appears to be a disadvantage for him in holding the philosophy, and leads him to be careful about how he talks about the philosophy.

> *I suppose you do have to be careful about when you talk about these things, because … it's quite a challenging notion to a lot of people and it can be very easily misunderstood … When we're talking about the awful things you've been doing to each other, to have a deterministic view can be seen as quite dangerous because people, as I said, misunderstand that as condoning it all, or saying it's okay, where of course, that's not what I say at all. (Andy)*

In responding to the critics, and trying to show how a non-judgemental approach can be helpful with forensic clients, while also not condoning forensic behaviour, John notes the following.

> *For want of a better phrase, you try to ... 'hate the sin while loving the sinner' I suppose, but it's difficult ... I think it's true of anybody who works in forensics … you know I don't think it's true of me specifically because I am a determinist ... but I think, as a determinist you do have to be warm*

> *and encouraging and try to reinforce the behaviours you want ... and you take a non-judgemental view of some things that are fairly horrendous*
>
> *(John)*

In thinking about the issue of blame and judgement, Graham considered those individuals who are not currently judged by society to have "free will", using this as an example to illustrate how he believes the concept of free will can lead to judgement.

> *We make moral judgments all the time about people. And we excuse people if they don't have what we call free will, for example, with dementia. People don't criticize people if they are suffering with dementia. There is a whole culture built around how we're expected to behave … And you're judged very harshly if you are behaving in a way which isn't seen as acceptable to society because you're thought to have the willpower to behave otherwise.*
>
> *(Graham)*

In reading the above, it appears Graham's view of free will and judgement links not only to therapy, but more broadly to society as whole. In reading it I can't help but think of the following quote from Ethan …

> *… my job is to help people to understand that essentially their difficulties are not really of their doing. Their difficulties have arrived through things that at every stage weren't really ultimately their responsibility.*
>
> *(Ethan)*

It feels that on different levels, the society and the individual, both Graham and Ethan are saying the same thing and have the same message – that criticism, blame and judgement cannot be levied at an individual if they have no moral responsibility. Given the lack of moral responsibility inherent in hard determinism, it seems a hard determinist cannot criticise or judge. I am left wondering how this comes across in the therapeutic relationship, and whether this lack of judgement is picked up on by clients and to what effect.

4.2.2.3 Compassion and humanity

In combining determinism with the empathic and non-judgemental approaches outlined above, participants felt that on the whole their therapy was compassionate.

> *It makes me have a greater sense of compassion towards other people generally … I feel greater compassion to my brothers I would say. And it makes me more accepting of other people and also myself. And I suppose I look at life as more of a process that is happening rather than something that I have to get through. (Ethan)*

In the above extract, Ethan shows not only compassion for others, but appears to utilise the determinist approach in enabling more compassion for himself. What also emerges from the above, is the way in which Ethan notes the influence of determinism on his overall outlook on life. Andy too felt that the determinist philosophy is a kind of "way of life", and he touches on how this way of life informs an empathic and non-judgemental approach, leading him to want to help and instigate change in others.

> *Do we need to distinguish between patients, clients and colleagues? We can think about it in terms of us all as human beings. Because this way that I am with family and children and carers and so on, is a way of being. If somebody is particularly challenging, a manager or colleague or whoever… bringing it back to determinism, I think, well, they hold this view because it's inevitable that they hold this view and I suppose I now am part of that person's influence. And in perhaps that way, that person can change. (Andy)*

It seems then, that both Andy and Ethan felt the determinist outlook enriched empathy and compassion, and was compatible with the notion of humanity. Ethan however, felt the philosophy changed the feel of some aspects of humanity slightly, noting the following

> *I think life loses a little bit of spark when you think that actually things were set in motion at the beginning of the universe or the Big Bang or whatever. And actually everything that's happening is simply part of a sort*

> *of a process that's unfolding and expanding and that we are sort of essentially going along with that.* A*nd what you do is you start reanalysing things like love and relationships. And it changes the feel of them a little bit. (Ethan)*

For the behaviourists in the study, the idea of humanity seemed important, since they raised that their philosophies on life are often seen in a dehumanising or mechanistic way, perhaps in line with Ethan's idea of life losing its "spark". This dialogue below between myself and John illustrates this point.

> *John: I think most people regard behaviourists and determinism as offering a simplistic and mechanistic view of human beings ... and regard them as in some way dehumanising and demeaning human beings.*
> *Interview: What do you think about that?*
> *John: I think ... by ignoring how much we are strongly influenced by the environment and by our contingencies, by down-playing how much the environment plays and influences us, is to deny a massive aspect and component of human experience. (John)*

From the above excerpt it feels as if rather than being "dehumanising", John is wanting to assert that actually determinism/behaviourism has something to contribute to the human experience, which may be missing if it wasn't considered. In later dialogue with John, it emerged that he felt that rather than determinism meaning a loss of some beauty or spark, he simply conceived of beauty in a different way to the "norm". This can be summed up in the following quote.

> *If you look at a fine machine tool and a work by Piccasso – which has the greater beauty? Clearly the machine tool which is precise and functional*
> *(John)*

As is captured in the above, for John there appeared to be beauty in pragmatism, in actually usefully helping people to function better. For the other participants too, compassion, empathy, non-judgementalism and the whole point of the therapeutic relationship seemed to be about promoting change and helping people.

Being a therapist and being in that person's life … I change … potentially the trajectory of somebody's life. (Andy)

4.2.3 Free will: A felt vs reflective understanding

This theme details the complex and intricate relation between the participants 'felt' experience of free will, and their reflective understanding of the concept. In particular, all clients noted the existence of a feeling of freedom, and a firm belief in the usefulness of this feeling, for clients and others. Participants also noted a movement in and out of the feeling, citing reflection and formulation as times when they became aware of the illusionary nature of the feeling of freedom and found it useful to utilise a deterministic perspective. For most of the participants, there was a sense of difficulty in vocalising their disbelief in the existence free will, with fears and concerns around the utility of this within the therapy room, and many having faced negative reactions from colleagues regarding their beliefs, outside the therapy room. Despite apprehensions to raise their beliefs, many participants noted a willingness and desire for the idea of determinism to be discussed within clinical psychology, feeling such discussions may have beneficial effects on the profession. Perhaps somewhat ironically, despite their disbelief in free will and personal agency, all participants (except Graham), noted a heightened sense of personal responsibility in interaction with others. This seemed compatible with their belief that all interactions will influence a person's life course. The sub themes within this section will now be discussed.

4.2.3.1 The illusion and the felt sense

For all of the participants, there was a sense not only that we, as humans, feel free much of the time, but that this felt sense of free will is very important both for therapist, and client. In the following two extracts, Justine refers to this felt sense of free will as both a "delusion" and a "feeling". Other participants also described it as a "feeling", while others referred to a "sense" or an "illusion". As can be seen from Justine's quotes, she considered the feeling of free will as important for both therapist and client, and even gave the feeling such status as to consider it the role of the therapist to develop this feeling and help clients feel free.

> *Even if we're both in the delusion that we can be of free will for that hour, I think that's sort of quite rewarding. (Justine)*

> *And the role of a therapist is to find ways that we can, not to give clients free will, but help them manage it so that they feel free (Justine)*

There was certainly a belief among all the participants that feeling free was necessary and important for change, and all the participants noted enhancement of feelings of choice and autonomy for their clients as being fundamental to their practice.

> *I think essential responsibility is one of the strongest qualities we can have. So I'm constantly trying to enable people to take more responsibility for their actions. Now, even though at a fundamental level, I don't think that responsibility truly lies with them, that very mind-set brings about very good things. (Ethan)*

> *People come to therapy because they are stuck, because they can't change. Free will is very important. People need to feel they have choices (Anna)*

The determination among the participants to give or enhance a sense of free will in their clients seemed, as Anna describes above, to have derived from a sense that such a feeling is necessary for change. However, in addition to this, Graham vocalised a fear of what might happen if he was to raise lack of free will with his clients.

> *… there is the slight disconcerting suggestion that if you invite people to see themselves as not having a free will they might go off the rails more.*
>
> *(Graham)*

While the participants all valued free will and tried to enhance this sense in their clients, they also noted a tendency to move in and out of this feeling themselves, using the movement out of the feeling to reflect on why events/thought/ behaviours had occurred, and to recognise that actually, the "feeling" did not reflect any real autonomy and was just an "illusion".

> *I have those illusions, of course I do. It's only when I analyse my behaviour I realise I didn't have conscious will and was just merely a victim of the contingencies. (John)*

As John illustrates above, participants generally described two levels of operating; within the illusion, and outside the illusion. It seemed that when 'in' the illusion, the therapists were not aware they were in it, and would themselves feel free. Outside the illusion, in a more reflective state, the therapists could reflect on how they felt 'within' the illusion, and used this state to think deterministically and trace the causes of behaviour. Formulating with clients was generally seen as occurring largely 'outside' the illusion, and in the reflective state, where clients and therapists tried to find and reflect on the causes of behaviour.

> *I guess the very nature of formulating, of formulation and hypothesizing and all of those kind of things, you're invariably linking past events to current experiences. And I think most people will understand their experiences in those ways … Whatever kind of therapeutic tradition you're working from, they all seem relatively deterministic in that sense of previous events causing that current behaviour. (Tony)*

4.2.3.2 Grappling with vocalising the belief

> *Justine: Oh, man I really don't want to be contributing to this, but I feel like I'm prescribing them free will, because I think it'd be better for them.*
> *Interviewer: How do you feel about that?*
> *Justine: I feel like a shit … I feel a little bit bad about the fact that I am imposing my judgement of free will onto someone else.*

As the extract above shows, many of the participants appeared to grapple with the degree to which they should be explicit about their belief in hard determinism, and how they felt about encouraging free will in their clients. For Justine, this was a particularly difficult area, largely because she felt that the usefulness of free will was her own belief, and she was not being explicit with clients about her disbelief in its existence. For Justine this led to a power imbalance in therapy – with her in the more powerful position, which she did

not like. For Justine, and others however, there was a sense that hard determinism was a minority position, and an expectation that clients would be free will believers. Thus being explicit about their own beliefs was not felt to be taking an individualised and empathic approach, may take up too much of the therapy time in discussion around the philosophical issues, or could be easily misunderstood. Andy for example noted

> *I would never say to a client there's no such thing as free will because that could be easily misunderstood … (Andy)*

Although he went on to note the following in relation to taking an individualised approach.

> *Interviewer: Have you ever talked to clients explicitly in hard deterministic language?*
> *Andy: I have done in the past with foster carers and…again, but I'd be very careful about that. And I would gauge…I have a relationship, a therapeutic relationship with them anyway so I would … gauge their individual, potential understanding of what I'm trying to say.*

Interestingly, many participants felt a dilemma not only about explicitly raising their beliefs in therapy, but about raising them to colleagues and even acknowledging them to themselves. Most had experienced negative reactions to their beliefs from colleagues, and most felt their beliefs to be in the cultural minority.

> *… I am just labelled as retro, 50s, mechanistic. (John)*

For most, like John, talking about their beliefs appeared to put them in the position of 'outsider' or 'rebel', and there was a need to find ways to 'fit in'. As the extracts below show, for Justine this was about keeping silent about her beliefs, whereas for Tony there was a sense of camaraderie in the difference, as he felt others within his workplace shared his "nerdy" views.

Dialogue 1 (Justine):

> *Justine: I just haven't thought about determinism much probably. Maybe I've just gone with the masses and have blocked it out across my mind.*

Interviewer: why do you think you might've done that?
Justine: To fit in with society. Not to be a rebel.

Dialogue 2 (Tony):

Interviewer: Does your belief in hard determinism impact on your relationship with colleagues at all?
Tony: They kind of tease me a little bit. But it's good natured. I think there's a few of us here, so there's at least a few of us in the … department. But I think they probably see us like the other one, you know, the one from the Big Bang Theory. They say something, we sort of back translate it into nerdy, behavioural language.

For Ethan, who did not know many other determinists, his method of 'fitting in', appeared to be to come alongside others by making known his dislike of the philosophy.

So often when I have conversations about this, I'm invariably talking with someone who is trying to argue the case of free will. But if nothing else, I'm able to maintain a position of, 'Well, I wish this wasn't true, but I'm convinced by the evidence that it is true.' (Ethan)

For many of the participants, there was a feeling that the determinism/free will debate should be spoken about more within the profession of clinical psychology as a whole. Some were attempting to do this within their lecture posts on clinical psychology training programmes, others within their roles as supervisors. The following dialogue between myself and Tony illustrates how he tries to incorporate thinking about determinism into his teaching.

Tony: I try to foster determinism in teaching … in Epistemology and … Philosophy of Science … I think it's essential actually to understanding what you bring to your practice. And somehow, you bring your knowledge to practice as well.
Interviewer: Why is it important?
Tony: Because … it aids in the understanding. Because if you take as an a priori position, that whatever is in front of you is a product of what's

gone before. Then, that allows you to start from a particular position. If you see what's before you as somebody making problematic life choices, but they could stop if they wanted to, then, that leads to a different type of intervention I think. And probably not a very accurate one, in my view.

4.2.3.3 Responsibility and feeling autonomous

Almost ironically, a major subtheme to emerge from the data centred around the participants' own sense of free will, with all of them expressing to a greater or lesser extent an inflated sense of their own personal responsibility. This can be summed up in the below extract from Tony's interview.

I think sometimes you can feel a great deal of inflated responsibility ... Because if you see yourself as part of a deterministic system, and you can influence aspects of that system, and you know that's going to have an impact .... I think, you've got to worry about the things you could have done, or even though of course, what you can do is determined. (Tony)

For some, this sense of responsibility was very difficult (see extract below from John's interview), while for others (such as Justine and Ethan, see below extracts) it appeared to be viewed in more optimistic terms, and gave a feeling of autonomy to influence, under an otherwise non autonomous frame.

If I'm nice to people they'll be nice back ... if I'm miserable to people, people are going to be like…you know. So whatever mood I'm in, I think it determines how people will respond to me. (Justine)

By my very input into someone's life, I then become another force. And so that can then start a snowball reaction or be part of a movement for a person in a more helpful direction. (Ethan)

John: Some people say, before they did something they'd think of me and what I'd say ... and you know ... how would I feel about them if they did

> *this that or the other ... so I suppose you then become part of the contingencies controlling their behaviour.*
> *Interviewer: How does that feel?*
> *John: It feels like a bloody awful responsibility. It feels like a terrible responsibility*

Although participants felt an inflated sense of responsibility, which they put down to their deterministic views, some also noted the use of this philosophy in mitigating the sense of responsibility they felt.

> *Let's say, for example, if I'm at work and I end up losing my patience with a member of staff, right? ... Now, I would go away from that and I would take responsibility ... and I would feel guilty ... Now, even though I feel all these negative emotions ... at a deep level, my guilt is going to be a little bit reduced by the knowledge that, actually, the reason why I did that was ... for factors that weren't really down to my doing. (Ethan)*

For Andy, in reflecting on the use of determinism to ease guilt or understand behaviour, he questioned whether this was letting himself "off the hook", or giving himself and others excuses for action.

> *Philosophically, I don't really have a sense of responsibility, or I shouldn't ... It's tough isn't it, it's always difficult to know whether you're letting yourself and other people off the hook too easily, which a lot of our non-deterministic colleagues would suggest. So, yeah, it's difficult. I think it's a constant negotiation, actually, between how you think about these things.*
> *(Andy)*

In her take on responsibility, Anna noted that a felt sense of responsibility, coupled with her belief in a hard determinist philosophy, led her to work specifically with children. For her, there was a sense of necessity in intervening early in someone's trajectory.

