

**Unearthing the complexity of stigma: a narrative inquiry into
clients' experiences of stigma and psychotherapy**
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Unearthing the complexity of stigma: A narrative inquiry into clients' experiences of stigma and psychotherapy

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Doctor of Counselling Psychology and Psychotherapy by Professional Studies

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Abstract

This study aimed to capture the lived experience of stigma that surrounds psychological therapy through in depth interviews. Each participant had attended at least twelve sessions of weekly therapy whilst also acknowledging a sense of stigma attached to it. Interview conversations took place on a one-to-one basis with three participants, on two separate occasions. Taking a narrative inquiry approach, the study aimed to contribute much needed deeper understanding to a field which is dominated by quantitative studies. Following analysis and interpretation of the transcripts, three main themes emerged. First, stigma is a complex phenomenon, experienced as an entanglement of external and internal influences, with societal and familial culture shaping subjective experience at both explicit and implicit levels. The second theme was stigma revealing itself during the process of therapy, how it was associated with reasons for engaging, and with intersubjectivity between therapist and client. The final theme was the dilemma that participants faced around disclosing their engagement in therapy, and how connection and relationships were central to resolving this. The participants' accounts conveyed stigma as a complex, interwoven, multilayered and multidirectional phenomenon. The understanding gained from the narratives led to the proposal of six areas of consideration for therapists in order to enhance practice. These were: paying attention to how stigma may present in the therapy room; the importance of assisting clients in tolerating uncertainty around mental health; how stigmatising beliefs may reflect deeper levels of psychological process; the potential for reframing and empowering; the value of the therapeutic relationship; and the importance of accommodation to the client's process and momentum.

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INTRODUCTION

Background to the study

I can still recall my initial reluctance to research the experience of stigma, and yet it was a topic that I seemed to keep coming back to. I came to realise that my reluctance was a reflection of my own experience of stigma that I was grappling with, especially in the early stages of my training as a counselling psychologist and psychotherapist. It was a strange situation, to feel drawn to undergo this training and at the same time feeling shame in doing so. A year or so into the course, when this study was conceived, I realised there was no place to hide in this work, that my weaknesses and inadequacies would inevitably be exposed. My fears were captured by Pines' (1990, p.7) description of shame being the "*inner language of failure*", where not only do we feel we have violated the laws of society, but also our own ideals; we feel rejected by others and we also reject ourselves. I was experiencing first-hand the embodied sense of shame upon which stigma thrives.

Before starting my training and throughout the majority of it, I worked in a male dominated environment and felt pressure to conform to the social and cultural norms which accompanied it. In this environment, as in many others, emotional expression and the inability to cope were perceived as weakness and were to be avoided at all costs. The desire to avoid this stigma meant that I adapted myself to it. I suppressed parts of myself that conflicted with it and reinforced my parts that aligned with it; such was the need to fit in. These behaviours, thoughts and beliefs were already in motion of course, as I had absorbed the more subtle messages of masculinity, strength and independence that filled my environment, family unit, and social group.

By fitting in with these direct and indirect messages, I was rewarded with a sense of belonging, to be thinking, feeling and behaving like the majority of those around me. This reward however, came at a price, which I understand now as the feeling of unease associated with a loss of authenticity and the denial of what Winnicott (1960, p.140) called my "*true self*". As I continued to face my own struggles in life, with feelings of depression and anxiety, I became increasingly ashamed of my 'true self' and felt increasingly disconnected and isolated as a result.

I have come to view my engagement in this training as a form of subversion of what I consider to be unhealthy models of masculinity and of the stigma that surrounds mental health and help-seeking. This training has not only enabled, but actively encouraged me to harness my 'true self' rather than suppress it. Had I not embarked on this process, I am fairly sure that I would never have engaged in therapy, the shame would have felt too great. And yet I find myself here, having completed four years of personal therapy, experiencing the highs and lows, the courage it requires, and the life changing benefits it can provide.

This leaves me in an unusual position, considering myself to be deeply impacted by stigma, whilst also having engaged in long-term therapy, and now working as a psychological therapist. My training means that I have specific understanding and insight into my experience, and when looking at the research field of stigma, the depth of my experience is not reflected there. The field is instead dominated by quantitative research that primarily focuses on attitudes and barriers to help-seeking, rather than the embodied experience of it. This study aims to capture the complexity of this embodied experience, the part which touches the core of our being, but which goes largely unrecognised in the existing quantitative research. By employing qualitative methodology, my aim is to uncover this depth of experience, and use it to inform therapists' understanding of working with people's experiences of stigma when they engage in therapy, and to provide further understanding of how to reach out to those who don't.

Note on terminology

The term 'stigma' is discussed and unpacked throughout this dissertation, but is initially understood as referring to negative feelings or associations that relate to particular circumstances or characteristics. When an individual *experiences* stigma, these negative portrayals are internalised and associated with oneself; often resulting in feelings of shame, of being "*fundamentally unacceptable, unworthy or defective*" (Joyce & Sills, 2018, p.95). The complicated relationship between stigma and shame is explored further in the literature review.

The terms 'mental illness' and 'disorder' are used throughout the existing literature and reflect the medical model through which mental health is currently viewed, assessed and treated. This model is criticised for pathologising emotional suffering, as James Davies

(2021) describes: *“It’s ‘normal’ for everyone to suffer emotionally at some point in their lives (often at multiple times & sometimes acutely). Yet, from a wider historical perspective, what seems to me to be ‘abnormal’ (& ideological) is to pathologise that widespread suffering as ‘mental illness’”* (For further discussion see Davies, 2014).

An alternative conceptual model to the current diagnostic system has been proposed, titled the Power Threat Meaning Framework (PTMF) (Johnstone & Boyle, 2018, p.1), which considers mental health issues in terms of *“threat responses”*, rather than *“disorders”*. Whilst the medical model continues to dominate and is likely to do so for the foreseeable future, I consider this debate as fundamental to the experiencing of stigma, as conceptualising all emotional suffering as ‘mental illness’ is problematic and ultimately harmful. Therefore, throughout this dissertation, I shall refer to mental health difficulties or issues rather than ‘illnesses’ or ‘disorders’. Where it has felt necessary to replicate the language used in the existing literature, or in the participants’ narratives, to maintain accuracy or clarity, I have done so with the use of quotation marks.

For consistency, throughout the dissertation I have chosen to use the terms ‘therapy’ and ‘therapist’ by way of encompassing all approaches of counselling, psychotherapy, clinical and counselling psychology.

Rationale: the role of stigma

Originating in ancient Greece, the word stigma comes from stig; a sharp stick used for tattooing or marking the skin and was originally used for decorative or religious purposes, or for branding slaves (Stuart, 2017). In the late 1800’s, Emile Durkheim (1982) was amongst the first to speak of stigma as a social phenomenon, in relation to crime and deviance. It was later referred to by Goffman (1963) as a mark of shame associated with a specific condition or characteristic, and more recently, by Hinshaw (2009, p.xi) as *“conveying a deep, shameful mark or flaw related to being a member of a group that is devalued by the social mainstream”*.

Stigma is founded upon difference; the identification of distinct groups and the subsequent stereotyping and discrimination against them. Stigma attempts to define people, and in relation to mental health, this can be particularly devastating as Stuart (2017, p.5) describes, whilst *“one **has** diabetes, cancer or a broken leg ... one **is** mentally ill”*. Stuart’s words speak

to the embodied nature of stigma and its intrinsic link to the experience of shame, where the very core of our being feels rejected by others and by ourselves; in those moments we are painfully aware of our *“hateful identity”* (Pines, 1990, p.1).

Developmental theorists propose that shame originates through non-verbal interactions between infant and care-giver (e.g. Schore, 2003). Where these interactions are misattuned, the infant vicariously experiences the care-givers disappointment or disapproval. If these interactions are repeatedly neglectful, rejecting or hostile, the infant can form a *“non-verbal sense”* of deficiency; of not being worthy of care (Joyce & Sills, 2018, p.97). It is this embodied nature of shame that led Orange (2008, p.85) to describe it as an all-encompassing *“world of experience”*, and which explains why experiences of stigma can run so deeply, just as mine does.

The experience of shame can be considered as universal (Durkee et al., 2019). However, the behaviours with which it is associated are culturally specific and context dependent. What might be considered perfectly acceptable in one culture can be deeply shameful in another. Take for example, the thumbs up gesture which is a sign of approval in the Western world but a sign of contempt in the Middle East, or how in Japan, eating all the food on your plate is actively encouraged, whereas in China it is polite to leave some food in acknowledgement of your hosts generosity (Today, 2013). We are taught what is acceptable and what is not, and shame is intrinsic to this process. Shame also has different emphasis across different cultures, with Japan for example, experiencing higher levels of shame than Western societies (Furukawa et al., 2012). Given the centrality of shame to the experience of stigma, cultural differences are also integral to this and will be discussed further in the literature review that follows.

Stigma is frequently identified as the most significant deterrent for individuals seeking help for their mental health (Corrigan, 2004). Furthermore, the experience of stigma has been described as more devastating and life-limiting than the mental health issue itself (Schulze & Angermeyer, 2003). According to McManus et al. (2009/2016), one in four people in the UK will experience ‘mental illness’ in any given year, and in England, one in six in any week. However, it is also suggested that on average, only a third of those people will consult a GP or mental health professional (Andrews et al., 2001; Kessler et al., 2001; Meltzer, 2003, Wang et al., 2007), and even fewer actually receive treatment (Andrews & Henderson, 2000, McManus et al., 2016). In addition, it is also claimed that less than 2% of individuals whose problems do not meet diagnostic criteria, actually seek professional help (Andrews et al., 2001).

These statistics begin to highlight the extent to which stigma deters people from seeking help for their mental health (Vogel et al., 2007), and the fear of stigmatisation has also been shown to deter individuals from acknowledging their mental suffering in the first instance (Satcher, 1999, Alvidrez et al., 2008). There is also a disparity here between genders, as men experience higher levels of stigma than women, in relation to seeking help (Vogel et al., 2006; Pederson & Vogel, 2007), due to the perception that it conflicts with the traditional male gender role (Wahto & Swift, 2014). This greater experiencing of stigma perhaps suggests why men account for almost three quarters of suicides in England and Wales (ONS, 2021). I expand on this discussion in the gender section of my literature review that follows.

For those people who do enter therapy, stigma has been linked with less compliance with therapeutic interventions (Fung et al., 2007), early termination of sessions (Sirey et al., 2001) and with missing appointments (Vega et al., 2010). Given the range of implications and the perpetuating nature of stigma, it is clear that greater understanding of how it is experienced is essential if we are to make therapy a more viable option.

Research focus

The aim of this study is to breathe the complexities of human experience back into the largely quantitative research field of stigma surrounding mental health and help-seeking. The existing research primarily seeks to deconstruct stigma into disparate parts and to identify influential processes that occur between them. Whilst this reductionist approach undoubtedly highlights significant elements associated with stigma, it also simplifies the depth and breadth of lived experience which I consider to be essential to informing our understanding. Stigma is not experienced as distinct elements in isolation, but as multifaceted, multi-layered complexity, which is context dependent, shaped by the past and anticipatory of the future. It is both intrapsychic and interpersonal. My aim is to capture and convey this complexity via the stories of those who have the experience of navigating stigma, and engaging in therapy.

In my work as a psychological therapist I embrace the complexity of lived experience, and understand this to operate at explicit and implicit levels (Beebe and Lachmann, 2005), and across different domains of experience; somatic, emotional, representational and reflective (Wallin, 2015). It is only by exploring stigma at this same depth and level of complexity that

we can contribute most significantly to therapists' understanding, and inform considerations for working with stigma when clients enter therapy. Furthermore, deeper understanding of this experience will also contribute further to helping those who are deterred by stigma, navigate their way through it and engage in therapy.

In order to unearth this complexity of experience, my research focus is on three domains of experience: stigma before therapy; stigma during therapy; stigma after therapy.

In the following section, I will review the existing literature on stigma surrounding mental health and help-seeking and in doing so highlight the aim of the current study and why it is important.

LITERATURE REVIEW

This literature review aims to provide a *“comprehensive background for understanding current knowledge and highlighting the significance of new research”* (Cronin et al., 2008, p.38). By drawing primarily upon online databases, accessed via EBSCOhost (<https://www.ebsco.com>), I employed a funnel approach to broadly reflect the research field surrounding stigma and help-seeking, before honing in on gaps within it. This process began with generic keyword searches, such as ‘stigma’ and ‘counselling’ and was expanded to include others, such as ‘attitudes’ and ‘barriers’, ‘psychotherapy’ and ‘help-seeking’. Studies were selected based on comprehensiveness and relevance to my research focus (Newell & Burnard, 2006), and to *“build an argument, not a library”* (Rudestam & Newton, 2014, p. 49). The literature review also conveys my critical thinking which guided the funnelling process as I began to search more specifically for qualitative studies reflecting subjective experience, which ultimately highlighted the need for my research.