> *.. I work a lot with children ... its why I work with children... if you don't help them and act now ...it will be a lot more difficult for them to be helped later ... Working with young families, you really realise it is important for*

> *them to get support at a young age or otherwise you will develop personality disorder, attachment disorder. That's an extreme, but there is a determinism in that sense. (Anna)*

4.2.4 Therapist as thinker

This final superordinate theme captures the overwhelming sense gleaned by the researcher, of the reflective and thinking nature of the participants in this study. Of course, the participants were being asked to reflect on their beliefs, so reflection was expected. However, in reading the transcripts it quickly emerged that all participants appeared to have thought deeply about their philosophical beliefs and their therapeutic practice, and most had arrived at their philosophical stance after much reflection. Furthermore, some related their philosophical beliefs to self-analytical tendencies, and others noted a relation between deterministic beliefs and how they viewed particular reflective practices such as supervision. Perhaps surprisingly, through their reflections, many participants had established a dislike for the philosophy of hard determinism, and a desire for free will to exist, yet they all described a fruitless search for this elusive concept, settling instead on the belief in its non-existence. Despite this settling of belief, all the participants raised uncertainties and doubts about their belief in hard determinism, perhaps due to their not wanting it to be true.

4.2.4.1 The reflector

From all the transcripts there emerged a sense that the participants were reflectors. There was a sense they had reflected on their beliefs a lot, and had settled on the hard determinist belief after much consideration. These quotes from Graham and John illustrate the point.

> *For me I suppose it's the conclusion of both what I read and my clinical experiences and my discussions with colleagues I suppose. So I suppose I don't end up with this conclusion because I like it, it seems to be the logical conclusion. (Graham)*

> *At a mature level it makes sense of human experience. In terms of understanding human behaviour – determinism ... with its emphasis not*

> *only on biology and … mainly on the environment, offers a full account of human behaviour….a most rich account of human behaviour. Most … accounts of human behaviour miss out … the role of the environment and learning history, and how important that is in eliciting and maintaining behaviour. (John)*

As well as participants having reflected on the philosophy, they also appear to have thought deeply about the therapy they deliver, making links between the two as illustrated in the many quotes threaded throughout this results section. It was clear too, from reading the transcripts, that as well as reflecting on their philosophies, some participants had a tendency to engage in reflection on their own actions and feelings. Tony linked his tendency to self-analysis with his deterministic beliefs, stating the following …

> *I generally experience my own behaviour mainly as determined. And you know, because of that, I suppose I do a lot of self-analysis, and am quite introspective at times. I'll think about why did I do that? What's going on? Why am I worrying at the moment? I don't know, whatever. Why am I checking the taps five times today and not yesterday? Am I anxious? You know, whatever it could be. So, I do that kind of analysis. (Tony)*

In addition to reflecting on self, there was a belief by some participants in the usefulness of shared reflection and the supervision space. In addition, some participants had their own reflections to make on the process of reflective spaces such as supervision, applying the philosophy of hard determinism to think about the impact of supervision on their practice and the impact of themselves on supervision. For example, Justine notes

> *Supervisors will come with their own experiences … and ideas of … where the person I'm working with should go. It would be determined by the training they've had … and the models … The supervisor has an opinion that determines where I go next in my process, in my therapeutic discussion. However, I might come in with my opinions about how I think something should go … it could be influenced or based on my previous experiences … that means … I can influence them. (Justine)*

4.2.4.2 Wanting and searching

I don't want to disbelieve in free will (Anna)
I'd much prefer to be a free willer! (John)

In reflecting on the hard determinist philosophy, some (like Tony and Andy) appeared to embrace and welcome it, whereas others stated they would rather believe in free will. This position of wanting free will, seemed to give the participants empathy and understanding for colleagues and clients who perhaps do not believe in the philosophy, as illustrated by Ethan in the below excerpts.

> *I think it's an unpalatable idea, I think and a difficult one, the idea that we're not the full agents of our behaviour. Because quickly, it can feel quite depressing because you think, 'Gosh, I'm just sort of being bumped around here by forces coming from all directions.' And it's analogous for being a bit like a puppet, I suppose. We like to think that we have true responsibility and influence over our lives. And so I think it's quite a difficult one to stomach that that may not be the case. So I think people want to hold on to free will, I know I certainly did. So I can certainly see why people struggle with the notion.*
>
> *(Ethan)*

While not all the participants reflected a desire for free will to exist, all the participants did describe having searched for it. There was a sense though, that no matter how hard the participants searched, they could not find free will. The following quotes sum up this search.

> *I just cannot find a piece of behaviour which spontaneously creates itself.*
>
> *(John)*

> *My view would be that, given the same set of circumstances and variables, one would always make the same decision because everything is culminated into a decision at that time. So therefore, I guess it's difficult to see where free will would fit in and where it resides. (Andy)*

> *Determinism really for me is a bit like an onion ... There are lots of different layers … That's kind of how I see it … as an individual, as a person we are bound by … lots of different layers around us, and then I just think that free will doesn't really exist within that … If you get to the middle bit, that's still within a layer. (Justine)*

For Justine, seeing that people are bound by layers and do not ultimately have a sense of free will underneath those layers, appears to have contributed to the way she formulates with clients, and an understanding of the different systemic factors which can influence behaviour. For example, she notes the following

> *What are the layers of the onion? … so you've got the society factor, you've got the environmental factor, you've got your personal factors … And I think that's often helped me formulate … when I'm working with a client. And I don't think that we ever, that even from a baby we don't have free will over those factors. (Justine)*

4.2.4.3 Doubt

Perhaps because many of the participants desired free will, or perhaps because not finding something from a search can never truly satisfy us that something doesn't exist, all the participants reported some doubt or uncertainty in their beliefs. For Tony, there was a sense of questioning the whole philosophy. That he may be wrong in determinism seemed to be a "worry" for him, but also a possibility. Given its possibility then, he seemed to desire to hold on to his hard determinist beliefs "lightly". However, as much as he may desire to hold on lightly to his beliefs, given the utopia status he earlier attributed to them (see first superordinate theme), and their significant link to the radical behaviourist model he utilises in his daily practice, I wonder how he would feel should hard determinism ever be proved wrong[7], and how significantly this would affect the delivery of his therapy. Looking at his quote below, I wonder too, if determinism was ever proved wrong, how all the participants in this study would view empathy, blame, compassion and all the other

[7] It is the researcher's belief that determinism and freewill are hypotheses that cannot be proven 'right' or 'wrong'. Nevertheless, the researcher acknowledges she may be 'wrong' in that belief, and thus determinism being "proved wrong" remains a possibility.

aspects of the therapeutic relationships which they felt were so enhanced by the philosophy.

> *I worry that maybe what if they are right? What if I did that just because I'm a pain in the ass? Rather than because it was predicated on some previous events, do you know what I mean? So, I try to hold my determinism lightly (Tony)*

For Graham, there seemed to be a number of contradictions and confusions in the literature which led him to feel unsure of his beliefs. Furthermore, perhaps born from this, there was an acceptance of this uncertainty and doubt, a belief that science and clinical psychology are constantly evolving, and a sense that the future will bring us more knowledge and different ideas. For Graham it seemed that part of the job of being a clinician was to work in this ever changing knowledge landscape. For him too, the mystery and uncertainty inherent in the profession of clinical psychology, seemed to be a positive thing and something which retained his interest in clinical psychology, as the following quotes illustrate.

> *That's basically why I'm a clinical psychologist, because there's constantly interesting things that don't entirely make sense or fit together (Graham)*

> *We psychologists study a very young science and there is much that we don't know. Over the next decade we will know different things ... and we'll see things in different ways. So what I suppose I have to do as a clinician is to work with paradox uncertainty. (Graham)*

I will end discussion of this subordinate theme, superordinate theme, and sub-section of this report with the following quote from Tony. It is interesting isn't it, to ponder how our therapy might look if everything we thought we knew, or everything we believed, turned out to be wrong.

> *Everything you know about religion, about physics, about whatever ... Everything we know has essentially come to us through the writings and verbal histories of human beings, just like us. And for that reason it could all just be bollocks. (Tony)*

5. DISCUSSION

In the following section, the above results will be discussed in the context of the superordinate themes highlighted. Implications and recommendations for clinical practice and further research will then be summarised, before the methodological considerations of this study are discussed. Section six will then serve to conclude the thesis.

5.1 From hell to utopia: How it feels to be a hard determinist therapist

As emerged from the data, and as has been shown in the above results section of this report, there appeared to be differences in the way in which participants felt about the philosophy of hard determinism, and how their feelings manifested and interacted with the therapy they deliver. Although each participant was homogenous in terms of their belief in hard determinism, they were diverse in terms of their theoretical orientation and the way in which their philosophy was viewed, utilised and integrated into the models and methods of therapy delivered. This appears to indicate the possible utility of the hard determinist philosophy as an over-arching philosophy compatible with a range of models and methods of working, rather than as necessarily tied to a particular model or way of delivering therapy.

For some participants in the study, there was a sense that the philosophy of hard determinism felt calming and enabled a helpful peace and acceptance of life, and of the therapeutic process. Both life and therapy were viewed as processes almost to be observed and allowed to unfold, rather than as being sources of worry and effort. Such ideas are similar to those found in 'Acceptance and Commitment Therapy' (ACT; Hayes et al., 1999), in which individuals are encouraged to accept (mental, physical and emotional) events, and not to battle or struggle against them. For some participants in this study, there was a sense that when life or a therapeutic encounter become difficult, reflection on the hard determinist philosophy helps the therapist to "defuse" (Hayes, 2004; p.654) from difficult emotions and associated worry, observe them, and allow them to unfold. It might be therefore, that a hard determinist philosophy contributes to the enablement of such techniques as 'defusion', 'mindfulness', 'acceptance' and a 'transcendent sense of self' (Hayes, 2004, p.653 to 656), incorporated within ACT interventions. It is of note that

ACT was founded on RFT (Relational Frame Theory; see Berens & Hayes, 2004), since RFT is itself founded on the work of Skinner (1957), a hard determinist. Further research on the felt sense of holding a hard determinist philosophy, and the relation between this and the utilisation of ACT techniques is recommended. This may help establish if some of the determinist ideas which underlay the foundations of ACT, could actually enhance the utilisation of this approach if adopted more explicitly by therapists.

Interestingly, two of the participants to hold strong (Skinnerian) radical behaviourist views (John and Tony), appeared to experience less sense of calm in holding the philosophy than some others, with John even attributing a 'hell' like feeling to holding the philosophy. While Tony attributed an opposing, 'utopia' status to it, both participants were united in linking the philosophy of hard determinism to the model of radical behaviourism. For John in particular, the link between the two was significant and inseparable, with hard determinism being viewed as a necessary belief system for working within the radical behaviourist framework. Interestingly, although hard determinism underlies the radical behaviourist model, as well as the psychodynamic approach, it doesn't appear to be taught on every clinical psychology training course, or to often enter the contemporary clinical psychology arena for discussion. According to Tony, consideration of determinism/free will is "essential actually to understanding what you bring to your practice" (Tony, p.67), and that it "aids understanding" (Tony, p.67). There is thus argument for discussions around this philosophy, to be more integrated into the clinical psychology consciousness. Graham also expressed a desire for hard determinism to be considered within contemporary clinical psychology, linking this to a need for clinical psychology to be grounded in theory and research. For Graham, there was a belief that neuroscience, and other sciences, think very much in a hard deterministic manner, and that the science is providing evidence for the hard determinist belief system. He thus expressed a belief that clinical psychology was lagging behind this science, by not incorporating discussion of deterministic ideas, and paying enough attention to research in this regard. According to the BPS (2010, p.4), "the background and training of clinical psychologists is rooted in the science of psychology, and clinical psychology may be seen as one of the applications of psychological science to help solve human problems". Thus, the researcher is inclined to agree with Graham, that consideration of the neuro-scientific evidence in favour of determinism, should at least be part of the discussions had by clinical psychologists.

For some participants in the study, there was a sense that hard determinism was tying or oppressive. For Justine, this oppression appeared to come from above, with a sense that control and power are held by, and exercised by, those in authority, and that the messages of these authority figures are being passed to clients through us (therapists). For Justine, this led to conflicting feelings about power in the therapy room, and her own power over clients. According to DeVaris (1994, p.589), ideas about power and control can "influence the therapist's definition of the treatment problem and the goals of treatment". Thus consideration of issues of power raised by reflection on a hard determinist philosophy, may enable positioning and reflection on power dynamics within the therapy room, which could ultimately influence treatment. In line with this idea and with the philosophical frame underlying this research, DeVaris (1994) notes that therapist's conscious and unconscious beliefs and attitudes can influence the treatment process and subsequently the beliefs and behaviour of clients. DeVaris (1994) thus suggests that therapist's beliefs about power that are not known and go "unchecked" (DeVaris, 1994; p.591) could negatively influence therapeutic outcome. She suggests therapists therefore "sensitize themselves to their own power issues" by exploring the roots of their beliefs regarding power. Since power was for Justine, intricately bound to the determinist philosophy, it could be argued that reflecting on this philosophy enables one route in to reflecting on issues of power and control within the therapy room, thereby enhancing or contributing to more positive therapy outcome.

Threaded throughout the super-ordinate themes, and in particular as highlighted by the liberalising and optimistic way in which Tony and Andy made sense of hard determinism, was the idea that the hard determinist beliefs of therapists, may be related to therapeutic change. As stated in the introduction to this thesis, the aim of clinical psychology is to "reduce psychological distress and to enhance and promote psychological well-being" (BPS, 2010, p.2). Presumably then, this requires a change from a distressed state to a less distressed stated. Thus whether determinism is compatible with change appears to be an important question. According to Rogers (1956; reprinted 1992, p.827), the following six conditions are necessary for therapeutic change:

> 1. Two persons are in psychological contact. 2. The first, whom we shall term the client, is in a state of incongruence, being vulnerable or anxious. 3. The second person, whom we shall term the therapist, is congruent or

> integrated in the relationship. 4. The therapist experiences unconditional positive regard for the client. 5. The therapist experiences an empathic understanding of the client's internal frame of reference and endeavours to communicate this experience to the client. 6. The communication to the client of the therapist's empathic understanding and unconditional positive regard is to a minimal degree achieved. (Rogers, 1956; reprinted 1992, p.827).

According to these conditions, determinism is not only compatible with change, but conducive to it, since according to the participants in this study, determinism can enhance such positive therapeutic qualities as empathy. Furthermore, as was discussed in the introduction section to this report, additional qualities have now been found to positively correlate with therapeutic change and positive therapy outcome including an empathic and genuine therapeutic relationship (Norcross & Wampold, 2011; Kolden et al., 2011), therapist allegiance to model (Wampold & Imel, 2015), therapeutic alliance (Norcross & Wampold, 2011), and self-reflection (Binder, 1999; Bennett-Levy et al., 2003). It does not appear from what the participants have stated, that a determinist approach would be incompatible with these qualities. In fact, as has been discussed, quite the opposite appears to have emerged, with the participants in this study at least, suggesting these qualities can be enhanced by holding a hard determinist philosophy.

5.2 Hating the sin, loving the sinner: Enhancing the therapeutic relationship

As was stated at the outset of this report, the therapeutic relationship, and in particular an empathic and genuine relationship, is considered important for therapy outcome (Wampold & Imel, 2015; Koldman et al., 2011). This idea would fit with research by Elliott (2011, p.8) which suggests "the most consistent and robust evidence is that clients' perceptions of feeling understood by their therapists relate favourably to outcome". In terms of the results of this current study, it would seem that participants generally consider the hard determinist philosophy as useful in enhancing the therapeutic relationship, citing its perceived benefits as enhancing empathy, a non-judgemental approach, and a compassionate approach to clients. The mechanism for the philosophy enhancing these aspects of the therapeutic relationship appears, from what the participants have said, to be in the philosophy aiding understanding of the reasons for client behaviour/thoughts/

feelings, and leaving little room for judgement notions such as 'good' or 'bad'. Participants in particular noted the enhancement of an empathic therapeutic relationship, gained from looking through a hard determinist lens, assisted with the delivery of therapy to clients who display challenging, even "horrendous" (John, see p. 60) behaviour (such as some forensic clients). The literature highlights that therapists working with offenders including sex offenders should be empathic and warm, since this positively impacts outcome (see for example, Marshall et al., 2003; Marshall et al., 2005). Thus delivering therapy from a hard determinist perspective may be particularly beneficial with offenders and forensic populations.

According to Wampold and Imel (2015), therapist allegiance to model is important for therapy outcome, since the "client in a therapy context expects that the therapist has an explanation for the client's disorder and the treatment strategy consistent with that explanation that will lead to improvement". Further, according to Wampold and Imel (2015), for effective therapy, the therapist must believe in the effectiveness of the model. The hard determinist philosophy in itself appears to be an explanatory model, suggesting every event has a cause. This appears to have prompted the participants in this study to look for those causes, and view client behaviour as due to these causes, rather than as due to the clients own autonomous self. In this sense, the determinist philosophy offered a causative formulation. Further, it is this explanatory/causative model which, as shown above, the participants in this study linked to increased empathy, reduced blaming and a non-judgemental approach. Whether allegiance to the determinist model would suffice to produce the same outcomes then, as allegiance to a therapeutic model in the absence of such an allegiance, is an interesting question worthy of further research. Moreover, given that several of the participants expressed no allegiance to any particular model, it also appears a pertinent question. It is important to note that for the radical behaviourists (John and Tony) in this study, grounding their therapy in the model of radical behaviourism appears to have enabled them to find methods to empathise with clients, reduce judgment and blame, and compassionately understand them. In this sense then, their allegiance to the model served to heighten the therapeutic relationship. However, it appears also to have enabled them a way of formulating and a treatment strategy which they very much expressed a belief in. In this way then, it could be considered that their allegiance to radical behaviourism could potentially positively influence therapy outcome. Given the

link between determinism and radical behaviourism, it is hard to know if this allegiance would remain in the absence of a belief in determinism.

5.3 Free will: A felt vs reflective understanding

One notable theme to emerge from the data was the participants' universal belief in the experience of free will, and the importance of this 'felt' sense. Although none of the participants believed in the real existence of a free will, they did all recognise the feeling of freedom, and believe it to be important. The importance of this feeling is also backed up by research such as that by Baumeister et al. (2009) who found that disbelief in free will reduces helping and increases aggression. Baumeister et al. (2009) suggests the mediating variable is 'self-control', with those exhibiting more self-control tending to be more conscientious and rule-following. The participants in this current study all felt, just as Baumeister's research shows, that feeling free is important. However, they described two different levels of free will. On the one hand they acknowledged feeling free and its usefulness, but on the other, they also felt it was useful to think deterministically on reflection. In such a reflective state they noted that people can reflect on the feeling of freedom they have experienced, and see it for what it is (or at least, for what the participants believed it to be), i.e. an 'illusion', or 'feeling', or as one participant stated, a 'delusion'. In this reflective state, the participants noted they could think about the reasons behind actions, making them more compassionate, non-judgmental and empathic.

According to Carey and Paulhus (2013, p. 132) belief in free will is associated "with a conservative worldview, including such facets as authoritarianism, religiosity, punitiveness, and moralistic standards for judging self and others". At first sight this would appear to contradict Baumeister's (2009) findings, or at least leave us confused regarding the usefulness of free will beliefs. However, if the two-levels model (as I shall call it), is considered, then both Baumeister's (2009) and Carey and Paulhus' (2013) research could be considered compatible. We have already seen in the above section that the participants in this study considered determinism to reduce judgementalism. The reduction in judgementalism, along with an increase in other positive therapeutic qualities such as empathy, a compassionate approach and a non-blaming stance, appear to occur during times, and at the level of, reflection. Thus one might assert that free will is a useful feeling to experience in the moment, to give a sense of 'self-control' (Baumeister, 2009),

but that on reflection, considering the causes of behaviour can reduce judgement, blame and punitiveness.

In the discussion of her research, Gatch (1965, p.31), notes (in line with the above idea) that the "therapist-as-scientist must assume determinism because explanation is difficult or impossible without it; the therapist-as-helper must assume a choice-making capacity because therapeutic change … is not otherwise possible". For Gatch (1965, p.31), this meant that both free will and determinism were "compatible", and even "necessary … assumptions in psychotherapy". However, it is the opinion of the researcher, based on the voice of the hard determinist participants interviewed, that this compatibility need not be necessary, and that for the participants at least, it felt possible to hold a hard determinist philosophy, while moving in an out of 'feeling' free.

Interestingly, in this study, participants as therapists acknowledged their own 'felt' sense of autonomy, and in particular, of responsibility. There was a sense from participants that due to their philosophical beliefs, they believed their interaction(s) with clients (and others) would necessarily cause a change in their client's (and others) trajectory. While this appeared positive for some, who appeared to like the sense of autonomy they experienced, others disliked the responsibility and associated guilt should the desired outcome of their interaction with a client, not be achieved. In this instance then, there was a feeling from some participants that reflecting on the determinist belief could assist in relieving guilt and unpleasant feelings, since it takes away the moral responsibility felt, and reduces blame on the therapist. In her discussion on the topic, Gatch (1965, p.31) noted the benefits of determinism for the client, suggesting "determinism is necessary to understand the patients history and personality, and to reduce the burden of guilt which patients carry …" However, in this current study, participants also noted the usefulness in reducing therapist guilt when therapy (or other interactions, such as interactions with colleagues) doesn't go as planned or hoped. In this way, determinism enables self-compassion and self-care. This is useful given the finding that a significant proportion of psychological therapists suffer from psychological distress and burnout (e.g., Hannigan, Edwards, & Burnard, 2004). Some therapists did struggle though, with whether using the determinist philosophy in this self-compassionate way was letting oneself "off the hook" (see for example, Andy's quote; p.69). Thus perhaps supervision taking on a hard determinist philosophical stance, or validating this stance, might enable therapist self-

validation and self-acceptance, and relieve the therapist of the caveat that they are "letting themselves off the hook".

For most participants within this study, there appeared a conscious grappling with the degree to which hard determinist ideas should be made explicit within the therapy room. The majority of participants appeared to see explicit discussion of the philosophy, without consideration on the effects/utility for the client, as unempathic. It was not considered to meet the client where they were at, or to be congruent with understanding the world from their client's perspective. Participants thus appeared to take a 'person-centred' or individualised approach to their therapy, in relation to the explicit vocalisation of their beliefs. According to Carl Rogers (1942), the founder of Person Centred Therapy (PCT), the use of empathy, unconditional positive regard, and congruence in the therapeutic encounter enable the therapist to get alongside their client and take a person-centred approach to therapy. As was discussed in the introduction, empathy, congruence and positive regard are related to positive therapeutic outcome (Norcross & Wampold, 2001; Kolden, 211). Furthermore, empathy is a quality participants in this study, specifically believed to be enhanced by a hard deterministic philosophy. Thus, a hard deterministic, person-centred and empathic approach to therapy appear, from this study at least, to be compatible approaches for the delivery of therapy. Furthermore, the person-centred and empathic approaches appear to have acted as a framework for guiding the use and degree of explication of beliefs by the therapists in this study.

In terms of making explicit their hard determinist views with colleagues and others, the participants in this study reported conflicting feelings. On the one hand, they felt the topic important to raise, and to be a useful discussion to be had within the profession of clinical psychology. On the other hand, some felt raising their views made them stand out as different, and be seen as a rebel or outsider. Interestingly, this feeling of being perceived as "different" by others appears somewhat akin to the experiences of BME (Black and Minority Ethnic) clinical psychology trainees, studied by Shah (2010). In her study, Shah (2010, p.88) noted that BME trainees "anticipated being judged by negative stereotypes" and that they felt "perceived as undesirable ... along with negative perceptions about being seen as the devalued other" (Shah, 2010; p.88). Shah also noted that standing out as different "resulted in trainees experiencing … pressure to conform to the group image ... to fit in". This is in line with the experiences of some of the participants in this study,

who noted a desire to fit in and a perception of being seen as an outsider. For John for example, there was a belief that others saw him as "…retro, 50s, mechanistic" (John, p.66). Interestingly, in Shah's (2010) study, as in the current study, there was a theme around 'speaking out', in which participants described a desire to speak out about issues of race to aid understanding and discussion. In this current study, participants also showed a desire to speak out, wanting discussion of the determinism/free will debate to be meaningfully considered within the profession of clinical psychology. However, as in Shah's (2010) study, there was some concern about the "feelings of discomfort" which may be invoked in others about speaking out, and some participants in the current study thus chose to remain silent rather than be "misunderstood, pigeon-holed and labelled" (Rajan & Shaw, 2008; p.13).

It is important to note that in Shah's (2010) study, the issue of difference was a visible one, with BME students unable to easily hide their physical appearance. Within the current study however, the focus of difference was less visible and more easily hidden, with participants being in a position to keep their beliefs concealed, at least explicitly. Within the research literature there appears to be little research around either visible or less visible aspects of difference, with respect to how such differences feel for the psychologist/therapist. In particular, I have not been able to find any published research on the experiences of therapists who hold minority beliefs. Further research may therefore be useful in this area, to aid understanding of the impact that holding minority beliefs may have on a therapist/psychologist, within their work context.

It is important to note that for some participants, where they knew others with similar beliefs, there was a sense of camaraderie in the difference, which appeared to enable less negative feelings about difference. In her study, Shah (2010, p. 98) notes that BME trainee clinical psychologists reported "relief to find safety and connection in the presence of other BME trainees, with whom it is assumed that there is an implicit and non-judgemental understanding around 'race' and culture issues". I wonder if the participants in the current study, also found safety and connection in the presence of others who share their beliefs. I wonder too how difficult it might have been for those participants who did not know of any other hard determinists, and how this might have contributed to feelings of not wanting to hold the belief. An internet search of google and professional websites has revealed no obvious professional or other groups focussing on therapists with

determinist beliefs. Thus it is hard to know how hard determinist therapists would currently be able to contact or source like-minded individuals to share ideas and feel connected.

5.4 Therapist as thinker

A prominent theme to emerge from the data, was that of the determinist therapist as a thinker. It was clear that many of the participants used their philosophical beliefs to aid reflection, and that such reflections were related to finding causes and reasons for individuals' behaviour, which they attributed to enhancing empathy, non-judgementalism, and compassion. In the introduction to this thesis, it was noted that therapist self-reflection has been associated with increased empathy (Gale & Schröder, 2014) and positive therapy outcome. It appears from the therapist experiences reported in this particular study, that this may be due to reflection providing space for consideration of the reasons behind behaviour, thereby doing away with blaming notions such as good/bad, and enhancing empathy and understanding. Further research in this area may shed light on this particular aspect of reflection and its utility.

In addition to the above, participants described arriving at their philosophical beliefs after some consideration, indicating a tendency towards thinking their beliefs through. Clearly determinism is a niche philosophical area, thus there may be something about therapists who hold this view that draws them towards consideration of philosophical ideas and a tendency towards reflection and abstract thinking. According to Bennett-Levy (2006), reflection is a cognitive skill comprised of three areas; focussed attention (stimulated by a number of different mechanisms including curiosity and discomfort), autoetic consciousness ("a special kind of consciousness... which allows healthy human adults to both mentally represent and become aware of their subjective experiences in the past, present and future" (Wheeler et al., 1997, p.331)), and cognitive operations (including following trains of thought, persistent self-questioning, logical analysis and problem solving). It might be that determinist therapists, with a natural tendency to think and reflect, have some combination of these three facets which enables such reflection. However, it is also likely that this comes with a down-side, since, as Tony (see p.71 of this report) points out, determinism can create a tendency to self-analysis, as well as a tendency toward an inflated sense of responsibility which may arise from analysing the

effects of one's own behaviour (see section 5.2 for more discussion of responsibility). Furthermore, according to a meta-analysis by Mor and Winquist (2002), self-focussed attention is generally associated with negative affect, including a propensity to depression, anxiety and negative mood. Since reflection is considered an integral part of therapy, and a desirable skill given its link to positive therapy outcome, research looking at the effects of reflection on the therapist, may help to shed light on the utility of this trait, but also any difficulties which may arise from it, for the therapist.

Interestingly, emerging from the data was the idea that, despite having considered their beliefs carefully, most of the participants did not like holding a hard determinist philosophy and would prefer to believe in free will. For John, this appeared related to the effort involved in "having" to find causes for behaviour which he believed inherent in the philosophy, as well as the sense of difference and negative reactions he had from others. For others, it was related it seemed to a dislike of not feeling in control, and wanting to have true (rather than illusionary) autonomy. Exactly why people should desire autonomy is not known and further research may shed light on this. However, there has been much research over the years looking at "Locus of Control" (Rotter, 1966), with most research highlighting the importance of perceived control to psychological functioning, and lack of perceived control appearing correlated to depression (e.g. Ryan & Deci, 2000, Tobin & Raymundo, 2010). This would indicate perceived control is important, and supports the ideas put forward by the participants in this study, both that free will is important for their clients, but also that they too see it as important to themselves. Interestingly, some participants (particularly Tony and Andy) did not mind, and positively embraced the idea that they lack free will, which may be related to new findings by Cheng et al. (2013). Cheng et al. (2013) suggest that an external locus of control (which could be linked to the environmental focus on behaviour seen under the behaviourist model, or the external causes attributable to determinism), does not have the same degree of negative connotations attached to it (such as increased anxiety) across all cultures. In their meta-analysis of locus of control and psychological symptoms across 18 cultures, Cheng et al. (2013) found that the relationship between external locus of control and anxiety was moderated by the effect of individualism, proposing that external locus of control is more detrimental in individualist cultures that collectivist ones. The reasons for this are not fully understood, and it would be interesting to further investigate why living in a collectivist culture might mediate the effect of external locus of control. Interestingly in

this study, the only female participants were non-British. There may therefore be something about the role of British woman in this individualist culture which makes tolerance of determinist/non-autonomous beliefs difficult. Further research in this area would be interesting, and it would be particularly interesting to see if there is a difference in the number of therapists holding hard determinist beliefs or beliefs which reject free will, across cultures. Understanding why there may be differences could potentially help us understand why a sense of personal autonomy is so important to some, but appears not important or less important to others. Given the link within the western culture, between lack of perceived control and psychological distress, this research could enable better understanding and intervention for individuals who display low levels of perceived self-control alongside psychological distress.

5.5 Implications for clinical practice

The results of the current study give rise to several implications for clinical practice, which can be drawn from the above discussion. These implications, and resulting recommendations, are summarised below. According to Blanche et al. (2006), when summarising, bullet points should be considered to aid readability and highlight key points. Thus a bullet point format is used for this section (and section 5.6) of the report.

- Based on the voice of the hard determinist therapists interviewed in this study, a 'two-levels' model is proposed for working with clients. It is proposed that free will is a useful feeling for client and therapist to experience 'in the moment', to give a sense of 'self-control' (Baumeister, 2009), but on a reflective level, considering the causes of behaviour from a hard determinist perspective may reduce judgement, blame and punitiveness.