I begin this review by highlighting the significant change in attitudes toward help-seeking for mental health that have taken place over recent decades, and provide a brief overview of the wider research field. I then go on to focus more specifically on literature relating to stigma and help-seeking.

Changing attitudes

Whilst stigma remains a deterrent to seeking help for mental health (Clement et al., 2014), attitudes have improved considerably over recent decades. This has been helped significantly by national social movements such as Time to Change (<https://www.time-to-change.org.uk>), and initiatives such as Heads Together (<https://www.headstogether.org.uk/>). Time to Change was established in 2007, and sought to improve the way we think and act about mental health problems. The organisation began working in communities, workplaces and schools throughout England, and also produced national social marketing and communications campaigns. Unfortunately, government funding was stopped in 2021, but over this 14 year period, Time to Change claims to have improved attitudes of 5.3 million people and seen a significant reduction in social and employment discrimination as a result (Time to Change Impact Report 2016–21, 2022).

The Heads Together organisation is spearheaded by The Royal Foundation of The Prince and Princess of Wales. Part of this initiative, which aims to tackle stigma and change the conversation around mental health, was conducted in partnership with the Football Association (<https://www.thefa.com/>), and produced a very powerful film where the Prince of Wales and numerous prominent figures from the world of football had a very frank and open discussion about their mental health (Heads Together, 2019). This spectacle alone demonstrates the significant change in society, as such a conversation would be unimaginable perhaps as little as ten years ago, and was seemingly very impactful; two of the participants in this study directly referenced the programme as indicative of progress and change.

This change in attitude is further supported by a public perception survey conducted by the British Association for Counselling and Psychotherapy (BACP) (2021), which found that 83% of people think it's more socially acceptable to discuss mental health than five years ago, and 85% of people agree that it is a good idea to seek therapy, when faced with a mental health problem. As this change in attitudes has gradually progressed over time, it has also recently accelerated as a result of the Covid-19 pandemic. A poll conducted by the Priory Group (2021) found that one in three adults between the ages of 18 and 44 sought help for their mental health for the first time during the pandemic, due to increased feelings of social isolation, anxiety and depression. These changes are incredibly encouraging, and show the potential for further change, highlighting why it is so important to maintain this momentum.

Stigma as part of a bigger picture

Whilst my study focuses on the experience of stigma in relation to help-seeking, it is important to consider stigma as part of a larger network of barriers and constraints. For example, Clement et al. (2012) found that in the UK, the most significant deterrent to engaging in treatment was concern that it may harm chances of employment. And in the US, Mojtabai et al. (2010) found the most significant deterrent was the desire to handle the problem oneself.

It is important to note, however, that Clement et al. (2012, p.14) categorised this most significant deterrent, along with many others, as being “*stigma-related*”, and I am in agreement with this. Informed by my own research, I would argue that many other barriers they identified as “*non-stigma-related*”, such as being too unwell to ask for help, or thinking the problem would get better by itself, are also related to stigma. Similarly, I would also argue that the most significant deterrent identified in the US, the desire to handle problems oneself (Mojtabai et al., 2010), is also intrinsically linked to the experience of stigma.

I continue this discussion in the following section, where I provide an overview of the research field of stigma in relation to help-seeking for mental health issues, and suggest why deconstructing the experience of stigma in this way is problematic, and why my study provides a valuable alternative.

Researching stigma: an overview

What is initially striking about the research field of stigma surrounding mental health and help-seeking is the dominance of quantitative studies and the relative scarcity of qualitative research. As a result, the general focus is on the deconstruction of stigma into disparate parts and the isolation of influential processes that occur between them and how these affect attitudes towards help-seeking. The quantitative studies frequently rely upon college students as participants, who often are not, and have never been, therapy clients. The studies then record their intentions or anticipated actions or responses to help-seeking rather than their lived experience of it. For such a complex and uniquely human experience to be encapsulated in this way is undoubtedly limiting and there is a need for additional qualitative research to delve deeper into individual experience, rather than continuing to fragment it. By

drawing upon lived experience of stigma at an affective embodied level, my aim is to more usefully inform the clinical work of mental health practitioners.

I shall begin this review by considering how shame is interwoven stigma, before looking at cultural and gender differences surrounding stigma, mental health and help-seeking. I will then look more closely at how stigma has been examined in the existing research and where the current study is located within it.

Stigma and shame

In addition to the social, political and economic implications, the experience of stigma thrives upon shame; they are intertwined and inseparable. Although this is acknowledged within the literature in relation to help-seeking, it features relatively infrequently. This is perhaps due to the dominance of positivist methodology which finds stigma easier to quantify than the embodied experience of shame. Or perhaps the attempts to deconstruct stigma with quantitative methods is also an attempt to control and manage something which is so deeply painful to experience.

It was Goffman's (1963, p.3) seminal work which defined stigma as a mark of shame signifying a *"spoiled identity"*. This spoiled identity resulted from *"negative social meanings or stereotypes assigned to a people when their attributes are considered both different from and inferior to societal norms"* (Dudley, 2000, p.449). Although these socially constructed meanings and stereotypes no longer result in the physical branding of people, or the donning of a mask or badge, the experience of stigma is still one of potential humiliation and shame.

Schore (2003) argues that shame originates from non-verbal exchanges between infant and caregiver, which also provide the foundation for attachment theory (Bowlby, 1979); this has led to shame being described as an attachment emotion (e.g. Lewis, 1987; Schore, 1998). Attachment theory proposes that the way caregivers respond to an infant's needs, wants and feelings, during crucial early interactions, determines the development of their internalised representations of the external world and their relationship to it. Furthermore, these interactions have been shown to have a direct link to the structural development of the infant's brain, and in establishing their self-regulatory capacity (e.g. Cozolino, 2010; Siegel, 2012; Schore, 2005). During their first year, when a caregiver is sufficiently available and

attuned to the infant, their attachment transactions, such as imitation, mirroring and modelling, generate increasingly higher levels of positive affect. However, it is in the infants' second year, where misattuned socialization transactions generate experiences of shame (Stern, 1998; Meltzoff, 1990; Schore, 1998).

From these early origins, shame is relational in all its forms (DeYoung, 2015). Its nonverbal inception means it is experienced at an embodied level; a felt sense (Gendlin, 1982) of deficiency or worthlessness that is woven throughout our very being. The intersubjective nature of shame creates what Lewis (1987, p.107) called a *"doubleness of experience"*, where not only do we experience our sense of failure through our own eyes, but also through the eyes of the other. At its extreme, chronic shame *"destroys our emotional well-being"* (DeYoung, 2015, p.4), but shame also has a function in that it socialises us. Joyce and Sills (2018, p.96) described shame as *"a signal of a boundary of social acceptance"*, which stops us from behaving in ways that might hurt us, our families, and our communities.

The experience of shame is complex, and intrinsic to the experience of stigma. It is this complexity that clients bring to therapy, and which also stops others from engaging in it. It is therefore imperative that we seek to understand it. The current study aims to capture the embodied and affective experience of stigma, which is most accessible through qualitative methods.

Cultural differences

Whilst stigma and shame relating to mental health and help-seeking can be considered to be universal (Durkee et al., 2019; Vogel et al., 2017), there are significant differences between cultures in the way they are conceptualised and experienced. These differences are largely accounted for by race and the systemic racism that perpetuates the world in which we live (Williams, 2018). People of colour suffer 'racial trauma' as a result of discrimination, injury and humiliation, whether that is experienced directly, or witnessed towards another person (Comas-Díaz, 2019). As this ongoing individual and collective trauma is only experienced by people of colour, it is often misunderstood by white mental health workers who may misdiagnose as a result (Gara et al., 2012). In the UK, black people are four times more likely to be sectioned than white people, and more likely to be prescribed medication than therapy (Schwartz, 2014; Jaye, 2020).

People of colour are also less likely than white people to seek help for their mental health (Conner & Brown, 2014; Han & Pong, 2015; Masuda & Boone, 2011) and have a significantly poorer experience when they do (Kim et al., 2016; Meyer & Zane, 2013). Whilst a full discussion of cultural difference is beyond the scope of this study, I will outline some of the central findings from recent research in order to situate the current study in wider context.

Dubreucq et al. (2021) conducted a systematic review of the literature from the last decade which suggested that overall, stigmatising experiences relating to mental health were higher in the Middle East, South and South-East Asia, and Africa, compared to Europe and North America. Other studies have also supported this, showing there to be higher levels of stigma in Eastern compared to Western countries (Cheon & Chiao, 2012; Griffiths et al., 2006; Mellor et al., 2013). Ahmed et al.'s (2020) study, for example, found that people from South Asian backgrounds attributed higher levels of prejudice, stereotypes and discrimination to people with psychosis compared to their White British counterparts. Furthermore, Winkler et al. (2015) highlighted the differences that also occur between Western countries, with participants from the Czech Republic exhibiting higher intentions of stigmatising behaviour and lower acceptance towards people with mental health difficulties, compared to English participants.

This apparent variation in levels of stigma has been shown to be associated with a number of specific cultural differences. Firstly, different cultures have different causal explanations of mental health issues. For example, South Asian Americans were more likely than white Americans to attribute 'mental illness' to a character deficit rather than a biological cause (Mokkarala et al., 2015), and similarly, Hispanics were more likely to attribute depression to having a lack of faith than non-Hispanic Whites (Caplan, 2019). Furthermore, different cultures also have different emphasis on "*spillover effects*" (Dubreucq et al., 2021, p.18), where family members are stigmatised by association, following an individual's disclosure of their psychological suffering. According to He and Williams (2021) for example, Chinese and Asians are more likely to denigrate relatives than Americans and Europeans. Different cultures also have different perspectives on support, and where it is acceptable to receive it from. Collectivistic cultures, such as East Asia, promote interdependence and social harmony; encouraging individuals to look within the group for support rather than outside of it. However, this is a double bind as the need to avoid shame may require individuals to demonstrate emotional restraint and endure their problems without causing disruption. By contrast, individualistic cultures, such as the UK and US, promote independence and prioritise personal interests above those of the group; this self-sufficiency perhaps encouraging issues to be addressed through personal resolve (Shea and Yeh, 2008;

Mojaverian et al., 2013). Furthermore, in Asian cultures, seeking professional help for mental health difficulties, may suggest failure or inadequacies in terms of family support, bringing disgrace and a “*loss of face*” (Zane & Yeh, 2002, p.123).

It is important to note that the majority of research in the field of stigma, and in psychology in general, is conducted by white male Westerners from Europe and North America who also develop the scales used to assess and measure stigma. These instruments are often adapted for use in non-Western countries but they are not culture-specific and may therefore struggle to capture and reflect the complexity of difference alluded to here (Dubreucq et al., 2021).

From this brief overview of cross-cultural differences it is clear to see that a great deal needs to be done to redress the racial disparity in mental health and the systemic inequalities that underpin it. As the majority of therapists in the UK and US are white, it is essential for us to continually strive to develop cultural competence and self-awareness of our bias and our privilege. As Jaye (2020, para.16) described:

“To understand the psychological trauma carried by many black people, we need to acknowledge two things. Firstly, the unconscious bias within belief systems that can stimulate and propel certain attitudes about black people and secondly, the colossal impact of systemic racism.”

Gender

The current study, along with the majority of the existing research discussed in this review, is situated in Western culture which is permeated by heteronormativity: “*the belief that people fall into distinct and complementary genders (male and female) with natural roles in life*” (Beattie et al., 2018, p.11). We are assigned our gender at birth as part of a “*cultural practice*” (Richards & Barker, 2013, p57). This practice not only fails to accommodate people who are intersex and do not fall neatly into either category in terms of their physiology, but also fails to accommodate the wide range of diversity that occurs within each category, and those who experience themselves outside of this dichotomy. As gender identity has gradually become more prominent in public discourse, language has developed to reflect

this, providing greater opportunity to create a more coherent sense of identity. Individuals are able to identify as transgender, mixed gender, gender neutral, gender fluid and genderqueer, as well as in many other ways (Richards & Barker, 2013, p.43/72).

There are further issues with the dominance of dichotomised gender in terms of the socially constructed norms associated with masculinity and femininity. From our first moments in life the gender we are assigned influences the way people interact with us, as was demonstrated in Seavey et al.'s (1975) research with 'baby X'. In these studies, adults were shown to interact differently with a three month old baby depending on whether they were informed it was a girl, a boy, or not informed at all. When participants were not informed of the gender they were later asked to guess, and they did this on the basis of stereotyped behaviour and physical cues; boys were identified by strength of grip and girls by their softness and fragility. These gendered norms and stereotypes are continually reinforced throughout the life span through societal messages, via friends, family, colleagues, institutions and the media, shaping who we are, how we see others and the world in which we live. The impact of these societal messages was encapsulated by the words of Jan Morris (2006, p.149), a male-to-female transsexual, as she stated: *"The more I was treated as a woman, the more woman I became"*.

Becoming male or female, whether assigned or chosen, involves complex biopsychosocial processes (Fine, 2010) which impact our lives on every level. In the context of this study, gender is integral to experiences relating to mental health, help-seeking and stigma. Although men and woman experience equal levels of mental health difficulties overall, they experience different types of difficulties, due to differences in power, responsibilities and characteristics (Rosenfield & Smith, 2009). Broadly speaking, women experience more internalised issues such as anxiety, depression, and those related to trauma and stress (Riecher-Rössler, 2017). These issues have been shown to be consistent with less power, greater caretaking responsibility, lower self-evaluation and less autonomy, combined with an expectation to express emotions in a way that is consistent with the nurturing and caring feminine stereotype (Rosenfield & Smith, 2009). In addition, arguably one of the most significant, but also most overlooked, psychosocial risk factors that women face is gender-based violence, which poses a *"serious threat to women's mental health"* (Kumar et al., 2013, p.4; Oram et al. 2014).

In contrast, men experience more externalised issues such as substance abuse and antisocial behaviours due to dealing with psychological distress by *"adopting lethal or unhelpful coping strategies"* (Reed, 2014, p.428). Men are more likely to have experienced psychosocial problems due to alcohol or drug use (Robbins, 1989), and in the prison

population, nine out of every ten male inmates has a 'mental illness' (ONS, 1998). These externalised issues have been shown to be consistent with greater power and productive responsibilities, higher self-evaluation and independence, combined with an expectation to suppress emotions that are perceived as weak, such as insecurity or helplessness, in favour of more acceptable ones such as anger (Rosenfield & Smith, 2009).

These differences in gender norms and stereotypes not only affect the type of mental health issues men and women are likely to face but also their attitudes towards help-seeking. Although it is women who are "*cursed with a tendency toward shame*" (Tangney, 1994, p.23), research suggests that men are more reluctant to seek help than women (Topkaya, 2014; Oliver et al., 2005; Gove, 1984) and that they experience greater 'self-stigma' when they do (Vogel et al., 2006; Pederson & Vogel, 2007). This reluctance is due to the perception that it conflicts with the traditional male gender role (Wahto & Swift, 2014). Following an extensive review of the literature on masculine socialisation, O'Neil (1981) described how men learn that power, control and dominance are integral to proving their masculinity and that feelings, emotions and vulnerabilities are to be avoided. Furthermore, O'Neil described how control of self, others and the environment, are essential components of masculinity and therefore seeking help is a sign of weakness and incompetence. The difficulty men face when conflicting with these gender norms has been demonstrated across different ethnic backgrounds and across different sexual orientations; although this is experienced in varying degrees (Vogel et al., 2011).

In addition to these implications relating to gender, its dichotomisation becomes increasingly problematic when the variation within these groups is also acknowledged, rather than *all* men being compared to *all* women. This is demonstrated in the 'Real men real depression' campaign (NIMH, 2003) in the US, which was aimed at raising awareness and normalising experiences of depression for men. The campaign used images and testimonials from men in traditionally male dominated occupations such as firefighting and military leadership, and emphasised the courage it takes to ask for help in attempts to directly address some of the reasons men theoretically avoid doing so (Rochlen and Hoyer, 2005). Despite the purposeful intentions of this campaign, Rochlen et al. (2006) compared the effectiveness of the 'Real men real depression' brochure against a gender neutral brochure and found that both were equally effective in improving attitudes towards help seeking. Furthermore, by intentionally targeting specific groups in this way, there is a risk of marginalising men who do not relate to these highly stereotypical roles (Rochlen and Hoyer, 2005).

I am a cisgender male and my experiences of stigma are strongly influenced by the traditional male gender role. From the inception of this study it has felt important to research

the stigma of therapy starting from a broader human perspective. This is not to suggest that stigma is experienced from a level playing field, as I have outlined here in terms of gender, but also in relation to all aspects of intersectionality, people continually face oppression from multiple stigmas at any one time (Turner, 2021). This is exactly why it felt important to remain open to people's stories of experience, rather than setting restrictive criteria from the outset based on gender or any other attribute. Whilst research clearly suggests that male gender role conflict is integral to experiences of stigma, my experience as a therapist has shown me that this is not solely a masculine issue, but a human one. The need to stay strong, to hide emotions, to not show weakness is shared by both men and women, and no doubt for those who identify outside of that binary.

A bisected field

A central tenet of the existing research into the stigma associated with mental health and help-seeking is the differentiation proposed by Corrigan (2004) between 'public stigma' and 'self-stigma'. Corrigan (2004, p.616) suggested that 'public stigma' refers to wider society's perception that a person is socially unacceptable, and defines it as *"what a naïve public does to the stigmatized group when they endorse the prejudice about that group"*. 'Self-stigma' refers to the internalisation of these wider held beliefs and has been defined by Vogel et al. (2013, p.312) as *"the reduction in a person's self-esteem or sense of self-worth due to the perception held by the individual that he or she is socially unacceptable"*. The term 'public stigma' features throughout the research field and although is widely accepted, is also rather ambiguous in its nature, seemingly referring to anything which is situated externally to an individual. Research has shown that communities often have negative attitudes towards people with a mental health diagnosis; they are considered to be unpredictable and hard to talk with (Crisp et al., 2000) and can be perceived as dangerous and to be avoided (Link et al., 1987). These negative attitudes also go beyond diagnoses and have been shown to apply to those who have simply sought help from a mental health professional (Jorm and Wright, 2008).

Corrigan's (2004) conceptualising of 'self-stigma' was informed by Link et al.'s (1989) Modified Labelling Theory, which was initially developed in relation to perceptions of mental health. This theory proposed that negative external perceptions, in this case 'public stigma', can have a harmful impact on a person's own sense of self if they label themselves as

having a psychological problem. This harm has been shown to manifest as lower self-esteem (Link et al., 2001), increased depression (Manos et al., 2009), and feelings of shame (Kranke et al., 2011). This process of self-labelling was expanded upon by Corrigan and Rao (2012) in their progressive model of 'self-stigma' which identified four consecutive stages in the internalisation of perceived stigma; awareness, agreement, application and harm. By way of an example, the first stage in the process might be an individual's *awareness* that society believes that people who struggle with their mental health are weak. The second stage would involve the individual's *agreement* with this belief and then the third stage would see the *application* of it to themselves; '*I struggle with my mental health so therefore I am weak*'. In the final stage, this belief results in *harm*; '*because I am weak I am not worthy or capable*'.

Whilst this model begins to reflect the complexity involved in the experiencing of 'self-stigma', which was previously equated with the initial awareness stage alone, it is also somewhat simplistic, static and linear in its nature, failing to acknowledge the process as a bidirectional, interconnected phenomena. What emerged from the participants' narratives in the current study is a more nuanced process which is complex, context dependent, and full of contradictions.

Specificity of help-seeking

When initially making the distinction between 'public stigma' and 'self-stigma', Corrigan (2004) proposed that both contributed to understanding people's reluctance to seek help for their mental health, in order to avoid being labelled. At the same time, Corrigan (2004, p.616) also emphasised that "*although public and self-stigma are presented separately ... their impact is likely to interact with and augment each other*". This, very significantly, highlighted the fluidity of stigma which is an evolving multifaceted phenomenon, and whilst this notion is maintained to a degree in the literature, to my mind the complexity becomes lost through this kind of deconstruction which is synonymous with a quantitative approach. In using qualitative methods, rather than fragmenting experience the current study aims to convey it in its entirety, incorporating embodied and affective aspects which are integral to the experience and which are currently underrepresented in the field.

The internal experience of stigma has not only been found to be conceptually different to the external perception of it, but has also been found to uniquely predict attitudes towards seeking psychological help (Vogel et al., 2006). Furthermore, a distinction has also been made between the internal experience of stigma associated with 'mental illness' and the internal experience of stigma associated with help-seeking. Initially considered to be a behavioural cue linked to mental health difficulties (Link, 1987), Tucker et al. (2013) claimed that help-seeking was a separate act with its own unique stigma. This means that just as people can self-label as having a mental health issue, they can also self-label as help-seekers (Vogel & Wade, 2009). These two processes however, are not intrinsically linked. People may, for example, seek therapy for bereavement, marital guidance or life transitions but not consider themselves to be struggling with their mental health. Similarly, those who are struggling with their mental health may not see themselves as help seekers; in fact they may actively avoid therapy so as not to acquire an additional label (Corrigan, 2004; Tucker et al, 2013).

Whilst the differentiation between types of stigma is a useful one, it is also deterministic, suggesting a static linear structure through which stigma can be understood. This process of differentiation also loses the context and complexity of lived experience, which becomes evident in Biddle et al.'s (2007, p.983) grounded theory study which offers a more dynamic understanding of help-seeking behaviour. Derived from in-depth interviews with young adults the study explores experiences and attitudes relating to psychological distress and help-seeking. A 'cycle of avoidance' (COA) was identified, which conceptualised help-seeking as a circular process involving *"lay conceptions of mental distress, the social meanings attached to help-seeking and treatment, and the purposeful action of individuals"*.

In contrast to the dominant positivist approach to researching stigma which focuses on identifying barriers that impede help-seeking, this study highlights the significance of the meanings attached to both psychological distress and help-seeking, and how individuals become *"tangled in loops"* before engaging in therapy (Biddle et al., 2007, p.999). Having successfully identified the complexity of navigating and negotiating distress and help-seeking, it raises questions as to what informs this process of meaning making? How does it evolve and develop over time and how does the process of engaging in therapy impact this? And given the prevalence of stigma, how do some people manage to internally negotiate their way into and through therapy, whilst others do not? By focusing on depth and complexity of experience in its entirety, the current study begins to address some of these questions.

Significance of subjectivity

The questions outlined above relate to the subjective experience of stigma. While a wider all-encompassing stigmatising view is held by society, it is something that functions most influentially at an individual level. As Corrigan (2004) posited, an individual's experience of stigma is informed by this wider societal view, but not determined by it. Vogel et al. (2009) went a step further highlighting the negative attitudes and stereotypes of those in an individual's immediate social network as being most influential.

The significance of subjectivity and individual agency is also demonstrated in the second and third stages of Corrigan and Rao's (2012) model of self-stigma, mentioned earlier. The second stage involves an individual *agreeing* with society's belief and the third stage involves the *application* of this belief to themselves; *'I struggle with my mental health so therefore I am weak'*. Whilst there is scope for individuals to agree or disagree with their perception of society's beliefs and to apply it, or not, to themselves, the model does not accommodate ambivalence and contradictions. The nuance of experience can only be appreciated through a more in-depth inquiry that seeks to reveal this. For example, a person may only partially agree with their perception of society's beliefs and only apply it to themselves in certain contexts. Or, they may recognise their family views mental health issues as a weakness, not agree with this themselves, but still experience harm as a result. It is this complexity that poses difficulty for Corrigan and Rao's (2012) model, but which exemplifies the lived experience of stigma which the current study aims to capture.

Similarly, Bathje and Pryor's (2011) study demonstrated the significance of an individual agreeing with the stigmatising beliefs they perceived to be held by society and how this influenced their attitudes towards help-seeking. Two additional factors were shown to be relevant to this process; controllability and sympathy. Controllability referred to the extent a person felt they were responsible for their suffering, that they caused or were complicit in their feelings of depression, for example. Sympathy referred to the self-compassion one might feel towards their suffering. The study showed the more sympathy one had, the less harmful internalised stigma became. Whilst controllability did not impact the degree to which stigma was internalised, it did have a direct negative influence on help seeking attitudes; *'I'm responsible for feeling depressed, so I'm the one that needs to fix it'*.

Bathje and Pryor's (2011) research is significant for several reasons. Firstly, it highlights the possibility for intervention at an individual subjective level, where stigma is most influential, as well as at the wider societal level (Vogel & Wade, 2009; Vogel et al., 2013). This means that therapists have the opportunity to work with clients' experiences of stigma when they

enter therapy. If a client feels responsible for their suffering or lack sympathy for their situation, making it to therapy in the first instance would have been extremely challenging, and so psychoeducation or developing self-compassion will be important first steps in assisting longer-term engagement. The importance of this was highlighted by Vogel and Wade (2009) who suggested that concerns people have about seeking help do not automatically disappear once they engage in therapy, but instead may actually intensify; which is a point I will return to later.

Secondly, by highlighting the influence that sympathy and controllability have on the experience of internalised stigma, Bathje and Pryor (2011) demonstrate the complexities surrounding it, and by doing so, beg the question as to how these complexities are actually experienced and what they might look like in real life? Why would some people feel they are responsible for their difficulties, whilst others would not? And why would some people struggle to feel sympathetic towards their struggles and others not? Answers to these questions cannot be provided by quantitative studies, but are vital to the field of psychological therapy, as it is founded on lived experiences. These experiences are not solely cognitive, but are embodied and affective, and can only truly be grasped through qualitative methods that intentionally seek to explore them.

By highlighting control and sympathy as significant aspects relating to stigma, Bathje and Pryor (2011) suggest a more transparent link to the experience of shame, which I consider inseparable from the experience of stigma, and which accounts for its pervasiveness. If stigma is the perception of having a flaw that is "*devalued by the social mainstream*" as Hinshaw (2009, p.xi) described, it is clear to see why it is synonymous with the life script often associated with shame, that "*something's wrong with me*" (Erskine, 1995, p.113). This notion brings shame to the forefront in relation to our understanding of stigma and the current study aims to unearth this aspect of experience further.