- The current study suggests that qualities of effective therapy, such as an empathic and genuine therapeutic relationship, therapist allegiance to model, therapeutic alliance and self-reflection, are compatible with, and potentially enhanced by, holding a hard determinist philosophy. Reflection on the utility of this philosophy by therapists, and within the profession of clinical psychology, is thus recommended.

- Due to the apparently non-judgemental and empathic nature of the hard determinist philosophy, delivering therapy from this philosophical stance may be particularly beneficial with offenders and forensic populations. It is thus recommended that consideration be given to the discussion and potential utilisation of this philosophy within forensic settings.

- Issues of power may be intricately bound to the hard determinist philosophy, and thus reflecting on the hard determinist philosophy may provide one route in to therapist reflection on issues of power and control within the therapy room.

- Hard determinist therapists may be particularly prone to an inflated sense of responsibility. Acknowledgement of this, and utilisation of reflection on the hard determinist belief system (possibly within a supportive supervisory context), may enable deflation and better management of responsibility feelings.

- Hard determinist therapists may have a tendency towards self-reflection. Since reflection is associated with positive therapy outcome, adopting a hard determinist lens may be beneficial in enhancing outcomes. However, hard determinist therapists may also have a tendency to self-analysis and potentially therefore, anxiety associated with self-focussed attention. Acknowledgement and discussion of the pros and cons of reflection (possibly within a supportive supervisory context) is recommended to aid enhancement of the useful aspects of reflection, while enabling support for self-analysis.

- Hard determinist therapists may perceive others as judging them by negative stereotypes, and they may experience perceptions of themselves as different, leading them to remain silent in their beliefs, or to make attempts to fit in with others by hiding or distorting their beliefs. It may therefore be helpful to consider hard determinist therapists in line with other minority groups.

- Hard determinist therapists may find comfort in the presence of others with similar beliefs. However, there are currently no networks/societies/professional groups for such individuals. It is thus recommended that the development of such a group be considered, so hard determinist therapists can share ideas and feel connected to other like-minded individuals.

5.6 Recommendations for further research

Following from the discussion and implications outlined above, the following recommendations for future research are proposed.

- Hard determinism appears to offer an explanatory/causative model of human action. Whether allegiance to the determinist model would suffice to produce the same positive therapeutic outcomes as allegiance to a therapeutic model in the absence of such an allegiance (to therapeutic model), warrants further research.

- Further research on the felt sense of holding a hard determinist philosophy, and the relation between this and the utilisation of ACT (Acceptance and Commitment Therapy) techniques is recommended. This may help establish if some of the determinist ideas which underlie the foundations of ACT, could actually enhance the utilisation of this approach if adopted more explicitly by therapists.

- It appears that individuals, even hard determinists, desire free will and autonomy. However, the reasons for this are not known, and further research may shed more light on this. Furthermore, understanding why some individuals desire free will and others don't, particularly across cultures, may enable better understanding, and inform future interventions for, individuals who display low levels of perceived self-control in conjunction with psychological distress.

- One participant felt there was strong neuro-scientific evidence in favour of determinism, and that discussions of the neuro-scientific evidence for determinism should be further incorporated into the profession of clinical psychology. Further research on the neuro-scientific evidence for determinism and it's relation to clinical psychology, may enable further recommendations for the profession, in relation to this point.

- It has been hypothesised that the mechanism for the hard determinist philosophy enhancing the therapeutic relationship appears to be in the philosophy aiding understanding of the reasons for client behaviour/thoughts/feelings, and leaving little

room for judgement notions such as 'good' or 'bad'. Further research on this is recommended to ascertain support (or otherwise) for this hypothesis.

- Research considering the impact that holding minority beliefs / hard determinist beliefs may have on a therapist within their work context is recommended, particularly since such research is currently lacking in the literature.

- Research looking at the effects of reflection and self-analysis on the therapist, may help to shed light on the utility of the reflective trait, but also any difficulties which may arise from it, for the therapist.

- While the participants studied here were all clinical psychologists, the topic of interest was therapy, and the implications and recommendations listed here all relate to the delivery of therapy. A replication of this study with a broader range of therapists is thus recommended, to establish whether the findings reported here can be generalised to therapists from fields outside clinical psychology. Given the potential utility of the philosophy in forensic settings, research related to the deterministic beliefs of forensic psychologists and other therapists working within the forensic setting, is particularly recommended.

5.7 Methodological considerations

Throughout this research, and in line with guidance by Elliott et al. (1999), I have consistently attempted to demonstrate reflexivity and to own my own position (see section 3.8 of this report). However, in an attempt to heighten quality and rigor, it should be noted that I did not make my philosophical stance explicit to the participants until after the interviews. This was done on the assumption that my own "empathy and enthusiasm for a subject dear to my heart may have kept them [the participants] from considering certain aspects of their experience" (Armstrong, 2001, p.243; cited in Dwyer & Buckle, 2009, p.59). Furthermore, I hoped that not making my position explicit would prevent "an emphasis on shared factors between the researcher and the participants and a de-emphasis on factors that are discrepant, or vice versa" (Dwyer & Buckle, 2009, p.58). However, in keeping my position from the participants, some of the benefits of 'insider research' may have been missed. For example, the insider perspective can give a certain legitimacy with the participants (Adler & Adler, 1987), a common language and identity (Asselin, 2003),

and a more rapid, complete and open acceptance by participants (Dwyer & Buckle, 2009). Further, the participants may have wondered during the interview about my allegiance to determinism (or not), distracting them from the questions, or leading them to hold back on certain expressions that they may have felt could be stigmatising or misunderstood by an 'outsider' (Adler & Adler, 1987). It is likely that from my manner, my understanding, and my use of certain language, that participants picked up on my allegiance to determinism despite this not being explicitly indicated to them. This could thus have enabled those positive aspects of 'insider research' previously mentioned to manifest. However, it may also have led participants to make "assumptions of similarity and therefore fail to explain their individual experience fully" (Dwyer & Buckle, 2009).

In order to ensure credibility of the analysis and resulting final set of themes, a number of steps were taken, and a full discussion of these can be found in section 3.8 of this report. In addition to these steps, some authors advocate the use of 'member checks' or 'participant validation strategies' (Ravitch & Carl, 2016) to heighten research rigor. Such checks were not conducted in this study for two main reasons. Firstly, the research study conducted here utilised an IPA approach (Smith et al., 2009), which recognises the interpretative aspect of data gathered. Thus, since the data presented is the researcher's interpretation of the participants' experiences, getting to the 'truth' or the 'actual' experience was not what was intended. Secondly, according to Sandelowski (1993, p.5), stories that participants tell in interviews represent their efforts to find meaning "at a particular moment in their lives. Stories previously told may elicit feelings members no longer have, regret, and/or have forgotten, and ... members may want such stories removed as data".

In addition to the above, it is important to note that within this report, I have attempted to provide verbatim quotes to enable illustration of themes in line with Elliott's (1999) guidelines for quality research and transparency. However, it is important to note that I have not had room within this report to include quotes from all participants, to illustrate all themes. Furthermore, due to word restrictions I have not had space to highlight all aspects of each interview, and include all the experiences of all the participants. Given that this research is my own interpretation of the participants' experiences, it might be that other researcher's would have chosen to include different quotes to illustrate themes, and/or that they may have found other themes more salient to include

Finally, it should be noted that a small number of participants were used in this study, due to the idiographic commitment of IPA. Thus readers should note caution in generalising the findings of this research study.

6. CONCLUSION

The study reported here has, for the first time, given voice to hard determinist clinical psychologists. This is important, since this group of clinical psychologists has not previously been explicitly heard from in the research literature. In the introduction to this report, it was argued that hearing from hard determinist clinical psychologists may enable understanding of whether this group of individuals perceive their beliefs impact (or not), certain qualities of effective therapy including an empathic and genuine therapeutic relationship, and self-reflection. This study has shown that, in the opinion of the participants studied here, delivering therapy from a hard determinist philosophical frame can indeed enhance these qualities. In particular, the participants interviewed felt that the philosophy enhanced their ability to empathise and to act non-judgementally with clients. Moreover, a number of further themes emerged from the data, which have given rise to some important implications and recommendations for both clinical practice and future research.

While there are some limitations to this study, and the small sample size and idiographic nature of IPA makes the results hard to generalise, the findings presented here offer a unique and novel contribution to clinical psychology research. Furthermore, this thesis offers new insights into a philosophical frame little considered in contemporary clinical psychology, yet one which has given birth to two major theoretical models, and which may still spawn new and interesting ways of working within clinical psychology.

> *We psychologists study a very young science and there is much that we don't know. Over the next decade we will know different things … and we'll see things in different ways …*
>
> *(Graham, p.74)*

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Appendix 1

LinkedIn call for participants

DETERMINISTS WANTED FOR EXCITING NEW RESEARCH STUDY

Are you a *clinical psychologist*?

Do you deliver psychological *therapy* as part of your job?

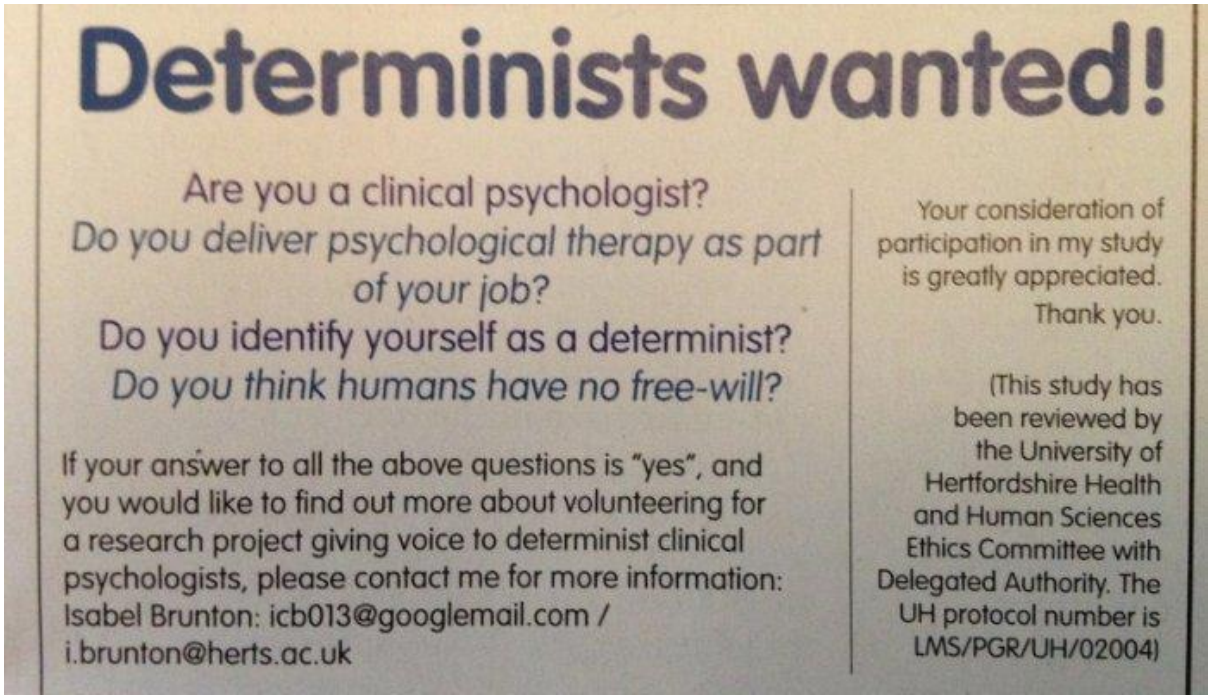
Do you identify yourself as a *determinist*?

Do you think humans have *no free will*?

If your answer to all the above questions is "yes", and you would like to find out more about volunteering for a research project giving voice to determinist clinical psychologists, please message me for more info! Thank you.

Appendix 2

Photograph of an advert placed in the November 2015 edition of the British Psychological Society's, "Psychologist" magazine.



Determinists wanted!

Are you a clinical psychologist?
Do you deliver psychological therapy as part of your job?
Do you identify yourself as a determinist?
Do you think humans have no free-will?

If your answer to all the above questions is "yes", and you would like to find out more about volunteering for a research project giving voice to determinist clinical psychologists, please contact me for more information:
Isabel Brunton: icb013@googlemail.com / i.brunton@herts.ac.uk

Your consideration of participation in my study is greatly appreciated. Thank you.

(This study has been reviewed by the University of Hertfordshire Health and Human Sciences Ethics Committee with Delegated Authority. The UH protocol number is LMS/PGR/UH/02004)

Appendix 3

Email to clinical psychology training programmes

Dear [name of course director]

My name is Isabel Brunton and I am a final year trainee clinical psychologist based at the University of Hertfordshire. I am writing to you in your capacity as DClinPsy course director, to ask for your permission and assistance in forwarding the below email to the DClinPsy course team members at your university. The email regards my current doctoral research, and asks for participants to take part in a semi-structured (telephone) interview. I would be very grateful for your help in circulating the email as I am in need of more clinical psychologists to be participants for this research project. If you have any questions about the email or my research, or indeed if you would like to take part yourself, please feel free to get in touch.

Thank you very much for any assistance,

Kind Regards,

Isabel Brunton

Dear DClinPsy course team member

- Are you a qualified clinical psychologist?
- Do you deliver psychological *therapy* as part of your job?
- Do you identify yourself as a *determinist* (i.e. believe that every event (including human thought and action) is necessitated by antecedent events and conditions, together with the laws of nature)?
- Do you think humans have *no free will*?

If your answer to the above questions is "yes", then I would really love to hear from you.

My name is Isabel Brunton and I am a 3rd year trainee clinical psychologist based at the University of Hertfordshire.

I am emailing you to see if you would be interested in volunteering for an exciting new research project I am heading up as part of my doctorate in clinical psychology.

The aim of the project is to consider how clinical psychologists who hold a (hard) determinist philosophy (i.e. believe in determinism and reject free will), experience delivering therapy.

If you were to decide to take part in this research project, you would be required to participate in a semi-structured interview. It is expected that this interview would take no more than 90 minutes. During the interview, you would be asked questions about how you experience delivering therapy, given your philosophical beliefs. Your interview would be recorded on audio file, and later transcribed for the purpose of analysis.

This study has been reviewed by the University of Hertfordshire Health and Human Sciences Ethics Committee with Delegated Authority. The UH protocol number is aLMS/PGR/UH /02004(2)

If you would like further information about the research project and/or wish to discuss your potential participation in this project, please feel free to contact me by email, phone or in writing:

Isabel Brunton, Department of Psychology, The University of Hertfordshire, Doctorate in Clinical Psychology, College Lane, Hatfield, Hertfordshire. AL10 9AB

Telephone number: 07725571213
Email: icb013@googlemail.com / i.brunton@herts.ac.uk

Thank you very much for your time,

Kind Regards,

Mrs Isabel Brunton
Chief Investigator
Trainee Clinical Psychologist
i.brunton@herts.ac.uk

Dr Helen Ellis-Caird
Research Supervisor
Clinical Psychologist
h.ellis-caird@herts.ac.uk

Appendix 4

PARTICIPANT INFORMATION PACK

Information Sheet

Title of study

Exploring how clinical psychologists who hold a hard determinist philosophy, experience delivering therapy.

Introduction

We would like to invite you to take part in a research study. Before you decide whether to do so, it is important that you understand the research that is being done and what your involvement will include. Please take the time to read the following information carefully and discuss it with others if you wish. Do not hesitate to ask us anything that is not clear or for any further information you would like to help you make your decision. Please do take your time to decide whether or not you wish to take part. The University's regulations governing the conduct of studies involving human participants can be accessed via this link:

http://sitem.herts.ac.uk/secreg/upr/RE01.htm

Thank you for taking the time to read this.