Navigating stigma

So far, this review of the literature has outlined the dominant focus within the field which seeks to deconstruct stigma into disparate parts and isolate the processes of influence that occur between them. Research has differentiated between stigma that is perceived to exist in wider society and that which is experienced internally. Studies have also differentiated between the stigma surrounding mental health and the stigma surrounding help-seeking,

which resulted in the suggestion of a unique correlation between the internalised experience of stigma and the act of help-seeking.

The majority of attempts to reduce stigma have focused on addressing that which surrounds mental health and is perceived to exist at a wider societal level, rather than the stigma that surrounds help-seeking. Whilst this is important work, it potentially serves to strengthen the link between 'mental illness' and help-seeking, deterring those who do not identify as 'mentally ill', which I discussed previously. A necessary addition therefore, is to specifically address the stigma surrounding help-seeking, which, according to existing research, would mean targeting the internalised experience of stigma which has been shown to be most influential in shaping attitudes towards this.

Vogel & Wade (2009) have suggested that a number of factors and processes found to be effective in the management of stigma associated with mental health are transferrable to help-seeking. These include the desensitisation and cognitive reframing of negative beliefs, the normalising of symptoms and emphasis on their commonality and reversibility, and empowerment, where clients are actively engaged and involved with all aspects of their care (Corrigan & Calabrese, 2005; Rosen, 2003; Corrigan, 2004). An example of how help-seeking can be reframed was demonstrated through the qualitative research of O'Brien (2005) which consisted of male focus groups discussing their experiences of help-seeking in relation to constructions of masculinity. The study revealed a general consensus that men *should* be reluctant to seek help, but also that exceptions were made if the purpose was to preserve or restore a more valued form of masculinity, such as enabling a return to work or maintaining sexual performance. This study also highlights the significance of power in relation to stigma. In this context, there is a suggestion that men relinquish power to their peers if they seek help, which is only justified if an alternate form of power is regained. In this sense, power is integral to the experience of stigma, and can be lost and gained depending on how help-seeking is navigated, and also disclosed.

Another example of reframing emerged through Farrimond's (2011, p.1) research, which was again a qualitative study. Fourteen men were interviewed and all described stereotypical "*Neanderthal Man*" approaches to help-seeking when referring to men in general, but described their own experiences as being more in line with "*Action Man*", where they were taking responsibility and control; again reflecting the significance of power in navigating stigma. This process of reframing emphasises individual agency. Crucially, however, this example was in relation to seeking help for physical rather than psychological health. When the participants spoke of their experiences with depression, they described their help-seeking as "*delayed*" and "*limited*" (Farrimond, 2011, p.1), which suggests the

need for further enquiry. These studies alone instantly begin to convey the contribution that qualitative research makes to the field by introducing context and depth via people's lived experience, in this instance, bringing the notion of reframing to life. The current study aims to contribute further to this process, and in addition, to provide even greater depth of exploration into individual experiences.

Breaking through the barrier and engaging in therapy

The research discussed in the previous section and that which dominates the wider field, considers the role of stigma surrounding help-seeking prior to entering therapy, and focuses on barriers to engagement and how they can be navigated. This predominant focus indirectly suggests that stigma no longer applies once that initial barrier has been broken. As a result, research rarely looks at the impact of stigma on the process of therapy itself, and as I referenced earlier, Vogel and Wade (2009) suggested that people's concerns about engaging in therapy may actually intensify after sessions have begun.

There are relatively few studies that have looked at the impact of stigma on the process of treatment. However, findings suggest that higher levels of perceived stigma in society are associated with early termination of treatment (Sirey et al., 2001); although this was in relation to pharmacological not psychological intervention. Research by Wade et al. (2011) looked at changes in the internalised experience of stigma following a session of group therapy, and found that overall participants reported a reduction, with the strength of working alliance and session depth being identified as significant contributing factors. To comment further on this study, by way of an example, it demonstrates the tendency within the field to recruit participants who are volunteers rather than therapy clients. In this instance, volunteers were students from the University where the study took place, and received course credits for participating. Of the 263 participants, only 17 had engaged in any previous form of therapy. Whilst the findings may be insightful, a different level of experience is unearthed through in-depth inquiry with people who have navigated and lived through the very experience we are seeking to understand. This is the contribution provided by the current study.

Only a handful of existing studies involve genuine therapy clients with lived experiences. One such study by Owen et al. (2012), found that the internalised experience of stigma was

negatively associated with perception of the working alliance. This was, however, a quantitative study, and the experience of internalised stigma and the working alliance were measured using rating scales, so the conveying of experience was confined to those parameters. Furthermore, across the 91 participants, the average number of sessions was six, providing a somewhat premature snapshot of their experience.

Similarly, there are few studies which involve previous therapy clients' experiences relating to the stigma surrounding help-seeking. One study involved men and their perceptions of masculinity, and although participants were asked about the reactions of others who knew they were engaged in therapy, their own stigmatising views were intentionally avoided due to concerns they may not be as honest about them (Reed, 2014). Another study which involved young people who had counselling at school, highlighted how they positioned themselves as "*problem-solver*" to avoid stigmatising discourse (Prior, 2011, p.697). This again demonstrated how therapy can be reframed in a way that the internal experience of stigma can largely be avoided, and a sense of power can be maintained, positioning therapy as a more viable option.

Despite their limitations, these studies suggest that the internalised experience of stigma remains relevant after therapy has begun and that there is a need for greater collaboration with those who have engaged in the process to provide the invaluable insight that lived experience can offer.

Gaps in the field

The wealth of quantitative research, which has formed the majority of this review, has successfully identified some of the complexities surrounding the stigmatisation of help-seeking, but in doing so, moves away from the very essence of human experience that we are seeking to understand. Stigma is an ongoing, ever evolving experience that is continually being negotiated. It is not experienced as distinct elements in isolation, but as multifaceted, multi-layered complexity which is context dependent, shaped by the past and anticipatory of the future. As I stated earlier, the aim of my research is to capture and convey this complexity via the stories of those who have experience of navigating stigma and engaging in therapy.

We need more in the way of qualitative research to gain further understanding of how stigma is experienced both cognitively *and* affectively, in order to most usefully inform therapists' ways of working with it. It is through the application of qualitative methods that the current study aims to access this at an embodied level of experience and uncover the hidden meaning which lies within; as Ponterotto (2005, p.129) suggested, this hidden meaning *"must be brought to the surface through deep reflection ... stimulated by interactive researcher-participant dialogue"*.

In the sections that follow, I outline how I designed a narrative inquiry to contribute to our understanding of the depth and complexity of the experience of stigma, before, during and after engaging in therapy.

METHODOLOGY

Philosophical underpinnings and research design

The evolution of research paradigms contextualises not only the development but also the subsequent contribution of quantitative and qualitative approaches to the field of counselling psychology. Born out of the Enlightenment period of the 17th and 18th centuries, positivism sought to move away from the unquestioning acceptance of religious or royal decree and instead viewed the world as “*objectively knowable*” (Ponterotto, 2005, p.128); that a single observable reality existed. Although the difficulty of capturing a ‘true’ reality was reflected by the emergence of postpositivism, both these paradigms sought to establish cause and effect relationships that allowed for generalisation and prediction. In addition, these paradigms also position the researcher as detached and objective, and together, these aspects form the “*primary foundation and anchor for quantitative research*” (Ponterotto, 2005, p.129).

The quantitative approach has dominated both natural and social sciences, including the research field of stigma, and it was not until the constructivist paradigm emerged that an alternative was proposed. In contrast to the positivist and postpositivist perspective, social constructionism proposes that a single reality cannot exist independently of the person who is experiencing it (Sciarra, 1999), and that instead, reality is constructed in the mind of an individual, within their social context. This means that “*different ways of understanding the world coexist in parallel and none of them can be said to be the truth*” (Burr, 2015, p.223). Whilst social constructionism assumes multiple realities, it locates these within the natural world (Denzin & Lincoln, 2017) that does exist, independent of observation, but which is open to interpretation. This interpretation occurs through subjective experience which is brought into a social realm through language and conveyed in narratives, as Etherington (2004, p.75) succinctly describes:

“Because there is a complex interaction between the world in which a person lives and their understanding of that world, narratives are particularly suitable for portraying how people experience their position in relation to a culture: whether on the margins, in the centre, or on becoming part of a new culture. Embedded in people’s stories we hear their feelings, thoughts and attitudes, and the richness of the narrative helps us to understand themselves, their strategies for living and how they make theoretical sense of their lives.”

From a social constructionist perspective, the methodology employed must be *“suited to the purpose of discovering something of how these constructions came about and the meanings people give them”* (Etherington, 2004, p.72). My chosen methodology for the current study is narrative inquiry, in the form of an oral history interview, which aims to gather personal reflections of events and their causes (Plummer, 1983). Narrative inquiry is based on the premise that people lead *“storied lives”* (Connelly & Clandinin, 2006, p.477), and it is through these stories that people make sense of the world and their place within it; as Squire (2008, p.43) explains, stories are the *“means of human sense-making”*. Narrative inquiry aims to capture stories of personal experience from the cultural context in which they are set (Clandinin & Connelly, 2000), treating them as knowledge, as they are *“the social reality of the narrator”* (Etherington, 2004, p.81).

Narrative inquiry is not only concerned with how and why a story is constructed and what meaning it holds, but also with how the audience affects which story is told (Riessman, 2008). From this perspective, reality is co-constructed between narrator and researcher, and so every narrative is uniquely constructed in a specific context, in a particular moment in time, which cannot be repeated; and so the same story will never be told twice (Squire, 2008).

Choice of methodology

I selected a narrative inquiry for the current study to keep the participants' stories intact, to fully capture the depth, breadth and complexity of experience. It felt important that each individual account was conveyed in this way, in its entirety, to counteract the tendency towards quantitative research seeking to deconstruct stigma, fragmenting the experience in the process. Furthermore, from my position as an integrative psychotherapist, there is congruence between the co-construction in narrative inquiry and the co-creation in the therapeutic relationship (Gilbert & Orlans, 2011). Narrative inquiry aligns with my intersubjective understanding of therapy as reciprocal and mutually influential (Stolorow & Atwood, 2014), acknowledging the integral role that I, as therapist and as researcher, play in the process.

These fundamentals of narrative inquiry are crucial to the aims of the current study and ultimately led me to reject alternatives such as Interpretative Phenomenological Analysis

(IPA). According to Creswell (2013, p.76), the purpose of IPA is to *“reduce individual experiences with a phenomenon to a description of the universal essence”*. It is this process that fragments and merges the intricate complexities of individual experience, which is exactly what the current study aims to preserve. Furthermore, I find the concept of *“bracketing”*, which is synonymous with IPA, to be problematic. The process requires the experiences of the researcher to be set aside in order to observe the phenomenon under study from a neutral standpoint (Smith et al., 2009). However, I consider the influence of the researcher to be unavoidable, as the process of interpretation will inevitably incorporate their own understandings and assumptions (van Manen, 1990).

Similarly, in wanting to counteract the reductive positivist methodologies that dominate the field, I also rejected a grounded theory approach (e.g. Glaser & Strauss, 1999). Although the current study shares the intention of grounded theory, to generate new insight that is *grounded* in lived experience of the process under study, it differs in that it does not seek to generate a *“unified theoretical explanation”* (Corbin & Strauss, 2007, p.107). Whilst being grounded in experience is important for the current study, it is also important that these experiences remain open to interpretation rather than being transformed into an imposing theory.

Narrative interviewing

According to Jovchelovitch and Bauer (2000, p.59), narrative interviewing avoids the imposing structures of traditional question-response interviews, and elicits a *“more ‘valid’ rendering of the informant’s perspective”*. Narrative interviews aim *“to generate detailed accounts rather than brief answers or general statements”* (Riessman, 2008, p.23), through an inductive process within the interactive context of the research (Creswell & Poth, 2017). This type of interview sees a shift from interviewer-interviewee, to narrator-listener (Allen, 2017). Whilst an asymmetrical power dynamic within the former is widely acknowledged (e.g. Arendell, 1997; Gubrium & Holstein, 2002), in the latter, the listener, or researcher, may *“deliberately take less powerful roles or abandon some of their power”* (Hoffmann, 2007, p.312) in order to elicit the ‘knowledge’ held by the narrator. By adopting a narrative approach, my intention was to level the power dynamic between myself and the participants, helping create a feeling of space, openness and opportunity, to elicit rich and meaningful dialogue.