What is the purpose of this study?

The aim of this study is to consider how clinical psychologists who hold a hard determinist philosophy (i.e. believe in determinism and reject free will), experience delivering therapy.

Do I have to take part?

It is completely up to you whether or not you decide to take part in this study. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. Agreeing to join the study does not mean that you have to complete it. You are free to withdraw at any stage without giving a reason.

Are there any age or other restrictions that may prevent me from participating?

To be eligible to take part in this study you must fulfil *all* of the following criteria:

- Be a qualified Clinical Psychologist
- Deliver therapy as part of your professional role

- Identify yourself as a Determinist and/or hold the belief that every event is necessitated by antecedent events and conditions, together with the laws of nature.
- Hold the belief that human beings have no free will

There are no or other restrictions on participation.

What will happen to me if I take part?

If you decide to take part in this study, you will be required to complete a brief demographic questionnaire before then participating in a semi-structured interview. It is expected that this interview will take approximately 1.5 hours. During the interview, I will ask you some questions about how you experience delivering therapy, given your philosophical beliefs. Your interview will be recorded on audio file, and later transcribed for the purpose of analysis.

What are the possible disadvantages, risks or side effects of taking part?

There is a small possibility that you might find some aspects of the interview upsetting. If you do find any of the questions particularly upsetting, you do not have to answer them.

What are the possible benefits of taking part?

This is the first study of its kind to give voice to determinist clinical psychologists. By participating in this study you will not only have the opportunity to get your voice heard, but you will also be part of an exciting new venture in clinical psychology research. Furthermore, it is hoped that by giving voice to an often unheard section of clinical psychologists, the findings of this study will offer new and exciting insights into therapeutic practice. Such insights could have beneficial effects not only for other researchers and clinicians, but ultimately for the clients with which we work.

How will my taking part in this study be kept confidential?

All information collected about you throughout the course of this research study will be kept confidential. Your name, demographic information, and any other identifiable information will be kept securely and separately from your audio recording. An approved transcription service may be used to transcribe your interview. Should this be the case, the audio recordings sent to the transcription service will be anonymised. Furthermore, the service will be required to sign a non-disclosure, confidentiality agreement. Your audio recording will be destroyed as soon as the chief investigator's degree has been conferred. Any other anonymised data relating to your participation will be kept for 5 years post research project submission (June 2020), after which time it will be destroyed.

This research study is being conducted in partial fulfilment of the requirements for the University of Hertfordshire degree of Doctor of Clinical Psychology. Thus, it will be necessary for some of the data to be looked at by authorised persons from the University of Hertfordshire. Furthermore, anonymised sections of the data may also be looked at by representatives from internal and external academic and professional assessment bodies, for the purpose of assessing the quality of this doctoral research. All and any of those individuals who may have access to your data for the reasons stated here, will have a duty of confidentiality to you as a research participant.

The findings of this research study will be written up in a doctoral thesis, and may also be disseminated via academic publication and presentation. Participants will not be identified in any report, publication or presentation. Any quotes used will be fully anonymised.

Are there any reasons why confidentiality might be breached?

Confidentiality will only be breached if you disclose something which leads me to feel sufficiently concerned about your safety or the safety of others. In this case, I would need to inform an appropriate third party.

Who has reviewed this study?

This study has been reviewed by:

The University of Hertfordshire Health and Human Sciences Ethics Committee with Delegated Authority. The UH protocol number is aLMS/PGR/UH/02004(2)

What will happen if the researcher changes the aim or design of the study at a later date?

In the unlikely event of any significant changes to the aim(s) or design of the study, the researcher will inform you. If you have already given consent to participate in the study, you will be asked to renew your consent to participate.

Who can I contact if I have any questions?

If you would like further information or would like to discuss any details personally, please get in touch with me by email, phone or in writing:

Isabel Brunton, Department of Psychology, The University of Hertfordshire, Doctorate in Clinical Psychology, College Lane, Hatfield, Hertfordshire. AL10 9AB

Telephone number: 01707 286322
Email: icb013@googlemail.com / i.brunton@herts.ac.uk

What should I do if I am interested in taking part in the study?

If, after reading this participant information sheet, you would like to take part in the research study described here, please email, phone or write to me to indicate your continued interest in the study. I will then arrange an appropriate day and time to contact you to ask you some brief eligibility screening questions and arrange a date for interview.

Thank you very much for reading this information and giving consideration to taking part in this study.

Kind Regards,

Mrs Isabel Brunton
Chief Investigator
Trainee Clinical Psychologist

Dr Helen Ellis-Caird
Research Supervisor
Clinical Psychologist

Although we hope it is not the case, if you have any complaints or concerns about any aspect of the way you have been approached or treated during the course of this study, please write to the University Secretary and Registrar

Appendix 5

Eligibility screening questions

All participants to be asked the following questions to screen for eligibility to take part in the study.

<u>Eligibility questions</u>:

Please indicate if verbal consent was obtained from the potential participant before asking the questions below? Yes/No

	Please tick the appropriate box	
	YES	NO
Are you a Clinical Psychologist	☐	☐
Do you deliver therapy as part of your professional role	☐	☐
Do you hold the belief that human beings have no free will	☐	☐
Do you identify yourself as a determinist (and / or I hold the belief that every event is necessitated by antecedent events and conditions, together with the laws of nature)	☐	☐

Thank you for your time

Appendix 6

Interview schedule

Note: The questions below acted as a guide, and further questions were used in order to flexibly explore participant accounts.

Nature and onset of beliefs

1) What do you understand by the terms determinism and hard determinism?

2) Had you heard the term "Hard Determinist" prior to volunteering for this study? If so – how and in what context?

   If not, at what point in the process of volunteering for this study did you learn of this term.

   How would you describe your relationship with this label?

3) Could you give me a brief history of your belief in hard determinism, from when you think the belief started to form until now?

Reflecting on the professional self

1) How would you describe yourself as a therapist?
   Prompt: What sort of therapist are you? Most important characteristics?

2) Does holding a hard determinist philosophy (HDP) impact on how you see yourself as a therapist? If so, how?

The work of therapy

1) Does holding a HDP affect your work as a therapist? How? (or why not?)

2) Does holding a HDP influence the models of therapy you use? How? (or why not?)

3) If you had to describe what working as a therapist who holds a HDP means to you, what would you say?

4) Does holding a HDP create any challenges for you, in relation to your work as a therapist?

Relationships with clients

1) What does holding a HDP mean to you in the context of the therapeutic relationship?

2) Has holding a HDP impacted on your relationship with clients? How? (or why not?)

Relationships with colleagues

1) How would you describe your relationship with your colleagues?

2) Has holding a HDP impacted on your relationship with colleagues? How? (or why not?)

Other

1) Do you have any other comments you wish to add regarding how you experience delivering therapy, given your HDP beliefs?

2) Do you have any comments or feedback for me regarding this interview schedule?

Thank you for your time

Appendix 7

Consent form – EC3

UNIVERSITY OF HERTFORDSHIRE

FORM EC3

CONSENT FORM FOR STUDIES INVOLVING HUMAN PARTICIPANTS

I, the undersigned *[please give your name here, in BLOCK CAPITALS]*

……
……

of *[please give contact details here, sufficient to enable the investigator to get in touch with you, such as a postal or email address]*

…..……
……

hereby freely agree to take part in the study entitled, "Exploring how clinical psychologists who hold a hard determinist philosophy, experience delivering therapy".

……
……

1 I confirm that I have been given a Participant Information Sheet (a copy of which is attached to this form) giving particulars of the study, including its aim(s), methods and design, the names and contact details of key people and, as appropriate, the risks and potential benefits. I have been given details of my involvement in the study. I have been told that in the event of any significant change to the aim(s) or design of the study I will be informed, and asked to renew my consent to participate in it.

2 I have been assured that I may withdraw from the study at any time without disadvantage or having to give a reason.

3 In giving my consent to participate in this study, I understand that voice recording will take place.

4 In giving my consent to participate in this study, I understand that some of the data will be looked at by authorised persons from the University of Hertfordshire. I also understand that anonymised sections of the data may be viewed by representatives from internal and external academic and professional assessment bodies in order to assess the quality of the research.

5 In giving my consent to participate in this study, I agree that anonymised quotes from my interview may be used in any reports, publications or presentations.

6 I have been told how information relating to me (data obtained in the course of the study, and data provided by me about myself) will be handled: how it will be kept secure, who will have access to it, and how it will or may be used.

7 I understand that if there is any revelation of unlawful activity or any indication of non-medical circumstances that would or has put others at risk, the University may refer the matter to the appropriate authorities.

Signature of
participant……..…Date…….

Signature of (principal)
investigator……Date……
……

Name of (principal) investigator *[in BLOCK CAPITALS please]*

……

Appendix 8

Demographic questionnaire

- Name: _____
- What is your age: _____
- How would you describe your gender (mark as appropriate):

  Male ☐

  Female ☐

  Transgender ☐

  Prefer not to say ☐
- How would you describe your ethnicity: _____
- How long have you been qualified as a clinical psychologist? _____
- Where did you do your clinical training? _____
- In which region (county) of the country do you currently work as a

  Psychological therapist ? _____
- What models of psychological therapy do you use most in your practice?
  _____
  _____

Appendix 9

PARTICIPANT DEBRIEF FORM

Thank you very much for taking the time to participate in this study. Your participation is much appreciated.

What happens now?

As you will be aware, the aim of this research study is to discover how clinical psychologists who hold a hard determinist philosophy, experience delivering therapy. Now that you have completed the interview, your interview will be transcribed and then analysed using Interpretative Phenomenological analysis (IPA). As part of this analysis, your interview will be compared with others to see if any similar themes emerge. These themes will then be discussed and written up in a research thesis to be submitted for partial fulfillment of the requirements for the University of Hertfordshire degree of Doctor of Clinical Psychology. The findings from this research study may also be written up for publication or presentation. As a research participant, you are entitled to request a summary of the research findings. If you request such a summary, it will be made available to you after completion of the research (anticipated to be June 2016).

It is important to note that the information you have provided will be kept confidential as explained in the participant information sheet.

Who do I contact if I have any questions about the study following my participation?

If you have any questions about the study following your participation, you are welcome to contact the researcher by email, phone or in writing:

Isabel Brunton, Department of Psychology, The University of Hertfordshire, Doctorate in Clinical Psychology, College Lane, Hatfield, Hertfordshire. AL10 9AB

Telephone number: 01707 286322
Email: icb013@googlemail.com / i.brunton@herts.ac.uk
The researcher will be available to be contacted up to 6 months after your participation in the study.

What should I do if I feel distressed following my participation in the research?

If taking part in this research has caused you any distress, you may wish to discuss this in clinical/peer supervision. Alternatively, the list below offers a selection of organisations who may be able to offer you support:

1. Samaritans
   www.samaritans.org.uk / 0845 790 90 90 (National 24 hour helpline)
   The Samaritans offer confidential telephone/email/face to face support for individuals in distress.

2. NHS Choices
   www.nhs.uk / 111 (24 hour free-phone, non-emergency support service)
   NHS choices/111 service, offers 24 hour, non-emergency advice on any issues related to physical/mental health.

3. SANE
   www.sane.org.uk / 0300 304 7000 (Evening helpline)
   SANE offers confidential emotional support and specialist information to anyone in distress or affected by mental health problems.

4. MIND
   www.mind.org.uk / 0300 123 3393 (Daytime helpline)
   MIND offer confidential advice and support to any individuals experiencing mental health difficulties.

5. Mental Health Foundation (MHF)
   www.mentalhealth.org.uk / 020 7803 1100
   The MHF offers advice and information on all aspects of mental health and well-being. They do not offer a helpline service.

Isabel Brunton
Trainee Clinical Psychologist
i.brunton@herts.ac.uk

Dr. Helen Ellis-Caird
Clinical Psychologist
h.ellis-caird@herts.ac.uk

Appendix 10

Ethics Approval Information

UNIVERSITY OF HERTFORDSHIRE HEALTH & HUMAN SCIENCES

ETHICS APPROVAL NOTIFICATION (1)

TO Isabel Brunton

CC Helen Ellis-Caird

FROM Dr Kim Goode, Alternate Chair, on behalf of the Health and Human Sciences ECDA Chairman

DATE 17/09/15

Protocol number: **LMS/PGR/UH/02004**

Title of study: Exploring how clinical psychologists who hold a hard determinist philosophy make sense of the therapeutic process

Your application for ethics approval has been accepted and approved by the ECDA for your School.

This approval is valid:

From: 17/09/15

To: 31/07/16

Please note:

Approval applies specifically to the research study/methodology and timings as detailed in your Form EC1. Should you amend any aspect of your research, or wish to apply for an extension to your study, you will need your supervisor's approval and must complete and submit form EC2. In cases where the amendments to the original study are deemed to be substantial, a new Form EC1 may need to be completed prior to the study being undertaken.

Should adverse circumstances arise during this study such as physical reaction/harm, mental/emotional harm, intrusion of privacy or breach of confidentiality this must be reported to the approving Committee immediately. Failure to report adverse circumstance/s would be considered misconduct.

Ensure you quote the UH protocol number and the name of the approving Committee on all paperwork, including recruitment advertisements/online requests, for this study.

Students must include this Approval Notification with their submission.

UNIVERSITY OF HERTFORDSHIRE HEALTH AND HUMAN SCIENCES

ETHICS APPROVAL NOTIFICATION (2)

TO Isabel Brunton

CC Dr Helen Ellis-Caird

FROM Dr Richard Southern, Health and Human Sciences ECDA Chairman

DATE 16/10/2015

Protocol number: aLMS/PGR/UH/02004(1)

Title of study: Exploring how clinical psychologists who hold a hard determinist philosophy make sense of the therapeutic process

Your application to modify the existing protocol as detailed below has been accepted and approved by the ECDA for your School.

Modification: Participants may be recruited via social media and the British Psychological Society.

Interviews may take place via telephone, Skype or other telephone/video phone methods .

This approval is valid: From:

16/10/2015

To: 31/07/2016

Please note:

Any conditions relating to the original protocol approval remain and must be complied with.

Approval applies specifically to the research study/methodology and timings as detailed in your Form EC1 or as detailed in the EC2 request. Should you amend any further aspect of your research, or wish to apply for an extension to your study, you will need your supervisor's approval and must complete and submit a further EC2 request. In cases where the amendments to the original study are deemed to be substantial, a new Form EC1 may need to be completed prior to the study being undertaken.

Should adverse circumstances arise during this study such as physical reaction/harm, mental/emotional harm, intrusion of privacy or breach of confidentiality this must be reported to the approving Committee immediately. Failure to report adverse circumstance/s would be considered misconduct.

Ensure you quote the UH protocol number and the name of the approving Committee on all paperwork, including recruitment advertisements/online requests, for this study.

Students must include this Approval Notification with their submission.

UNIVERSITY OF HERTFORDSHIRE HEALTH AND HUMAN SCIENCES

ETHICS APPROVAL NOTIFICATION

TO Isabel Brunton

CC Helen Ellis-Caird

FROM Dr Richard Southern, Health and Human Sciences ECDA Chairman

DATE 17/12/2015

Protocol number: aLMS/PGR/UH/02004(2)

Title of study: Exploring how clinical psychologists who hold a hard determinist philosophy make sense of their role as therapists

Your application to modify the existing protocol as detailed below has been accepted and approved by the ECDA for your School.

Modification: Revised title as above;
Additional recruitment as stated in the EC2 .

This approval is valid:

From: 17/12/2015

To: 31/07/2016

Please note:

Any conditions relating to the original protocol approval remain and must be complied with.

Approval applies specifically to the research study/methodology and timings as detailed in your Form EC1 or as detailed in the EC2 request. Should you amend any further aspect of your research, or wish to apply for an extension to your study, you will need your supervisor's approval and must complete and submit a further EC2 request. In cases where the amendments to the original study are deemed to be substantial, a new Form EC1 may need to be completed prior to the study being undertaken.

Should adverse circumstances arise during this study such as physical reaction/harm, mental/emotional harm, intrusion of privacy or breach of confidentiality this must be reported to the approving Committee immediately. Failure to report adverse circumstance/s would be considered misconduct.

Ensure you quote the UH protocol number and the name of the approving Committee on all paperwork, including recruitment advertisements/online requests, for this study.

Students must include this Approval Notification with their submission.

Appendix 11

Confidentiality / non-disclosure agreement

University of Hertfordshire

Transcription Agreement

Doctorate in Clinical Psychology
University of Hertfordshire

Transcription confidentiality/ non-disclosure agreement

This non-disclosure agreement is in reference to the following parties:
Isabel Brunton ('the discloser')
And
Dictate2us ('the recipient')

The recipient agrees to not divulge any information to a third party with regards to the transcription of audio recordings, as recorded by the discloser. The information shared will therefore remain confidential.

The recipient also agrees to destroy the transcripts as soon as they have been provided to the discloser.

The recipient agrees to return and or destroy any copies of the recordings they were able to access provided by the discloser.

Signed:.....
Name:... DARIC LEICH
Date:... 7/12/15

INVESTOR IN PEOPLE

Major Research Proposal Student No:
1.

Appendix 12

Audit trail and illustration of analysis

Appendix 12 shows one complete transcript (appendix 12a), the list of initial emergent themes drawn from this transcript (appendix 12b), an illustration of how these emergent themes were clustered into sub and super-ordinate themes (appendix 12c), and a map illustrating the final set of super-ordinate and sub-ordinate themes (appendix 12d).

Ethan's transcript has been provided for illustrative purposes here because his transcript was considered to show a balance of themes, to entail most of the themes described in the results section of this report, and to be fairly short and concise. However, for the reader's interest, appendix 12d also shows John's pictorial map of themes, illustrating how two particular super-ordinate themes appeared to dominate his data.

APPENDIX 12a

Full transcript

Transcript	Notes / Comments	Emerging themes
So the first question is, what do you understand by the terms determinism and hard determinism?		
By determinism, I think about that every event is the product of prior events before it.		
Okay, okay. And the definition that I have of hard determinism is that there's also no free will. Would you also therefore consider yourself a hard determinist?		

Yes. I would say that I have probably reached a point of sort of 95% conviction in hard determinism and 5% agnosticism.	Tentative – not entirely wanting to say "hard determinist". Some doubt in the belief? Sense of "not knowing" – "agnosticism"	Uncertainty / doubt Not knowing
Okay. So what do you mean by agnosticism?		
Well, I suppose I'm…my belief in hard determinism has increased particularly over the last three years. So I've now kind of reached 95%. So there's still about 5% where I'm almost sort of holding out hope that there might be free will.	Hope in free will – doesn't want to believe fully in hard determinism? A sense that there "might be" free will – possibility belief in hard determinism not true?? Hardening beliefs	Wanting free will Doubt Hardening beliefs
Okay. So there's sort of two bits in there that I'd like to ask you about. The first bit is that you said your belief has increased over the last three years.		
Mm-hmm, yes.		
Could you just tell me a bit more about that?		
Yeah, absolutely. I think I've always, probably since particularly doing Psychology I sort of have always held the belief that people's actions are heavily determined by prior causes to which they have not	"Absolutely" – indicating happy to talk about increase in beliefs? Always been kind of determinist ("had belief people's actions heavily	Wants to vocalise belief Lack of autonomy in own beliefs

chosen. But then about three years ago I discovered a neuroscientist called Sam Harris who is very sort of, he's kind of a famous often called militant atheist who really champions the idea of hard determinism. And so he then sort of increased the idea that actually not only are people's actions not heavily influenced by prior causes but that they are totally influenced by prior causes.	determined". Influenced by an individual (Sam Harris): Lack of autonomy Shift from "influenced" to "totally influenced" – no autonomy in the shift – "*he* ... increased the idea ..." (still using the word "influenced" – perhaps still doesn't quite want to say "caused" – not 100% - some room for doubt / uncertainty	Lack of autonomy in own beliefs Doubt
Okay.		
So probably a product of Sam Harris and then doing my research around it. And then the very nature of Clinical Psychology which I think implicitly takes a hard deterministic view but it doesn't…it never talks about that.	"product" of Sam Harris – lack of autonomy? "Doing research around it" – interested enough to research? wanting to know more? Clinical Psychology as taking an *implicit* hard determinist view - *not talking about it* (is there a sense he maybe wants it talked about? ...not to be implicit?)	Lack of autonomy in beliefs Curiosity Clinical psychology as hard deterministic Wanting the profession to talk about it?
Okay. So….		

So say for example I mean the very notion of formulation, it's a very hard deterministic process. Because what we're doing is we're locating people's difficulties in their past or current circumstances. And in nowhere in a formulation do we put things like choice. So it's as if we're taking a hard deterministic view but we don't really stop to think about kind of the extent to which we're doing that or the philosophy behind it.	Formulation - very hard deterministic "Nowhere in a formulation do we put things like choice" Clinical psychs as taking a hard deterministic view – but not stopping to reflect on extent to which we do it or philosophy behind it Values stopping to think / thinking about beliefs	Clinical psychology/ formulation as hard deterministic Value on reflection / thinking on philosophy
Okay. And what do you think about the fact that we don't really stop to do that?		
Well, I think it's an unpalatable idea, I think and a difficult one, the idea that we're not the full agents of our behaviour. Because quickly, it can feel quite depressing because you think, 'Gosh, I'm just sort of being bumped around here by forces coming from all directions.' And it's analogous for being a bit like a puppet, I suppose. We like to think that we have true responsibility and influence over our lives. And	Determinism – unpalatable, being a bit like a puppet We like to think we have true responsibility over our lives Difficult to stomach that we don't have reposnibsility People hold on to free will I held on to free will	Dislike of determinism Wanting free will / autonomy Dislike of determinism Wanting free will

so I think it's quite a difficult one to stomach that that may not be the case. So I think people want to hold on to free will, I know I certainly did. So I can certainly see why people struggle with the notion. And it goes against everything that most people think about the way humans behave and about the legal system and about culpability and about things like punishment. So, yeah. I think people just, they probably struggle to understand it because it doesn't quite marry up with our subjective experience of how things work out. But also there's a lack of, there's probably a sense perhaps hopelessness and lack of control if we are just entirely sort of arriving at a point at which none of which really was down to our doing.	Goes against everything most people think about the way humans behave Goes against legal system, culpability, punishment People struggle to understand it – doesn't marry up with subjective experience Sense of hopelessness, lack of control if none of life was out own doing	Going against the tide Different / going against the tide Others lack of understanding Dislike of determinism
Yeah, and that kind of links to a point you said before where you still got 5% you said hope in free will.		
Yeah.		

Just, could you tell me a little bit more about that, what you meant by that?		
Yes, well, I suppose I would rather that we lived in a universe where there was free will.	Would rather we lived in a universe where there was free will	Wanting free will
Okay.		
Because that's a nicer notion for me.	Free will – "nicer notion for me"	Wanting free will / liking free will
Okay. So how do you make sense of that then? How do you put that?		
Well, it's…I suppose it feels like an inconvenient truth really. So often when I have conversations about this, I'm invariably talking with someone who is trying to argue the case of free will. But if nothing else, I'm able to maintain a position of, 'Well, I wish this wasn't true, but I'm convinced by the evidence that it is true.'	Determinism – an inconvenient truth Coming alongside the free will believers by saying – "I wish it wasn't true" – but deviating by saying, "I'm convinced of the evidence that it is true" – attempting to fit in by saying he wishes it wasn't true?	Dislike determinism Fitting in vs difference Wanting free will
And why would you like it to not be true?		
Why?		
Mm-hmm, yeah.		
Because I think life loses a little bit of spark when you think that actually things were set in	Determinism – life loses a bit of spark – start re-analysing things like love and	Losing spark

motion at the beginning of the universe or the Big Bang or whatever. And actually everything that's happening is simply part of a sort of a process that's unfolding and expanding and that we are sort of essentially going along with that. So immediately what you do is you start reanalysing things like love and relationships. And it changes the feel of the a little bit.	relationships – changes the feel a little bit Re-analysisng things – Is he a thinker? Analysing things? Why would you do that "immediately"? – perhaps tendancy to analyse / think	Determinism as a process Thinker / analyser
Okay, okay. Okay. So you said that you kind of…you're getting harder in your determinist thinking and you were more free will previously but now you're less so.		
Yeah.		
So I don't know if you could give me sort of a history of your belief in free will from when it started until now?		
My belief in free will?		
I mean your belief in hard determinism, sorry.		
Well, so a little bit like I said before, it was that since I can…. I think probably when I was young I would've taken the view that we're all free agents	Reflecting on change in beliefs	Reflection Story / reflection on past

and that's the end of the matter. And then probably as I got older in my teenage years, maybe doing things like A Level Psychology. I started to understand some of the factors involved in shaping who we are. And then that probably gathered momentum throughout my undergraduate psychology degree where actually increasingly I was thinking, 'Hang on here. We are heavily, heavily influenced by our histories and the circumstances around us. And then it sort of reached a point of, as I say, discovering Sam Harris, this particular advocate of hard determinism, doing my research, the doctoral training. It became increasingly more difficult to put things like choice and sort of real freedom in understanding people's behaviour. I mean in Psychology, I'm still yet to be offered it to someone where I don't have a feel of where their current problems have come from. So it just seemed to me that actually the strongest	Hardening beliefs: Started teenage years – a-level, then undergrad – getting stronger through clin training, and then hardened by S.harris Questioning the status quo / thinking about things in more depth More thinking about it = hardening of beliefs? researching Increasingly more difficult to put things like choice and .. real freedom in understanding people's behaviour" Can't find free will – yet to be offered scenario where it exists / can be found Thinking – "deciding" (autonomy?) on determinism after much thought / reading / consideration etc…	Hardening of beliefs (beliefs as process) Thinking / questioning Hardening of beliefs Researching Can't find the free will Can't find the free will Deliberation then belief Searching / not finding free will

theory was that we are entirely produced by our history and the people around in our relationships and economic situation and the culture we're in and all of these things come together. And in sum they can entirely explain everything and there's no room for anything else like choice, free will.	There's no room for ... free will (looked but can't see it?)	
Okay, okay. So in terms of your work as a therapist ...		
Yeah.		
So how would you describe yourself as a therapist? What kind of a therapist are you?		
Well, I suppose there's different ways of answering that on different levels. I mean if….		
Well, what kind of characteristics do you have or qualities do you have as a therapist?		
Okay. Well, I can probably only talk about the qualities I'd try to espouse. The level at which I'm successful at that, I'm not sure but I hope so. So I suppose I just try to be understanding, empathic, positive, validating, non-judgmental and hopefully	Qualities *I try* to espouse – not assuming he already has these. Self doubt Identity as therapist: understanding, empathic, positive, validating, non-judgemental, useful	Therapeutic relationship as important

useful. I mean all the sort of the basic kind of stuff that a Clinical Psychologist is sort of trained to be. So yes, I suppose most of my focus goes on sort of interpersonal factors.	Values "interpersonal factors" Sees own values as therapist as reflecting the values of the profession?	Own values reflecting values of the profession
Okay. And do you think that holding a hard determinist philosophy impacts on how you see yourself as a therapist?		
Yes, it probably does in a way. I mean I suppose…so one way I could conceptualise it is that when people meet me, I will try to become a new variable or factor in their life that brings about some kind of meaningful or helpful change for them.	I try to become a new variable or factor in their life that brings about some kind of meaningful or helpful change for them. Sense of agency over changing another?? / importance / responsibility maybe??? Wanting to do good, give meaningful intervention (bring helpful change) Importance of self in the therapeutic relationship – cog in the chain – bringing change	Changing the trajectory Sense of autonomy in creating change? Self as important to bring change
Okay, okay. And so in terms of your own identity, your own professional identity, how does determinism fit with that?		

Yeah. Well, I think it fits perfectly. Because as I say, I think that I go to work with a hard determinist suit on, and my job is to help people to understand that essentially their difficulties are not really of their doing. Their difficulties have arrived through things that at every stage weren't really ultimately their responsibility. And that's the nature of formulation and validation. So we constantly try to create a shared understanding where essentially I could look to the person opposite me and think, 'If I had your brain and I had your past experiences, I will be sitting opposite with exactly the same difficulties as you had.' So hopefully when I validate people's difficulties, I can do it not as a sort of as a nice helpful thing to do because that's nice for people to hear, but with genuine authenticity. I literally think that I would have their difficulties if I were born at their moment of time with their biology	Go to work with a hard determinism suit on. – Job as deterministic Job as a therapist is to "help people understand that .. their difficulties are not really of their doing" – nature of formulation and validation "I could look to the person opposite me and think, 'If I had your brain and I had your past experiences, I will be sitting opposite with exactly the same difficulties as you had." – empathy Genuineness – validating genuinely Belief that "I would have their difficulties if I were born at their moment of time with their biology."	Therapists as determinisitc Lack of autonomy as helpful Determinism and empathy? Determinism and empathy Genuineness and empathy

Okay, okay. So you feel that there's a sort of a genuineness that comes through from you to the client?		
I do believe that everyone does sort of the best they can with what they've got. So I take that notion to its absolute degree rather than, this is a helpful way to look at people's problems.	Deterministic/empathic way to see people - Helpful way to look at people's problems	Utility of beliefs
Yeah, yeah, yeah. And is there any other way you think that holding the hard determinist philosophy affects the work that you do as a therapist?		
I think probably it reduces the negative emotions that, you know. It reduces things like frustration and anger, I think.	Determinism reduces negative emotions – like frustration / anger	Reducing negative emotion
Okay, okay.		
Because as I say, and of course people induce those things to me at work. I get frustrated with people, staff and clients. But it does temper it a little bit, because I just have to think, 'Well, actually this isn't really of their doing.' And so that just sort of, yes, I get less caught up in those sort of more critical emotions towards other people, I think.	In moment – frustrations etc ... feeling free. On reflection/thinking: consider reasons for behaviour. Reflecting on reasons prevents getting "caught up" in critical emotions. – why? Because enables empathy / understanding of why people act as they do	Felt vs reflective sense of free will Determinism linked to empathy / understanding Reflective state – formulation/understanding

Okay, yeah. So one of my questions is about your relationship with colleagues. I'm just wondering if in any other way hard determinism has affected your interaction with colleagues?		
No, I don't know if I could entirely pin this on hard determinism, but I think it's certainly involved. I suppose I probably draw less of a dividing line between colleagues and clients.	Links hard determinism with viewing less divide between clients and colleagues	Lack of own / other's autonomy
Okay.		
So I generally kind of heap us all in the same thing and just it's down to fortune really for the most part. I think that the people we work with have simply been less fortunate than a lot of my colleagues.	Relating determinism to fortune? – events as good fortune rather than own agency	
Okay.		
So I try and talk the same principles and beliefs when I'm maybe dealing with a challenging member of staff or someone that I don't have a lot in common with. I try to sort of be kind of…I probably have a greater level of consistency with them, as I do with clients,	Linking use of determinism with dealing with challenging people – Colleagues and clients closer in mind now? – coinciding with hardening philosophy??	Utility with challenging populations All human, no divide

so that colleagues and clients are sort of closer in my mind now than perhaps they were before.		
Okay.		
I think the distinction's fairly arbitrary a lot of times between colleagues and clients.	Arbitrary distinction between clients and colleagues – all same – determinism as leveller? / equalness?	All human, no divide
Okay. And has holding a hard determinist philosophy in any way negatively impacted your relationship with colleagues?		
I don't think it has.		
Okay.		
No. I think intrinsically you become more compassionate because you really have no reason to blame or judge or criticise anyone above and beyond you thinking that will be a useful exercise to bring about change.	Determinism as aiding compassion No room for blame / judgement / criticism Blame etc... only useful to bring change	Aiding compassion Non-blaming / non-judgemental approach
Okay. All right. And in terms of the therapeutic relationship then, it sounds like you think that it's kind of similar to your relationship with colleagues. But what does holding a hard determinist philosophy mean to you in the context of the therapeutic relationship?		