Etherington (2004, p.77) described each interview as “a *snapshot in time*”, acknowledging that researcher and participant are also simultaneously embedded in their daily lives. I understand this snapshot as incorporating what Connelly and Clandinin (2006, p.479) referred to as the “*three commonplaces of narrative inquiry—temporality, sociality, and place — which specify dimensions of an inquiry space*”. In terms of temporality, that is to acknowledge that people, places and events, are in a process of transition and “*have a past, present, and a future*” (Clandinin et al., 2007, p.23). Whilst there is no way of knowing how different the narrative may have been if the interviews had taken place six weeks later, the important point is acknowledging that it would have been different. The ‘commonplace’ of sociality refers not only to the feelings, hopes and moral disposition of both myself and the participants, but also the context and surrounding forces which also contribute to the creation of the narrative, such as the political and economic landscape. In addition, sociality also refers to the relationship between participant and inquirer, as I enter into “*an inquiry relationship with participants’ lives*” (Connelly & Clandinin, 2006, p.480). This relationship is unique and unrepeatable, as is the narrative that emerges from it. The final ‘commonplace’ is place, which refers to the physical location of the encounter and the acknowledgement that each and every place will in some way impact on the experience; as Connelly and Clandinin (2006, p.481) state, “*all events take place some place*”.

‘Trustworthiness’

The way in which quality and rigour are demonstrated in qualitative research depends on the epistemological perspective which is taken (Ballinger, 2004). I position myself and this study somewhere between ‘subtle realism’ and ‘relativism’, and so consider ‘trustworthiness’ as integral to establishing its worth (Lincoln & Guba, 1985), or what Morrow (2005, p.250) simply refers to as “*goodness*”. Numerous criteria have been identified for facilitating this process (e.g. Elliot et al., 1999; Henwood & Pidgeon, 1992; Lincoln & Guba, 1985), however, those that reflect a ‘realist’ perspective are problematic for the current study. Terms such as ‘credibility’ and ‘dependability’, and techniques such as ‘triangulation’, all imply that there is a ‘truth’ to be uncovered which can be confirmed by multiple sources. Narrative inquiry does not set out to uncover a ‘truth’. It is instead concerned with the negotiation of meanings and interpretations relating to complex social and psychological processes (Willig, 2013). The current study takes a social constructionist perspective, acknowledging the existence of multiple realities, and so the narratives and their subsequent interpretation, cannot be

replicated. There are however, certain processes highlighted by Lincoln and Guba (1985) which are applicable to the current study and which contribute to demonstrating its 'trustworthiness'; these are 'prolonged engagement', 'member-checking', 'peer debriefing', 'inquiry audit' and 'audit trail'.

Conducting two separate interviews enabled me to obtain 'prolonged engagement' with participants, helping build trust and facilitate the telling of their stories, as well as an understanding of the wider context from which they were being told. My collaboration with participants throughout the study provided a comparable process to 'member-checking', where *"data or results are returned to participants to check for accuracy or resonance with their experiences"* (Birt et al. 2019, p.1802). I chose to share both the original transcripts and my interpretation and *"restorying"* (Creswell, 2013, p.74) of them with the participants, not for confirmation of the 'truth', but by way of ensuring that they did not feel they were being misrepresented. This process is a contested one. Josselson (2013, p.178) for example, advises against 'member-checking' unless there is a *"very clear purpose for doing so"* as *"the report that the researcher creates from the interview will represent 'a truth' rather than 'the truth'"*, and so questions what it is that the participant is meant to be 'checking'. Whilst I agree with Josselson, the decision for me was an ethical one that I felt I owed to the participants, *"to whom I consider myself permanently accountable"* (Speedy, 2008, p.52).

Having shared the original transcripts with participants, I asked them to confirm they reflected their thoughts and experiences at the time. I also invited their comments or any concerns and proposed a phone call to discuss these, but this was not taken up. Two of the participants commented on their surprise at some of their sentence structuring and frequency of filler words, but had found it interesting to read their accounts. All the participants confirmed they were happy with the content of their transcripts. I later sent the restoried (Creswell, 2013) narratives to the participants and these were also well received. Whilst my hope had been to build a sense of involvement with participants beyond the interview process, I was particularly moved by a reply from Claire informing me she had arranged to return to Northern Ireland to visit family, bringing her therapy experience *"full circle"*.

As well as collaboration with participants, collaboration with colleagues also contributed to the 'trustworthiness' of the study, providing a form of 'peer debriefing' and 'inquiry audit'. As before, this process was not concerned with establishing 'credibility' or 'dependability', but I sent sections from the transcripts to colleagues as a way of reflecting on my coding and themes. This was helpful in developing my thinking around interactions between the themes and how this reflected the participants' deeper level of experience. For example, from

Sarah's narrative, the interaction between the themes of 'family view of therapy', 'her view of therapy', 'view of self' and 'alternatives to therapy' resulted in her strong feelings of guilt; if she attended therapy she would also be conveying that actually, her family were not enough. The discussions with my colleagues lead to the consideration of this process as the family system's psychological defense (McWilliams, 2020), which left Sarah conflicted between maintaining the family's sense of cohesiveness and her need to alleviate her own suffering.

I also consider the ongoing engagement with my research supervisor throughout the research process to be, in part, a form of 'peer debriefing', assisting further with reflection on coding and development of my themes, whilst also ensuring these were embedded cohesively within the wider piece. The consistency and longevity of this relationship provided an invaluable alternate perspective as well as support, and helped me consider my own experience of stigma and how this intertwined with the participants', which I refer to throughout the dissertation.

For transparency and by way of an 'audit trail', I have included sections from the original transcripts showing line-by-line analysis in the appendices (Appendix A), and also a summary page of preliminary coding (Appendix B). I have also included my 'one sheet of paper' (Ziebland & McPherson, 2006) exercise used in my organising of themes (Appendix C), and excerpts from my research notes (Appendix D). I discuss the process of how my themes developed in the 'analysis of the narratives' section that follows.

In addition to these criteria for 'trustworthiness' outlined by Lincoln and Guba (1985), I have also been guided by a more generic framework provided by Morrow's (2005, p.250) identification of "*transcendent standards for conducting quality research*". Morrow's standards refer to 'social validity', 'subjectivity and reflexivity', 'adequacy of data', and 'adequacy of interpretation'. This framework has enabled me to hold these standards as questions in my mind throughout this process, encouraging ongoing consideration and reflection, rather than set tasks or procedures to undertake. I shall consider Morrow's (2005) standard of 'subjectivity and reflexivity' in more detail in the following section, as I consider this to be integral to the process of narrative inquiry.

Subjectivity and reflexivity

Narrative inquiry sees the researcher's history, experiences and values as integral to the co-construction of the participant's narrative, and therefore should be honoured (Creswell and Poth, 2017). I am in agreement with Finlay and Gough (2003, p.5) who state that the researcher is not a detached expert but rather *"a central figure who actively constructs the collection, selection and interpretation of data"*, meaning that *"subjectivity in research is transformed from a problem to an opportunity"*.

I am a white, middle class, cis male, living without disability. This has enabled me to move through life largely unobstructed and able to blend into the background. With a tendency towards introversion, this has suited me well, but as a psychological therapist I am required to stop and notice, to reflect on who I am and how I move through the world, and how this might be different for others. When meeting with clients, I am central to the therapeutic endeavour, both explicitly and implicitly. There are two subjectivities, and *"we are both influencing, and being influenced by, our partner's words and actions"* (Beebe and Lachmann, 2005, p.25). My awareness of the role I play is paramount for my client work, and of equal importance for this research. This awareness is developed through an ongoing process of reflexivity, defined by Finlay (2016, p.7) as *"being thoughtfully and critically self-aware of subjective/intersubjective elements and of how these impact on the research"*.

I described earlier, some of my own experiences and relationship with stigma and it is from this starting place that I initially approached this research, and also from where I conducted the interviews and restoried (Creswell, 2013) the participant's narratives. My experience of shame in navigating stigma has made me aware and empathic to this same struggle faced by others. Whilst my interest in understanding others experiences feels entirely genuine, I also accept this may reflect my ongoing efforts to further understand myself by comparison, as Fay (1996, p.241) proposed: *"There is no self-understanding without other-understanding"*. Aspects of the participants' stories that I have focused on will not only be those which I considered interesting and 'socially valid' (Ballinger, 2004), but inevitably will also be those which have resonated with my own experience in some way.

Having my own experiences of stigma and seeking therapy, to an extent, position me as an *"insider researcher"* (Robson, 2002, p.7). I prefer, however, the notion of an *"insider-outsider"* described by Dwyer and Buckle (2009, p.54/61), which sees the researcher as both embedded in the research, but also distanced from it, meaning that I *"occupy the space between, with the costs and benefits this status affords"*.

In attempts to increase my awareness of my experiences of stigma, I asked a colleague to interview me prior to my meeting with participants; my intention was to further explore my attitude, assumptions and predispositions. What struck me most following this process, was how deeply rooted my feelings of shame were, and how alive they remained. This was later emphasised further as I sought to re-engage in my own therapy, and I talk more about this process in a later section. Reconnecting with my own experience of stigma in this way helped me attune to the participants as they shared theirs. In addition, as part of my ongoing process of reflexivity, I kept a journal throughout the research process, noting my experiences and reactions. Excerpts from this, following the first interview, can be found in Appendix D.

Participant criteria and recruitment

The inclusion criteria for this study were that participants had completed at least 12 sessions of weekly one-to-one therapy and had finished working with their therapist within the last six months. This was in an attempt to allow participants to have *settled in* to the process of therapy, although this can often take significantly longer, whilst also wanting their experiences to be recent enough to assist recollection and reflection. Whilst it felt necessary to set timeframes to these criteria, I acknowledge this was done speculatively and that equally insightful interviews could have transpired from experiences that lay outside of these parameters. Participants were also required to feel there is a stigma that surrounds therapy and be willing to share their experiences of it. The inclusion and exclusion criteria did not involve the type of therapy received, or the age, gender or ethnicity of the clients, as the study aimed to capture the complexity of subjective experience which these criteria might represent.

Participants were recruited through two avenues. First, recruitment posters were sent to three general counselling services in London and the Home Counties and were requested to be placed in their waiting rooms (Appendix E). The second avenue was via my professional network that I asked to share my recruitment poster with any potential participants.

Over the proceeding weeks I was contacted by three people. Given the sensitivity of the research area the recruitment process began with an initial phone conversation to ascertain the robustness of the participants, along with their willingness and ability to talk in depth about their experiences. This initial screening process also enquired as to the participants'

general wellbeing and available support network to ensure they were well placed to participate in the study, and to avoid any unforeseen risk. Following this phone call, I forwarded on an information sheet (Appendix F) and consent form (Appendix G), for the participant's reference. The three people who made contact went on to participate in the study, details of whom are in Table 1, below. To preserve anonymity, all participants were given pseudonyms and their ages are approximations; where they grew up and their field of work were left intentionally broad.

Table 1 – The participants

Pseudonym	Age	Grew up in	Field of work	Number of counselling Spells and duration
Andy	33	London, England	Technology	Two (6 weeks / 1 year)
Claire	47	Northern Ireland	Corporate	One (1 year)
Sarah	48	North of England	Teaching	Two (9 months / 2 years)

It is interesting to note that the people who came forward to participate in the study were white, heterosexual, middle class professionals. Reflecting on why this might be, I considered that people of colour, or those from non-Western cultures, may have been less inclined to participate due to experiencing higher overall levels of stigma (Dubreucq et al., 2021; Eylem et al., 2020). In addition, failure to provide culturally responsive therapy means that people of colour are also less likely to be engaged in therapy in the first instance (Kim et al., 2016; Meyer & Zane, 2013; Conner & Brown, 2014; Han & Pong, 2015). In order to reach a more diverse population I could have purposefully looked to recruit from services that work with people of colour, such as the Black, African and Asian Therapy Network (BAATN), and I feel the project would have benefitted from this.

The interview process

I began the interview process by attempting to “*abandon some of the power*” (Hoffmann, 2007, p.312) that I was automatically assigned as the ‘interviewer’ (Arendell, 1997; Gubrium & Holstein, 2002). I did this initially by offering to travel to the homes of the participants for their convenience, which they all agreed to. This enabled participants to control the physical dynamics of the encounter, where we sat and our proximity to one another. In all instances, we sat in either the living room or living area of the kitchen, and I was offered a seat that was perpendicular to the participants. Whilst room layout played a part in this, I wondered if it may have signified a desire to avoid an oppositional set up associated with a therapy setting, which is arguably more confronting and perhaps reflected the personal and sensitive nature of the topic. From my perspective, the arrangement felt appropriate and gave a sense of me being *alongside* the participants whilst we explored their experience. I referred earlier to Connelly and Clandinin’s (2006, p.479) “*commonplaces of narrative inquiry ... which specify dimensions of an inquiry space*”, one of which is “*place*”; and how this impacts on the experience and the narrative. My comments above illustrate the potential significance of this, and whilst it is unclear how the narrative may have been different if it took place elsewhere, the point is again to acknowledge that it *would* have been different.

I also attempted to redress the imbalance of power by disclosing my own engagement in long-term therapy as well as acknowledging my own experiences of stigma; although I did not elaborate on this as, not wanting to inadvertently set an ‘agenda’ for the interview. I was also open and explicit in conveying my aim of the meetings, to simply learn of the participants’ experiences of stigma, before, during and after engaging in therapy. My approach aligned with Anderson and Kirkpatrick’s (2015) suggestion that narrative interviews do not set out with a fixed agenda, but instead allow participants to control the direction, content and pace of the encounter. I saw my role as assisting the telling of the stories by encouraging expansion and exploration of experiences through follow-up questions based on initial responses. It is this open style of interview that increases the amount of narrative collected and also the study’s trustworthiness (Denzin & Lincoln, 2017).