Well, as I said, I'm not sure how much different it is in a therapeutic context having a hard deterministic view or not because as I said, I think that therapy takes a hard deterministic view. So the fact that, so say I might think of some other clinical psychologist let's say who don't hold a hard deterministic view. I think they are still trying…they are still looking at things the same way as I am except that they might be more susceptible to…. When they work with some clients for example, they might be more likely to attribute blame and judgement particularly in areas where a client's behaviour has perhaps been very negative on someone else, they're an abuser or if they've done some things that were really quite difficult to stomach.	Therapy taking a hard determinist view Non determinists are more likely to attribute blame and judgement Utility with challenging clients – determinism aiding non-judgemental / non-blaming approach in challenging clients	Therapy as deterministic Utility with challenging clients Non-blaming / non-judgemental approach
Yeah, yeah.		
Probably an easier position to empathise with that person than then perhaps someone, a therapist without a hard deterministic view.	Determinism creating easier position for empathy	Determinism enabling empathy

Okay, okay. And are there any other ways you think that holding a hard deterministic philosophy has impacted on your therapeutic relationship?		
No. I suppose the one thing I sometimes think of is, I sometimes think, is there a danger that I perhaps let people off the hook too easily.	Danger of letting people "off the hook" – Why dangerous??	Letting "off the hook"
Okay. What do you mean by that?		
Well, I suppose because if I think that people are at a fundamental level sort of blameless for whatever heinous behaviour they have done, the danger is then to that I could possibly become colluding with some of their more difficult behavioural patterns.	People as blameless – opens possibility for colluding	Collusion potential People as blameless
Okay.		
And that I could, because…and that I could become fatalistic.	"Danger" of becoming fatalistic. Danger in beliefs?	Fatalism danger
Okay.		
So the danger could be that because I think we are all puppets to an extent, I could work with someone and I could get sort of slowly sucked in to their difficulties that I end up thinking, 'Gosh, nothing's	We are all puppets Could get sucked in to thinking, "nothing's going to work"	People as puppets Determinism vs fatalism Self-agency

going to work with you.' And so I don't think on that, but that's where I have to sort of monitor that.	I have to monitor that (sense of some agency over beliefs – monitoring) Reflecting on beliefs – linking to potential therapeutic difficulties – influence therapy. Reflecting on beliefs effecting practice?	Reflection on beliefs aiding practice
Okay. So why do you think that that could happen?		
Okay, well, because I think people are more limited in their scope to exercise decisions. So with that in mind, I could be working with the services and perhaps be more pessimistic about their outcomes than someone else without a hard deterministic view. And then by doing that I might be less useful because I might simply…it might appear as if I'm more giving up on them than someone without a hard deterministic view. Now…	"Limited" in scope to exercise decisions?? – so does this mean he thinks there may be some scope? Determinism linked to pessimism for outcome – more pessimism than a non-determinist?? Concerned to be useful Worry it would appear he was giving up on people?	Determinism and pessimism for change Desire for usefulness Not giving up
And would that be…?		
…I don't do that….	Doesn't give up on people	
Okay. So what stops you doing that?		

Because just because people themselves don't have that bedrock fundamental ability to change without things changing around them, it doesn't mean that people don't change in remarkable ways. So it's very compatible to have a hard deterministic view and to be very optimistic about people.	Need for systemic change, to change Optimism that people can change (in "remarkable" ways) Compatible to be determinist and optimist for change	Determinism and change Determinism and optimism for change
Okay, that's good.		
So I just have to sort of, I reflect on it, I suppose. And if I ever feel that I'm getting a bit fatalistic, I stop and I think, 'Hang on a second here. No, let's be optimistic. What can we do here?'	Reflection on belief to retain optimism Values optimism?	Reflection Value of optimism
So can you tell me more about the compatibilism between determinism and optimism then?		
Yeah, absolutely. So I suppose that comes down to the difference in determinism and fatalism. So often people confuse the two. So if I was fatalistic, I would walk into work and think, 'There's nothing I can do or anyone else is going to do to change someone's circumstances. If it	Fatalism and determinism as different Fatalism as meaning no point to action Fatalism as leaving things to fate	Determinism NOT fatalism

happens, it's going to happen and nothing we can do about it. If it doesn't happen again but that's again because it's just…that's just fate. It will all be….'		
Okay.		
But that's not true. I mean by my very input into someone's life, I then become another force. And so that can then start a snowball reaction or be part of a movement for a person in a more helpful direction.	Ethan as rejecting fatalism. Ethan as optimistic for change – seeing self as instigator of change Ethan as changing direction of clients path	Determinism NOT fatalism Changing the trajectory Self as important to bring change
Okay.		
So you can be just as optimistic with a hard deterministic view as you can be without one.		Compatibility of determinism and optimism
Okay. Do you think that having a hard determinist view has influenced the client group that you work with? Like influenced your kind of choice, so to speak.		
Yeah. Oh, do you mean…right, have I sort of sought out…		
Influence who you've chosen to work with...		
…the client group because of my ideas on this?		

Yeah.		
No.		
(Laughter). Okay. So how has it not impacted on your…on the choice of client group?		
Because in my eyes, a hard deterministic view does not fit any more with one particular type of client group over another.	Hard determinism as fitting with a particular group – compatible with all?? Hard deterministic beliefs not influencing 'choice' of client group	Compatible with all client groups Beliefs not influencing client group worked with
Okay.		
So I don't think, 'Oh golly, I know who would sort of very nicely with my hard deterministic view. I'm going to go and work with them.'		
Okay, okay.		
So no, not at all.		
Not at all.		
More stronger factors are at play the service group I've ended up working with.	Other factors at force – lack of self autonomy??	Lack of self autonomy
Okay. And what about the models of therapy that you use or the models that you use in your work?		
Yeah, so at the moment it's predominantly CBT.	Uses CBT	Uses CBT
Okay.		
But that's also because of the service I'm working in, that's the main model that's used.	Service influencing model (lack of autonomy??)	Service influencing model

		Lack of self autonomy
Okay.		
And so my sort of, you know, my preponderance to CBT is less to do with hard determinism and more to do with the model itself, my understanding of it, its applicability and my experience with it.	Model used not linked to philosophical belief – beliefs separate from model? 'choice' of model based on experience and applicability	Model used separate from beliefs Utility of model
Okay.		
But I also draw on systemic theory, some ideas from Kant and a little bit of existential.	Use of systemic, Kant & existential models	
Okay. Do you think that a hard determinism fits better with one model or another?		
Good question. Well, interestingly it doesn't… philosophically it doesn't seem to marry up with existential theory so well. Because one of the core principles of existential theory is free will and freedom and that we are free to make whatever decisions we want. But I still consider fit existential theory with hard determinism rather neatly although I suspect a purist might have something to say about that. CBT certainly fits with hard determinism.	Philosophical misfit between existential and determinism. BUT Ethan thinks they DO fit (rebelling? Different? Does things own way?? Thinks for himself) A purist might have something to say ... (rebelling? Different? Does things own way?? Thinks for himself) Existential with hard determinism fits neatly	Thinker Thinks about own action

	CBT fits with hard determinism	Hard determinism compatible with existential Hard determinism compatible with CBT
Okay.		
And systemic theory does as well and Kant's. I mean with all of them, you are explaining people's current difficulties with all these factors around them.	All models as explaining problems with factors around them. – so all models fit with hard determinism?	Compatible with all models
Okay. So when you're working with a client, do you make explicit your beliefs or are they more implicit?		
They must be implicit. I would never use the word hard determinism. But in my sort of…I voice my ideas and things in my explanations and in my validating of people. There will be hard determinism running through all of that, but I don't think anyone would come away thinking, 'Oh gosh, Ethan doesn't believe in free will.'	*Must* be implicit? Why? *Never use* term hard determinism?? – why?? Voice ideas in explanations and validation – ideas voiced *implicitly* Determinism running through what Ethan does Clients as not knowing Ethan's beliefs	Implicit NOT explicit Hiding of beliefs in therapy
Okay. Has holding a hard deterministic philosophy		

created any challenges for you with any particular models or in any particular way of working?		
No.	Determinism as presenting no challenges	Determinism as no challenges / positive
Okay.		
In fact, it would be more challenging to not believe in my opinion.	Challenging not to believe	The challenge of not believing
Okay. And can you tell me more about that?		
Well, because you'd be conflicted. Because what would probably happen I suspect is it would be very easy to work with individuals whom you perhaps saw an affinity with or whom you really see their struggle and that if you see that they're kind of doing the best they can and actually there's some real kind of good bits to their struggles, that's all very easy. But what do you do with the people where you think, 'Gosh, this person is a real sort of danger to other people,' and you aspire real negative qualities for him. You might think they're very	Not believing = conflicted Without hard determinist philosophy – more difficult to work with challenging clients	

critical, they're abusive, they are stuck up themselves, they are, you know, just not very nice to be around.		
Yeah.		
That's when it will become more difficult because you're suddenly sort of losing all of your positive kind of therapeutic qualities. But if you sat down and thought about it, it'd be very difficult to justify that…	Hard determinism as compatible with challenging clients?	
Okay. Can you tell me…?		
…intellectually.		
Can you explain that a bit more?		
Ultimately if I'm working with someone who I think has done just the most horrific thing, I think they are just as responsible for those horrific things as I am for having not done those horrific things.		Importance of responsibility
Okay. Can you just explain what you mean by their responsibility when you say they're responsible?	Importance of responsibility Important for clients to "take responsibility"	
Yeah. So I think they're…so first of all, I talk about		

responsibility a lot and it sounds like a paradox here. But I think essential responsibility is one of the strongest qualities we can have. So I'm constantly trying to enable people to take more responsibility for their actions. Now, even though at a fundamental level, I don't think that responsibility truly lies with them. That very mind-set brings about very good things. I mean I'm hard deterministic, but I still try to take as much responsibility for my actions as I can.	Clients should take responsibility. I take responsibility	Clients should take responsibility Self autonomy / responsibility
How do you do that, being a hard determinist?		
Yeah, yeah. I suppose because I recognise that A, it's to my benefit.	To benefit – then do it. Feeling responsible/autonomous - beneficial	Usefulness of autonomy
Okay.		
Because my life is more likely to bring better things and my relation to other people are more likely to be better if I hold responsibility to be an important aspect and strive for	Feeling responsible/autonomous – beneficial – brings good things	Usefulness of autonomy Striving for autonomy

it. And the other thing is, it feels good to be responsible. So I mean it's a strange one and it instantly feels like a contradiction in terms, but it's not necessarily…it just depends on the level of responsibility you're talking about.	Strive for autonomy is good/useful Feeling responsible/ autonomous, feels good Differentiation of different "levels" of responsibility	Responsibility feels good Different levels
Okay. So when you're talking about level.		
Yeah.		
Would you be able to explain that just a little bit more?		
Yes. So…okay. Let's say, for example, if I'm at work and I end up losing my patience with a member of staff, right? And let's say I end up saying something a bit nasty back, right? Now, I would go away from that and I would take responsibility for that. And I would feel guilty and I would really question why I did it and I would take responsibility for that because it's an action that I've done.	Taking responsibility as related to feelings such as guilty, questioning. Taking responsibility for actions done	Responsibility as emotional Responsibility as linked to action
Okay.		Different levels – "feelings" = responsibility
Now, even though I feel all these negative emotions and I probably want to put it right and I want to think, 'How can I	Negative emotions, wanting to "put it right", not do again. On a different level,	

make sure I never do that again?' at a deep level, my guilt is going to be a little bit reduced by the knowledge that, actually, the reason why I did that was obviously for factors that weren't really down to my doing. Why was it that I did that then, whereas the other day when I spoke to that staff, I didn't have any compulsion or it wasn't even on my menu of activities to do that?	deterministic level – those feelings reduced Determinism as reduction of guilt feelings Actions not down to "own doing"	"rationalising" = not responsible Determinism as guilt reduction Determinism as explaining action
Okay.		
So I can sort of rationalise it but I'm still human. So I'm still left with the kind of the emotional effects of that.	Still human – emotional effects. Humanity as linked to emotion??? I am human – asserting humanity??	Humans as emotional Ethan as human
Okay, okay. Right, that makes sense. Yeah. Okay. So I'm just thinking in terms of determinism and what that actually means to you. And if you could sort of sum up what having this philosophy and having this view on life means to you, what would you say?		