I spoke with the participants on two separate occasions, several weeks apart. The interviews were open-ended, lasting approximately 75 – 90 minutes. Throughout the process I sought to develop rapport through attentiveness, respect and authenticity (Allen, 2017). In addition, by conducting multiple interviews my intention was to build trust in the hope of yielding richer narratives. The first interview allowed the participants and me, to move beyond our pre-transference and become familiar with one another. This meant that the second interview

began from a very different footing, with a relationship already established. In addition, other aspects were also more familiar; the specific location for the interviews, as well as the structure and nature of the encounter. The time in between interviews was also valuable and significant, as this enabled the participants to reflect on their experiences recalled in the first, as well as the process of having conveyed them to me. The second interview was introduced as an opportunity to hear the participant's reflections on the first interview and also their own stories; to raise anything that had stood out or stayed with them, or anything they wanted to add, or clarify. The time in between interviews also gave me the opportunity to listen back to the recordings and to reflect on them; immersing myself in the participant's stories in this way also facilitated my connection and attunement at our second meeting.

Having two separate interviews seemed to result in deeper reflection and sharing of experience. Claire, for example, stated that *"obviously, there were taboos and you know, even in my head there were taboos about the idea of actually having counselling ... maybe I hadn't realised quite how much until I actually sat down and really thought about it, or why"*. For Sarah, the scheduling of a second interview provided her with the opportunity, and the level of trust, to share that she *"was surprised at how much emotion came up"*, and we were then able to talk through and explore this further. In the discussion section, I further highlight the value of multiple interviews in helping to yield richer narratives.

Throughout the interview process I held in mind, Schwalbe and Wolkomir's (2002, p.205) suggestion that participants often perceive interviews as an *"opportunity"* to consolidate and share their experiences, but can also perceive them as a *"threat"*. Talking about stigma could serve as a reminder of the challenges, conflicts and implications it raised for them, threatening their psychological equilibrium. I was also aware of the potential for the interviews to be triggering for the participants, and so I remained open and attuned to this possibility, paying close attention to their emotional state, body language, and tone and pacing of their narrative.

The interviews were recorded on a digital recording device and transferred to a laptop with password protection, at the earliest opportunity.

Analysis of the narratives

Having completed the interviews with all three participants, I was tasked with converting what Riessman (2008, p.28) described as *"messy talk"* into a suitable text for narrative

analysis. In the absence of a universal form of transcription, I made a number of decisions about how this was done; guided by theoretical commitments and practical restraints (Mishler, 1991). Rather than presenting the narratives as a series of thematic stanzas, I chose to present them as a story of their experience which reflected the interactional context in which they were created (Riessman, 2008). This approach emphasised the co-constructed nature of narrative inquiry, and acknowledged the narratives were developed and tailored for the context in which they were being told.

Riessman (2008) described how during interviews with South Indian women about their experiences of infertility (See Riessman, 2000, p.32), she was “*saturated with concepts*”. This not only shaped her listening and her questioning, but also her later description of their experiences. I was similarly aware of the filter through which I was listening to the participants, informed by existing theories and concepts, as well as my own experiences, and this can be seen in the extract below from my meeting with Andy.

Me: So if that's the underlying suggestion if you go to therapy, there's something wrong with you (A: Mmm), perhaps that's the thing that's trying to be avoided?

Andy: Yeah it could be, and until you actually admit that, then you haven't, you haven't admitted there's something wrong with you, like, so until you, until you actually make that decision, I guess you could be pretending in some sense, that there isn't. So yeah, that would make sense.

Me: And that ability, or that desire then, to tolerate feeling depressed, or whatever it may be, for longer, that kind of moves and shifts (A: Yeah), and you'll tolerate that for longer.

Andy: Yeah, that makes sense to me, I think that would be connected, those two things, yeah.

At the time, Andy's narrative was bringing to mind Biddle et al.'s (2007, p.990) 'cycle of avoidance' that people go through when considering seeking help and how the threshold between “*normal*” and “*real distress*” is continually shifting. I was also reminded of the words from Farrimond's (2011, p.1) study, that help-seeking for mental health was usually

“delayed”. This extract illustrates the co-constructed nature of narrative inquiry and the role that both researcher and participant play.

I chose to personally transcribe the interviews, partly as it raises an ethical issue if this is done elsewhere, and also to help me *“keep intimately connected to the data”* (Etherington, 2004, p.79). My connection with the accounts also contributed to how I presented them, as Riessman (2008, p.50) described: *“By displaying text in particular ways and by making decisions about the boundaries of narrative segments, we provide grounds for our arguments, just as a photographer guides the viewer’s eye with lenses and cropping”*. I was guided by Savin-Baden and Van Niekerk’s (2007) strategy, to present a collection of narratives without fragmenting individual voices, by writing a summary of each person’s story. The content and the manner in which this is done, highlights the significance that I have given to parts or themes from within the stories. As the current study focuses on exploring experiences of stigma before, during and after engaging in therapy, I selected sections where participants spoke directly or indirectly in relation to this. The stories were interpreted and restoried (Creswell, 2013), largely in my own words, but incorporating the participant’s language and interspersed with verbatim sections from their transcripts; these can be found in the ‘Participants’ Narratives’ section that follows.

There is a tendency within narrative inquiry to produce what Connelly and Clandinin (1990, p.6) described as the ‘Hollywood plot’, *“where everything works out well in the end”*. This involves a process of ‘narrative smoothing’ (Spence, 1986) that must be counteracted with the acknowledgement of ‘narrative secrets’ (Kermode, 1980). These are the stories that exist but which are not told, and I touch on these later in my reflections. A different researcher, or research focus, would have resulted in very different stories from these same narratives.

My decisions on which aspects of the participants’ stories to focus on and which sections of verbatim text to include or omit, were complex and multilayered, and ultimately shaped the themes which form the basis of this study. This process began with the transcripts, which were produced by listening to the interviews numerous times, to ensure accuracy and to immerse myself in the stories (Riessman, 1993). Once the participants had given approval of these transcripts, I embarked on meticulous line-by-line analysis, noting themes against the text (Appendix A). Once completed, I returned to the beginning and began to colour code each theme, grouping them together, enabling me to produce a summary of coded themes from each interview (Appendix B). Immersing myself in the participants’ stories helped me interpret and “restory” them (Creswell, 2013, p.74). In addition to my line-by-line analysis, this process was also guided by my felt sense (Gendlin, 1982) of the participants’ experiences, gravitating to aspects which held most emotional resonance; as Braud and

Anderson (1998, p.210) suggest, emotional reactions are *“important indicators of validity”*. This process was also integral to my collating of themes and subthemes which was further facilitated by Ziebland and McPherson’s (2006, p.409) *“one sheet of paper”* (OSOP) technique, devised to assist analysis of qualitative data as part of the DIPEX project, looking at perspectives on health and illness. This technique consists of a visual ‘mind map’, as a way of gathering many complex themes in one place, and highlighting links between them (Appendix C). From this ‘mind map’ I was able to identify and extract the three main themes that formed the foundation for my discussion, as well as the subthemes within them.

When writing the discussion section, I employed a further strategy proposed by Savin-Baden and Van Niekerk (2007, p.466), to avoid the fragmentation of the participants’ individual voices by writing in the first person. In taking this approach, I attempt to make clear *“what is interpretation and what is our reflection on that interpretation”*.

Ethical considerations

This study received ethical approval from Metanoia Research Ethics Committee (Appendix H) and followed the guidelines set out in the British Psychological Society’s Code of Ethics and Conduct (2009), regarding respect, competence, responsibility and integrity. In addition to this, at a more relational and embodied level, I was guided by my own ethical principles and guidelines, which Etherington (2004) proposed, left me with greater responsibility but also greater flexibility. This enabled me to use my skills as a psychotherapist, to respond in the moment to the participants’ emotional experience; positioning ethics as an ongoing issue rather than a single event to be *ticked off*.

Foremost in my ethical considerations was the safety and wellbeing of the participants throughout their involvement in the study. This began when deciding upon the inclusion criteria, one aspect of which was that participants must have finished working with their therapist in order to take part. This was to avoid triggering any experiences or feelings around stigma that may interfere with the therapeutic process in any way. Following this, during the initial screening phone call I enquired as to, and gauged, the participants’ robustness to talk of their experiences, as well as their general wellbeing and available support network. Participants were also comprehensively informed about the study and their involvement in it during this phone call, which was reiterated in the participant information

sheet; this sheet also included numerous contacts for support services. I obtained written consent to take part in the study and informed participants they maintained the right to withdraw from the process, with all records and recordings being destroyed. Although this posed a potential risk for derailing the study, it felt important for the participants to maintain ownership of their experiences and awareness of my interpretation of them, as far into the project as possible. This is by way of an acknowledgement of the limitations to the extent to which participants are 'informed' when they are asked to give their consent to take part in the study at its inception.

Throughout the interviews themselves I maintained what Finlay (2016, p.7) described as a preparedness to "*grapple reflexively with ethical uncertainties and power issues that arise*". I also remained vigilant to the possibility of the reactivation of potentially shaming experiences associated with stigma and sought to maintain a safe, regulating relationship through affect attunement (Stern, 2000; De Young, 2015). During the interview, Sarah became quite emotional as she recalled her experiences. I empathised with her sadness and upset and we shared a moment of silence together in acknowledgement of this. Rather than moving on or drawing the interview to a close, I asked if Sarah was ok to continue or if she would like to take a pause; she was happy to proceed. I was aware of my own desire to continue with what was clearly a rich, emotional and meaningful account of Sarah's experiences, and I also considered the expectation that Sarah would likely be feeling to do so, but in that moment it felt that together, as two therapists, we had contained her feelings in a safe and reassuring way.

On completion of each of the interviews we debriefed, taking time to reflect on the process and consider what had stood out most for the participants, and whether any additional support was needed. I followed this up with an email or phone call a few days after each interview to *check in* with participants; they were grateful for this and confirmed they did not require any further follow up or support.

During the write-up process, I sent the original transcriptions of the interviews to the participants, asking them to confirm that the content reflected their thoughts and experiences at the time and also to invite any comments or concerns. My intention was to involve them from the start of the process in acknowledgement of the value of their stories, and my gratitude for them having shared them. I had myself, recently been a participant in a study exploring male therapists' experiences. Following the initial interview and subsequent follow up discussion, I remain unaware of how, when, or even if, my experiences have been used.

My discomfort of this meant that I paid close attention to the involvement and ongoing communication with participants in the current study.

Whilst interpreting and “*restorying*” (Creswell, 2013, p.74) the participants’ narratives, I was guided by Clandinin et al.’s (2007) approach of imagining I was doing so in the presence of the participants themselves. As I selected sections of their narratives and discounted others, I imagined them reading their own words, how vulnerable I was making them, and how our stories may or may not align. By way of maintaining anonymity, as far as is possible, any potentially identifying details were altered and they were each given a pseudonym. As Etherington (2004, p.82) proposed, due to the collaborative nature of narrative inquiry, I was able to discuss this with the participants, arriving at “*mutually agreed and morally satisfactory decisions*”. I asked the participants to read through their restoried (Creswell, 2013) narratives in order to maintain involvement and transparency, as it was ethically important that the participants were aware of and comfortable with which aspects of their stories were being retold, and how. I made sure to convey that it was my interpretation of their experiences rather than a direct relaying of them (Josselson, 2016) and so the emphasis may well feel quite different. As before, I invited any comments or concerns and again none were raised. All participants gave their approval for the narratives to be included in the research.

Throughout the process, all recordings, transcripts and writings were stored electronically and password protected. Any written notes were stored in a locked cabinet.

As consideration for my own safety and well-being, details of the location and timings of the interviews was left with a third party who was contacted after each interview was completed. In addition, throughout the research process I have had support and guidance from my research and primary supervisor, along with peers colleagues and my therapist.

PARTICIPANTS' NARRATIVES

In this section I present the participants' narratives, interpreted and "*restoried*" (Creswell, 2013, p.76) in my own words, interspersed with verbatim extracts from their transcripts. The narratives are presented in the order in which the interviews took place.

Andy

Introduction

Andy is a 33 year old white male, born and raised in London with his parents and sister. He has been in a relationship for the last two years and is currently living in shared accommodation. He works fulltime for a technology company and had an easy going presence and a very active mind.

Andy had engaged in therapy on two occasions. The first was around five years ago, when he attended six sessions via IAPT (Improving Access to Psychological Therapies), following a referral from his GP. The second was last year, when he attended weekly sessions for just over a year with an integrative therapist working in private practice.