I think that the way I … so it makes me have a greater sense of compassion towards other people generally. To humans and to animals to a certain extent. But if we just stick with humans, I feel greater compassion to my brothers I would say. And it makes me more accepting of other people and also myself. And I suppose I look at life as more of a process that is happening rather than something that I have to get through.	Hard determinism gives compassion Hard determinism as enabling self acceptance Hard determinism as process	Hard determinism and compassion Hard determinism and self acceptance Hard determinism as process
Okay.		
Now, I can't attribute all of that to hard determinism, absolutely not. But that certainly influences that whole view.	Hard deterministic beliefs not as sole reason for compassion etc.. – but an influence	Beliefs as influencing compassion
And do you think you would be a different therapist if you weren't a hard determinist?		
I think that I might different to a degree. So I don't think I'm doing anything fundamentally different ever since my hard determinism some of which I have since shut up. But as I say, hopefully there's real sort of therapeutic qualities, the	Nothing fundamentally different from a non determinist therapist, but ...	No fundamental difference from other approaches Determinism as enhancing warmth,

warmth, the compassion, the non-judgmental, the empathy. I could only think that they've been tuned up…	Determinism as enhancing warmth, compassion, non-judgementalism and empathy	compassion, non-judgementalism and empathy
Okay.		
…with this.		
Okay. That's….		
So hopefully sort of interpersonally at work that I'm more useful hopefully.	Determinism linked to being more useful	usefulness
Okay. (Laughter). Okay, so we're coming to the end of the interview schedule. Before I close the interview, I just I wanted to ask if you've got any particular comments that you want to make about hard determinism and your experiences delivering therapy from this philosophical frame, that we might not have talked about yet?		
No. Let me just think. No, I suppose I'd be interested in hearing your view on this, but I'm guessing that's probably something not to talk about right now.	Interested, curious	Interested, curious

Appendix 12b
Initial set of emergent themes

Uncertainty / doubt
Not knowing
Wanting free will
Doubt
Hardening beliefs
Wants to vocalise belief
Lack of autonomy in own beliefs
Lack of autonomy in own beliefs
Doubt
Lack of autonomy in beliefs
Curiosity
Clinical psychology as hard deterministic
Wanting the profession to talk about it?
Clinical psychology/ formulation as hard deterministic
Value on reflection / thinking on philosophy
Dislike of determinism
Wanting free will / autonomy
Dislike of determinism
Wanting free will
Going against the tide
Different / going against the tide
Others lack of understanding
Dislike of determinism
Wanting free will
Wanting free will / liking free will
Dislike determinism
Fitting in vs difference
Wanting free will
Losing spark
Determinism as a process

Thinker / analyser
Reflection
Story / reflection on past
Hardening of beliefs (beliefs as process)
Thinking / questioning
Hardening of beliefs
Researching
Can't find the free will
Can't find the free will
Deliberation then belief
Searching / not finding free will
Therapeutic relationship as important
Own values reflecting values of the profession
Changing the trajectory
Sense of autonomy in creating change?
Self as important to bring change
Therapists as determinisitc
Lack of autonomy as helpful
Determinism and empathy?
Determinism and empathy
Genuineness and empathy
Utility of beliefs
Reducing negative emotion
Felt vs reflective sense of free will
Determinism linked to empathy / understanding
Reflective state – formulation/understanding
Lack of own / other's autonomy
Utility with challenging populations
All human, no divide
All human, no divide
Aiding compassion
Non-blaming / non-judgemental approach

Therapy as deterministic
Utility with challenging clients
Non-blaming / non-judgemental approach
Determinism enabling empathy
Letting “off the hook”
Collusion potential
People as blameless
Fatalism danger
People as puppets
Determinism vs fatalism
Self-agency
Reflection on beliefs aiding practice
Determinism and pessimism for change
Desire for usefulness
Not giving up
Determinism and change
Determinism and optimism for change
Reflection
Value of optimism
Determinism NOT fatalism
Determinism NOT fatalism
Changing the trajectory
Self as important to bring change
Compatibility of determinism and optimism
Compatible with all client groups
Beliefs not influencing client group worked with
Lack of self autonomy
Uses CBT
Service influencing model
Lack of self autonomy
Model used separate from beliefs
Utility of model

Thinker
Thinks about own action
Hard determinism compatible with existential
Hard determinism compatible with CBT
Compatible with all models
Implicit NOT explicit
Hiding of beliefs in therapy
Determinism as no challenges / positive
The challenge of not believing
Importance of responsibility
Clients should take responsibility
Self autonomy / responsibility
Usefulness of autonomy
Striving for autonomy
Responsibility feels good
Different levels
Responsibility as emotional
Responsibility as linked to action
Different levels – "feelings" = responsibility
"rationalising" = not responsible
Determinism as guilt reduction
Determinism as explaining action
Humans as emotional
Ethan as human
hard determinism and compassion
Hard determinism and self acceptance
Hard determinism as process
Beliefs as influencing compassion
No fundamental difference from other approaches
Determinism as enhancing warmth, compassion, non-judgementalism and empathy usefulness
Interested, curious

Appendix 12C

The clustering of emergent themes into super- and sub- ordinate themes

Therapist as thinker (Superordinate theme):

Doubt:

- Uncertainty
- doubt
- Not knowing
- Utility of beliefs vs doubt about beliefs

Wanting and searching:

- Wanting free will vs the challenge of believing
- Researching
- Can't find the free will
- Searching / not finding free will
- Determinism not fatalism
- Dislike of determinism

Reflector:

- Hardening beliefs
- Curiosity
- Value on reflection / thinking on philosophy
- Thinker / analyser
- Reflection
- Story / reflection on past
- Questioning
- Researching
- Deliberation then belief
- Determinism vs fatalism
- Reflection aiding practice
- Thinks about own action
- Reflection on utility of belief
- Interested

Free will: A felt vs reflective understanding (Superordinate theme):

Vocalising the belief:

- Wants to vocalise the belief

- Wanting the profession to talk about it
- Fitting in vs difference
- Implicit not explicit
- Hiding beliefs in therapy
- Going against the tide.
- Others lack of understanding

Responsibility and feeling autonomous:

- Lack of autonomy in own beliefs
- Changing the trajectory
- Sense of autonomy in creating change
- Self as important to bring change
- Determinism letting "off the hook"
- Collusion potential
- Determinism not fatalism
- The importance of change
- Importance of responsibility
- Responsibility feels good
- Responsibility as emotional
- Determinism as guilt reduction

Illusion and the felt sense:

- Lack of autonomy as helpful
- Felt vs reflective sense of free will
- Reflective state as formulation state
- Importance of autonomy/responsibility
- Usefulness of autonomy
- Different levels
- Feelings vs reflections

Enhancing the therapeutic relationship (Superordinate theme):

Model vs relationship:

- Therapeutic relationship as important
- Discussion of therapeutic relationship more than of models.
- Compatible with all models

Empathy and understanding:

- Determinism as enhancing empathy
- Determinism as enhancing genuineness

- Utility with challenging populations

Non-Judgemental/non blaming approach:

- Utility with challenging populations
- Non-blaming
- Non-judgemental

Compassion/humanity:

- Determinism as process
- Humanity vs losing spark
- Reducing negative emotion
- All human – no divide
- Aiding compassion
- People as puppets
- Ethan as human
- Humanity as emotional
- Hard determinism as compassionate
- Determinism as aiding self compassion
- warmth

Professional dilemmas (Superordinate theme):

The profession and the philosophy

- Clinical psychology as hard deterministic
- Formulation as hard deterministic
- Own values reflecting the profession
- Therapists as deterministic

Compatibility with all models and client groups

- Compatibility across clients and models
- Model as separate from beliefs
- Compatibility with all (even existential) models.

The philosophy and change

- Determinism and change
- Optimism vs pessimism for change

Appendix 12d

Thematic maps to illustrate themes, and some links between themes.

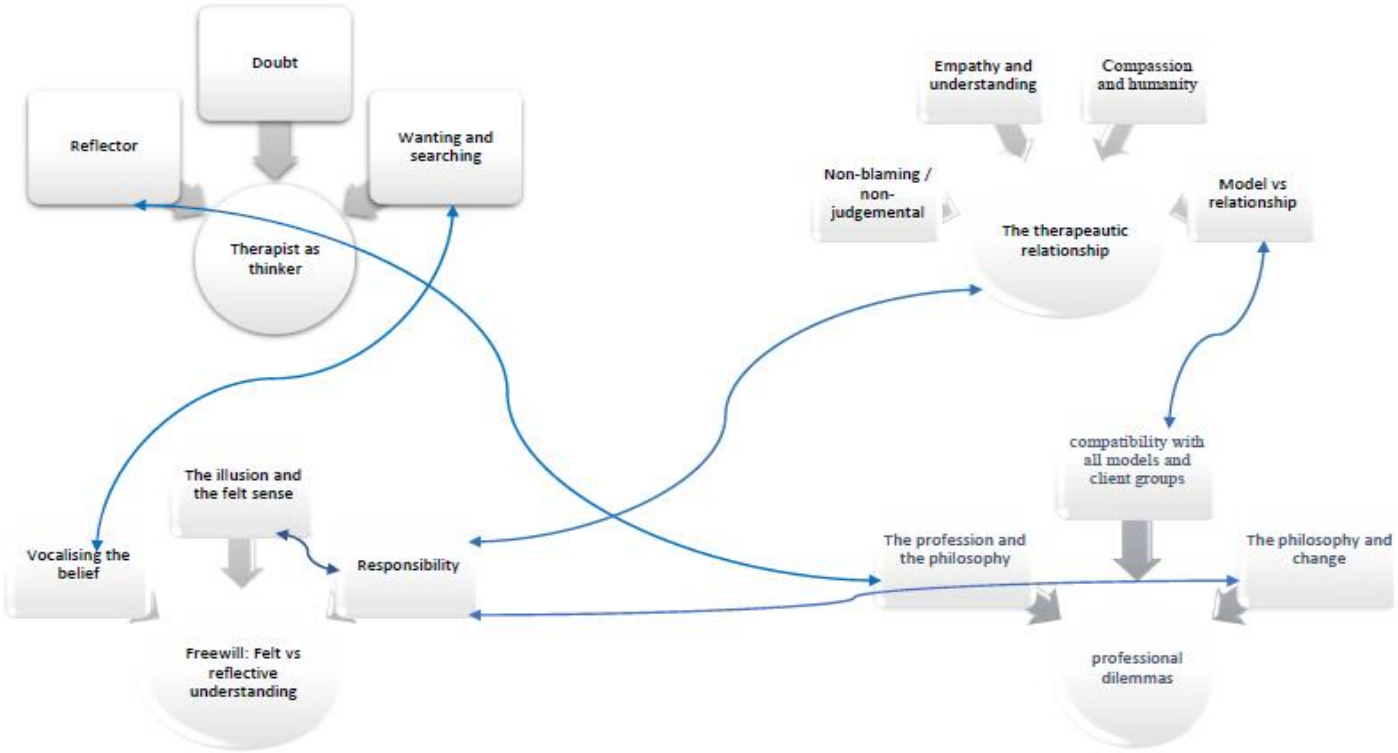


Figure 1: Ethan's thematic map.

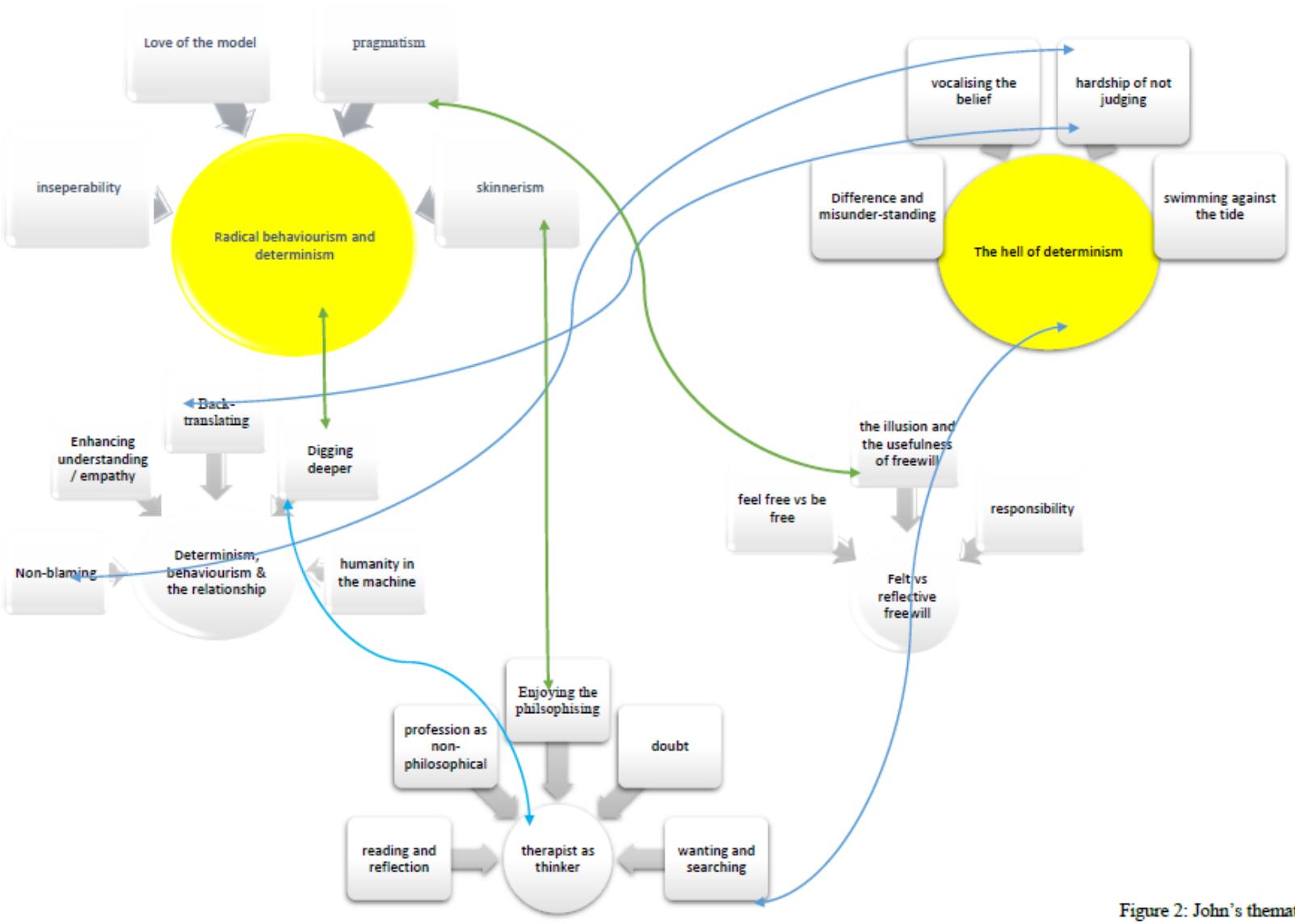


Figure 2: John's thematic map.

Appendix 13

Post results reflection

As stated within the methodology section of this thesis, reflexivity within qualitative research requires self-reflection and the researcher to specify their values and beliefs "both as known in advance *and as they become apparent during the research"* (Elliott et al., 1999, p. 221). I thus here wish to briefly outline the changing nature of some of my beliefs as the research progressed. The main purpose of this is for the interested reader to engage with me in a reflexive process beyond that made possible within the main body of this research thesis, and for the reader to consider the more in-depth interaction between changing beliefs and reported results. However, I hope too that it will serve as an acknowledgement of the influence the participants in this study have had on me.

Responsibility

Prior to conducting this research, I was aware of my own inflated sense of responsibility towards others. I had always situated this within the context of my personal formulation, considering it related to my experiences growing up, and as related to family dynamics. However, in conducting this research, and hearing the inflated sense of responsibility felt by the participants, this view has changed. The participants clearly related their own sense of responsibility, at least within the therapy setting, to their hard determinist beliefs. Hearing this, I cannot now help but feel that my own sense of responsibility is also intricately bound to my hard determinist belief system. Understanding this has enabled me to consider a different angle to this aspect of myself, and it has enabled me to feel that this tendency towards responsibility is a shared experience.

Radical Behaviourism

Prior to conducting this research, while I was aware of the deterministic roots to radical behaviourism, I had not given much thought to the model and have never been drawn to the model. Hearing from the radical behaviourists in this study has changed my impression of

behaviourism. It has helped me see some of the beauty in this model that John, Tony (and to a certain extent, Graham) see, and enabled me to understand more about it and its utility. I had strong reactions to, and found the interviews with, John and Tony particularly interesting and inspiring. In John's case, this was because most of his views were in complete opposition to my own. For Tony, it was largely because he thought very similarly to me, but through a lens I had not looked through before (radical behaviourism). Both John and Tony challenged my preconceptions, prejudices and assumptions, and enabled me to view a model (radical behaviourism) I had previously disregarded, in a new light. Following these interviews I have been inspired to think and read more about behaviourism, for which I am very grateful since this has been enlightening, interesting and a fascinating learning experience.

Power and control

Prior to this research I had not considered determinism much in the context of power, control and oppression. Hearing from Justine opened my eyes to this link, and how some people see determinism as intricately connected to authoritarianism and a sense of being controlled by authorities and higher powers. I found Justine's interview incredibly interesting, as it was a view new to me, and one I did not entirely agree with.

The Philosophy

I have always viewed hard determinism in a positive light, perhaps even attributing a similar utopia status to it, as Tony did. I was therefore very surprised to find that most of the participants in this study would prefer a world in which free will exists. This significantly challenged my own view and made me think in a different way about the philosophy. I still view determinism in a positive light, but my eyes have been further opened to the opposition felt towards this view of the world, even, surprisingly, by those who hold it.