The Shepard tone and engaging in psychotherapy

Andy was into technology and considered the brain to be an "*organic computer*". He had an interest in psychology, especially his own, and one of the reasons for his recent engagement in therapy was as an "*intellectual activity*"; seeking greater understanding to help him see life through a "*cleaner lens*". Andy also sought therapy as he was feeling depressed. Although these feelings were not ruling him, as he was easily distracted through work and social life, he felt it was a good thing to go and explore.

Previously, when Andy attended therapy for the first time, it was under quite different circumstances. He had felt that he "*needed help*", that he was in trouble and "*couldn't approach life in a normal way*". He had been experiencing feelings of depression for a few

months following a relationship break up and he likened his experience to a musical crescendo, known as the Shepard tone, often used by the film director Christopher Nolan.

“It’s like a note in music ... where you play a rising crescendo and then you do it again, and it sort of rolls over and so it never breaks, and so it makes you feel very uncomfortable ... the whole thing keeps you on edge, it’s constantly coming to something but it never does. And that was what it felt like, I think, in my experience. So yeah, it was just trying to get out of that extreme discomfort.”

On both occasions, Andy felt his decision to engage in therapy was a relatively easy one. He was aware of how to access services and believed they could provide the solution. His view of therapy was positive, and he felt his upbringing and cultural inputs were significant in developing this. His family were “*super supportive*” of his engagement in therapy, despite his sister having had a negative experience, attending one session but not proceeding any further. The American TV show *Frasier* was also hugely influential; “*As fictionalised as that is ... I looked at it in quite a positive way and it wasn’t like it was crazy people doing it.*”

Stigma and game theory

Stigma was not something Andy felt in relation to seeking therapy. Instead, it was something he located externally, existing *out there* in society, and so it mainly impacted him in terms of whom he would talk to about his attending. He was aware of “*semiconsciously*” avoiding stigma by arranging sessions outside of work hours so he did not need to explain why he needed time off. He also chose a Monday evening so it was unlikely to clash with any social arrangements. When thinking about disclosing his attending therapy, Andy made reference to game theory, the science of logical decision making. He felt there was no advantage to admitting he was attending therapy, it was rarely viewed positively so why you would ever choose to bring it up?

“From what I knew about therapy, that process intrigued me, I suppose. So yes... I viewed it in a good light, but then, I don't think I told any of my friends at the time that I had done therapy, or was doing it. So that's definitely, that's where I felt stigma. I don't think I felt stigma in approaching therapy, I really don't think it's ever been a force holding me back from doing it, but it definitely has been a, 'this is something I wouldn't necessarily talk about'.”

By disclosing he was attending therapy, Andy felt he would introduce uncertainty into relationships, fearing the “*social repercussions*”, and so was very cautious around this. In addition, his circumstances and feelings at the time, and his reasons for engaging in therapy also influenced his disclosure.

“The first time I didn't really, I don't think I told anyone about that, but then I wasn't in a very closely connected situation at that point in my life. So my immediate family knew about it, as I was living with them at the time, but I don't think any of my friends did and I didn't, I don't know, I think I maybe would have hidden it at that point, perhaps, just 'cause there's something different about that time, I felt like I was kind of in trouble, like I needed help from someone.”

“So that time, I suppose, I was more in the camp of like, there's something wrong with me, you know, in a big way, it felt like that. Whereas this latest time it felt more like, I don't need it, but it's something that I really want to add to my life, to explore. And there are definitely things about, you know, it's not like I was a really super happy person and everything was going great, but like, 'oh I'll add this to my life as well', you know ... but I didn't feel a need, that I was in trouble and I needed help.”

Andy felt there were subtle nuances around disclosing his engagement in therapy. In addition to the reasons above, he also wondered if being more mature was a significant factor, as well as being familiar with the process of therapy. On this second occasion, after a couple of months of attending he felt more open to talking about it. Outside of his immediate

family, Andy remained very cautious, only opening up to those with whom he felt incredibly close and could avoid things becoming “*awkward socially*”. He developed a desire to talk about therapy and on a occasions, he did. The first was whilst out with a friend and a little drunk; “*I’m itching to say it, and now I’m inebriated so I will*”. Although this was “*cathartic*” it was also out of context and he was left feeling he had introduced eggshells into the relationship which were then tiptoed around.

On another occasion, the experience was quite different. A friend was talking about his girlfriend who had been going through a rough period and Andy disclosed how positive his experience of therapy had been, and how it might be something that could be helpful for her. For Andy, his disclosure was “*really positive ... in that you’re trying to help ... it felt like that glow of altruism*”. This felt more “*charitable*”, rather than “*cathartic*”, and it initiated a very open discussion, without an eggshell in sight.

Mind vs body analogy

Andy understood stigma through an analogy of the mind versus the body. He felt people were enthusiastic about disclosing they have a personal trainer, as it would probably be met with interest and curiosity. But when it came to disclosing they have a therapist, he felt people were reluctant, that doing so would probably be met with awkwardness and limited superficial questions, if any at all. Andy used this same analogy to draw comparisons between the initial process of engagement in either therapy or personal training, from society’s view and also from his own experience.

“If you feel your body is going in a direction you don’t want it to, if you’re putting on weight or whatever, I think that people would be very quick to go, ‘right I need to do some exercise now’. Whereas if you feel like you’re having depressed thoughts or things like that, I think you would leave it way longer before you decide, ‘right, I need to go to therapy then’, and it would be almost like, ‘it’s got to this level, that now I have to do this thing that perhaps I don’t want to do’. That’s how I feel any way.”

This view was also shared by some of Andy's friends where there was a distinct hesitancy to seeking help for mental health compared to physical health. Andy felt this was connected to admitting there was "something wrong with you".

"I think for most people, the mind is what you see yourself as, rather than the body, in a more complete way ... so I think it's more affecting to you as a person that there's something wrong there, because it's kind of actually you, that there's something wrong with. Whereas your body, it's like, it's just my body, it's this thing I use, where there is something that I can make better. But for psychotherapy, it's like, it's you [Chuckles] and that seems to be deeper in some sense."

Stigma as a strange dichotomy

Andy primarily saw stigma as something external, something that was located in society, which was separate from him.

"I think it's all external, I think the perception is in the other person, that something is wrong, not in me ... I don't think in admitting it to someone, that that somehow solidifies that something's wrong for me. That's my personal experience, I can completely see how that might be very different for other people ... because you've admitted it then there's something wrong, like you've got a label, when you attach a label to something, it becomes more real in some sense."

Andy was also aware however, that he was influenced by this external view, that it was internalised in his beliefs and so there was a degree of overlap between the two.

“There’s some sort of perception from yourself, or from others, that something’s unstable perhaps, in you, or that you don’t approach the world in a way that you’d want to ... it just seems that’s the lens people view it through, I think, and in some degree I do as well.”

Andy felt some confusion over his conflicting thoughts and feelings, describing stigma as a “*strange dichotomy*”. Whilst he firmly believed that stigma was wrong, he also agreed with it on some level. Engaging in therapy was not something he was ashamed of or he wanted to get away from, but it was something that impacted how he viewed others, especially in relation to a partner.

“If you were searching for a partner and you heard that about someone, or they were incredibly open about that, that they were in therapy, I think it would, you know, even though I have this positive view of it in an objective sense, I would feel that er, do I want to get involved with you? I think that would go through my head. I don’t necessarily like it, but it goes through my head ... I realise that’s not fair really, because someone who’s not seeking therapy may be in a really unstable place in their life and someone who is, may be getting much better, so it doesn’t really follow.”

“It would very much depend on ... the conversation around it, I suppose. If you were on a first date and someone said ‘what do you do? What are your hobbies?’ kind of thing, and they said, ‘oh, well I have a lot of these fucked up thoughts so I go to therapy quite a lot’, like that would be a big red flag. But if someone said ... I don’t know, ‘my parents are psychotherapists and I’ve always seen that in a really positive light, so I tend to go quite regularly to psychotherapy’, then I don’t think that would be any sort of red flag, I’d be really interested in that.”

Part of you wants to hide

Although Andy became more likely to tell people about his engagement in therapy after a couple of months of attending, he then experienced “*kind of a flat line*”, and the level of stigma he felt remained the same.

“I didn’t feel like a steady drop off of stigma, it was still, there was still something different about walking into that building [Chuckles], that people see you on the street going into that building, rather than a different one, that some part of you wants to hide and people not see that.”

The ambiguous notion of “*something being wrong with you*” was however, something that altered for Andy whilst he was in therapy.

“When I think of what could happen to that feeling, I can see, and I probably experienced some of this, that you just become more comfortable with that fact, that there are these things that are wrong, if you want to call it that, although that’s not the kindest word to yourself, but there is something you would want to change, let’s say, about your psychology.”

So Andy’s notion of ‘something being wrong’ became ‘something he would want to change’, and this shift came through therapy. Part of the work he had done was about developing self-compassion, thinking about how he viewed and spoke to himself.

“That’s all subjective obviously, like that’s all how I’m seeing it about myself, I don’t think it changes how I think society see it, so that stays the same. But I guess for me, yeah, I think there’s a bit of that about doing therapy that I found useful, that kind of acceptance and not seeing it as this terrible thing, more, it’s just a part of your make up.”

There was something about this gradual shift in Andy's understanding that reflected his overall experience of therapy. There was no "sea change moment", no "massive impact", but more of a gradual improvement over time.

I'm more of an engineer than I am a poet

Andy felt he did not approach life from an emotional perspective. He was aware that he probably experienced it that way but that his mind didn't really go there, he was less interested in the emotional experience of therapy and more interested in the "craft", stating; *"I'm more of an engineer than I am a poet"*. Andy had considered whether this focus was due to his personality, or whether he was avoiding his emotional experience. Either way, he knew he had a tendency to externalise his experience and to universalise things. He also knew there was always a point at which he would stop short in talking about his experience of therapy, even in a perfect world that facilitated openness.

"So in terms of like, swapping stories about our personal emotional experience, it's just not something that I would naturally go to because of who I am, I think ... I'm more interested in the methodology and what actually happened for them in that sense, rather than their emotional experience, because also, that can vary massively. So this is connected to the way I think I approach things ... Whereas if they talk about, like, what they did and their methods, that's really interesting to me because then I can go and read about them and you know, the theories behind them and all that kind of thing. I can't really do that with somebody's emotional experience, you just take it at face value, so yeah. So I don't know if that's the society that I imagine in a perfect world is ... people to be able to talk about that personal emotional experience if they wish, but I just don't know if I'd do that, I suppose."

Integrating medical and lifestyle spheres via technology

Andy combined his interest in technology and psychology when thinking about ways to tackle stigma surrounding mental health, by again drawing comparisons with physical health. Just as fitness trackers have made monitoring our heart rate part of everyday practice for many, Andy thought we could soon find ourselves monitoring our mental health in a similar way. By making self-monitoring “*part of everyday life*”, it becomes a constant backdrop, helping to demystify the issue, increasing understanding and reducing the associated stigma. For Andy, the routine nature of this would help to promote a “*preventative mind set*”, addressing the reluctance he felt most people have to seeking help, preferring instead to adopt an “*I hope it’s nothing*” stance, and delaying engagement.

“In terms of admitting that there’s something wrong, there is a parallel there, with a doctor, I think. You kind of ignore something for a while and be like, I hope it’s nothing, and then when you realise it’s not nothing, you go to the doctor. But you definitely do that at a stage before you would with the mind, I think.”

Andy felt that it was widely accepted in society that you visit your GP when “*something is wrong*” and that a visit to a therapist was seen in the same way; with both residing in the “*medical sphere*”. He felt the key to reducing stigma was to position seeing a therapist within the “*lifestyle sphere*” alongside personal training, which was generally viewed positively.

“Someone who’s got to a point with their fitness where they’ve thought, right, I need to do something about it, and that’s seen as positive. But I think generally, the picture in your head when you think of someone who has a personal trainer, is someone who is already very fit, like that tends to be, I think, the kind of people who do that, or at least some sort of perception of that. So it’s like there’s no problem there, it’s just they’re maintaining a life style they enjoy and it’s seen like it’s a healthy addition to life. Whereas a therapist is very different to that, I think, or the perception of it, in that if you decided to go to that, there’s something wrong with you, like the perception of somebody who is going to therapy is not someone who is of mental fortitude,

it's someone who is in trouble, mentally. So that's like a big difference I think, in how we see those."

Reducing the fear of mental health and therapy

In moving therapy from the medical to the lifestyle sphere, not only did Andy feel this would help to reduce stigma, he also felt this would help to reduce the fear associated with it. This fear was the possibility of a permanent change in who you were, rather than a temporary phase that you would pass through. There was also a distinct difference between the fear of a threat to your physical health and the fear of a threat to your mental health.

"I think the fear for me is it's going to be something that's going to completely change your way of life in terms of some kind of chronic illness, or kill you, right, so they're the big fears about physical health. And then mental health is really different in that it's you that's changing, it's not like it's a threat to you, which is what I see as something like a cancer ... but if your mental health is changing and possibly going to stay that way, in that new state, then that's really you that's changing, it's kind of, it's not like there's some looming threat on the horizon that might end you, it's like you are becoming someone different, and that's really difficult to grapple with I suppose. So it's a very different kind of fear I think."

Fear of becoming awkward socially

Although Andy viewed this fear as separate to stigma, he did feel that both were related to introducing uncertainty into relationships, *"So maybe the stigma is very connected to that kind of social unease of what to do with that person."* Andy felt this unease was experienced in relation to both physical and mental health, however with mental health there was an additional element of potential danger.

“You’re just not really sure where the line is, if they want to talk about it or if they don’t, or it feels like you have to treat that person with kid gloves or something like that ... I think there’s so many questions and not knowing the right thing to do, and whether, in an extreme case, it’s safe to be with that person because lots of times mental health is depicted in pop culture as something very dangerous, and that person could become dangerous. Or just if you want to do the best thing for them, which I think is some kind of underlying impulse, is like, what is that? I don’t know what that is, do they want to, is this something we talk about and ask about if you’re not sure, or, should it be left alone and treated as if it’s not there and all that kind of thing.”

Andy felt this element of danger associated with mental health was probably due to how it was depicted on TV and in films, as this was often extreme, with multiple personality disorder being the “go to ... when you’re talking about some crazy person”. He also felt that a series of advertisements aimed at increasing mental health awareness were actually positioned in a way that reinforced the notion that something was wrong by suggesting that we shouldn’t be scared of a person with a mental health issue. Andy felt this only served to contribute to the “*public misunderstanding*” of mental health and the reasons for seeking therapy. As an alternative, he proposed promoting the idea of bringing therapy into all our lives and emphasising how “*we are all that in-group*”.

For Andy, interactions with people were held within a “*societal contract*” that determined accepted levels of reactions to things, and when an element of perceived mental instability is introduced, “*that goes out the window*”.

“I don’t know how to treat that person, if I annoy them just a little bit are they going to fly off the handle? And again, could that become a dangerous situation? All of those kind of things, I think there are so many unknowns introduced and it throws a lot of baseline expectations out, of dealing with someone.”

These unknowns were most problematic where you had little else to go on. For example, with Andy's work colleagues who he only knew at a surface level, if he learned that one of them was attending therapy, that would introduce uncertainty into their relationship, and at the extreme, a concern for safety: *"I don't know if I want to be alone with that person, what exactly are they experiencing? Are they angry? Or do they have problems with that?"*

With these unknowns and uncertainties introduced, Andy would question how he should interact with them, would his normal way of interacting be appropriate? He felt not. Rather than *"taking the piss"* out of people as a friendly way of breaking down barriers, he would instead focus on not causing *"mental harm"*. The prospect of someone changing their behaviour towards him in this way, based on the knowledge he was attending therapy, was not an attractive one. Andy was aware he was *"breaking the golden rule"* by not acting in the way he would want to be treated, but he just wouldn't feel confident enough to do that. He was left feeling a little uncomfortable and conflicted about this.

Summarising Andy's experience of stigma

For Andy, stigma is something that was located *out there* in society and so it mainly impacted him in terms of whom he would talk to about attending therapy. By being open, he would be introducing uncertainty into his close relationships, changing the dynamic and how he was viewed. There is also a tenuous link, for Andy, between stigma and fear. Fear of social awkwardness, of potential danger, and of fundamental change in who you are as a person.

Claire

Introduction

Claire is a 47 year old white female. She was born and grew up in Northern Ireland, is an only child, and was raised by her mother after her parents separated when she was young. Claire is now living and working in London for a large corporate company. She is single and lives alone. She had a confident presence and spoke with an open and reassuring directness.

Claire had only attended therapy on one occasion, which was last year. She attended weekly sessions for about a year with an integrative therapist working in private practice. As part of this work she had a number of sessions of EMDR (Eye Movement Desensitisation and Reprocessing).

Engaging in psychotherapy: a last resort

Claire made the decision to get in touch with a therapist because she didn't want to just carry on with the second half of her life feeling the way she had done during the first. Throughout her life, Claire had felt strange, like an outsider. She was unsure if she had suffered from 'depression', but she suspected that she probably had. Her decision to engage in therapy was not an easy one.

"I knew there were obviously psychological and developmental reasons for it, but I didn't know how to find out about those things and I always shied away from it because, I suppose, because of the stigma and because I was worried ... if people thought that I was looking for any sort of help for mental issues ... I was embarrassed and ashamed."

It was a combination of this long standing feeling and difficulties she was facing with her relationship at the time, that led Claire to engage in therapy. She was in a relationship that

she wanted to leave, but felt that she couldn't and this feeling was driving her "mad", it felt like the last straw.

"I just couldn't seem to find a way to get myself out of it and it was really messing with my head, not being in control of myself, thinking, that's what I want to do, I don't want this, that's the action I want to take, I want to break away from this, but I can't, and I just couldn't understand it, I could not get my head around the fact that I couldn't do what I wanted to do."

Clare was getting desperate, she knew something had to change; she just didn't seem able to do it for herself. She felt she needed to get some help, to get some perspective. She began looking online to figure out what was going on, but this just worried her more when she started seeing stuff about borderline personality disorder. It was at that point she looked up therapists in her area and as "*last resort*", fired off an email.

The stigma was mine as well as other people's

As soon as Claire sent the email she felt scared and afraid. She had made the first step and was going to have to see it through. She didn't know what to expect. She only knew of one friend who had seen various therapists and it had been very "*hit and miss*". Claire had no great expectations of therapy actually doing her any good; it was more a case of having nothing to lose. When she saw the therapist had replied she began to doubt the difficult decision she had made.

"Maybe this was really stupid, because maybe I should just be able to deal with this myself, what is wrong with me that I can't just get on with it, and this is ridiculous ... I can't afford to be paying money for sessions, and also the fear of the unknown I suppose, this could be an absolute disaster or this could make things worse ... and the fear of having to talk about things that I hadn't talked about ... forever."

Claire was aware that her view of therapy was a cultural and generational one; people should buck themselves up and get on with their lives. This was *“the old school way of thinking ... the Northern Irish way of doing things”*. It was not something she even thought about, it was just understood, it was just there. Claire felt that she had picked up this way of thinking from hearing adults talking when she was growing up, from seeing stuff in papers and on TV. Mental health issues were something that was *“laughed about ... it was a running joke”*. Therapy was only for serious mental health issues, like psychosis, anything else was simply *“wallowing in self-pity”*.

“Back in the day there was a view that somebody who’s really mentally ill, it would be obvious that they’re mentally ill; they would be walking around with visible symptoms of being mentally ill. Whereas somebody who might be quietly suffering, but seemingly getting on with a normal life and able to have a normal conversation, whatever that may be, yeah, I certainly think there was a view of, there’s nothing wrong with you.”

Growing up, Claire remembered feeling there wasn’t much time for talking about problems. Any attempts she had made over the years to talk to her family about things that had happened in the past, *“never ended well”*. There was a suggestion that problems were of your own making and you should be able to sort them out, you shouldn’t be complaining to other people, you should consider yourself lucky for what you’ve got. Claire was aware that these taboos were not just the thoughts and opinions of others, they were also in her own head, she had internalised them; *“the stigma was mine as well as other people’s”*. She had made comments herself, about people or situations; she had joined in with the jokes and laughed things off.

I didn’t want it on my record

Claire covered up her own suffering. Not doing so would have felt naïve, not brave; to let people know that level of detail about her would have made her feel vulnerable. She always

believed, and still does, that many people see going to therapy as a weakness or an excuse. She feared that people might have used it against her, especially in the workplace.

“Where I work now, there’s this employee assistance scheme and things like that, but I didn’t dream of approaching them, I’d rather go and spend money I couldn’t afford to spend on having private therapy rather than trying to go through my GP or any other source where I might have got it free.”

Although many companies support and promote mental wellbeing in the workplace, Claire felt this was largely superficial, to utilise this support would actually be putting yourself at greater risk of further distress. This was the unfortunate experience of a friend of hers, who tried to stand up to being bullied in her workplace, but claims she was subjected to breaches of confidentiality and her mental health suffered even further as a result.

“I know that now a days, obviously, we’re all a lot more PC and employers are told they have to look after their staff and you can’t discriminate against someone if they have mental health issues or whatever, but I’m sure it does still happen.”

Once Claire had made the decision to see a therapist, she wanted it to happen quickly, and thought there would be lengthy waiting lists if she went via her GP. There was also a concern that her needs might not be serious enough to get a referral; therapy was only available if there was *“something wrong with you”*. The biggest deterrent however, was that visiting the GP for her mental health could potentially affect her medical insurance and she was concerned as to who might have access to that information and how might it be used against her.

“I didn’t want to go through my doctor because I didn’t want it on my record ... I wanted to deal with it myself and know that it was completely private and no way anybody else could find out. And when I had my sessions, I lied to them in work about where I was, I told them that I had a doctor’s appointment or I

had this, or I had that, or whatever, I never spoke to anybody in work to tell them exactly where I was.”

After six months of therapy however, this changed. Not only did Claire tell her manager at work she was having therapy, she also told some of her friends and even her mother; *“I just felt totally different about the whole thing”*.

Brain as an operating system

The process of therapy completely changed Claire’s view of stigma and how she felt about herself. She felt some instant relief within a few sessions, just to be able to talk to someone who was not judging her in any way. She also felt she got lucky with her therapist, in that she was quickly able to recognise what it was that she needed. For Claire, the key factor was the therapist’s recommendation of a book, which helped her to see her brain as an operating system and to understand what she had been experiencing for all these years. The book felt like a *“turbo boost”*, enabling her to do a lot of the work herself, to develop her own understanding so that the therapist did not have to *“pull it out of her”*. As vital as the book was, Claire’s felt it would not have been sufficient on its own. The follow up conversations with her therapist enabled her to apply the concepts to herself and also to really feel her physical feelings, to become curious about her experience rather than stressed by it.

“Thank god, I’m not crazy. This isn’t me, there isn’t something wrong with me, this is just a natural process that’s happening in my body and there’s a reason why it’s happening and you know, when I started to then think of my brain more as an operating system, something like that, looking at it purely from a physical point of view and attributing the things that had happened to me and thinking, ok, so there are hormones being released and that’s why this is happening, and that’s why I’m feeling that, and that’s why I’m thinking this way, I was able to then take the blame away from myself, and stop thinking I was just wallowing in misery.”

It was this new understanding that had completely turned her head around in terms of how she viewed herself and other people. Claire had gone from feeling that something was wrong with her, to knowing there was nothing wrong at all. She had learnt that people have strong emotions and it's important to know what they are and where they come from, and most importantly, that you can change them. This understanding was very powerful; it felt like it had *"unlocked everything"*. Knowing how her mind and body worked felt like a weight had been lifted, and this was not just her mind and body, but everybody else's as well. Although this understanding did not result in a complete change in her behaviour, as she would find herself getting caught in old familiar patterns, it did mean that she was able to recognise this and rather than feeling confused, overwhelmed and powerless, she simply felt annoyed.

"There are still old habits and whatever, that I may never be able to completely break away from, but, but I no longer sit there and mull over them and think, well what's wrong with me, when I find myself doing something, I can catch it and understand why I've done it and step back and think, Ok, well you've just done it again, but anyway let's just, you know, think about why that might have arisen."

Claire had experienced strange feelings in her gut since she was a child. Her mother had taken her to the doctors as she thought it was an ulcer, but nothing was found. Claire instinctively knew it wasn't a physical pain, but she had no idea what it was. She thought she was the only person in the world who had ever experienced it and so wouldn't dream of talking to her friends, or anyone else, about it. Claire still has the feeling now at times, but *"a little bit of knowledge goes a hell of a long way"*. She wondered how different things would have been if she had realised that what she was thinking in her head, was also manifesting in her stomach.

Why are we not told about this?

As much as this new understanding was transformational for Claire, it also left her feeling really quite angry and frustrated. She considered herself to be well educated and intelligent

and yet until now, was completely unaware of this logical explanation of how life experiences can manifest themselves physically. It left her feeling disbelief; *“It’s scandalous ... why are we not told about this?”*

“I can’t say that this wouldn’t have been available to me earlier because it would have been, if I had gone looking for it, but that’s the thing, I would have had to go looking for it which would have involved me having to, I suppose, go against everything that felt right to me, that felt normal.”

“Instead of having to find it, more by luck than anything, it should be unavoidable. Obviously it would be up to each individual how deep they want to go into it, or how they want to embrace it or learn about it for themselves, but you should know the basics at least.”

Claire felt it was not only adults’ responsibility to feed their children but also to look after their wellbeing, to ensure they know this stuff. Claire grew up feeling ashamed of how she felt; understanding why would have undoubtedly made a huge difference for her.

“There should be something that just explains to people how their brains and their bodies are developing, what it is that’s happening, and how circumstances and events and everything that you experience has some sort of impact on what’s going on in there.”

Claire considered early intervention to be extremely important, that children and young people need to be aware their future wellbeing depends very much on what they do *now*. That understanding changes everything. People of her age and generation in particular, are unlikely to engage without this understanding; the need to do so is less recognised and therefore less important. To ensure this trend doesn’t continue, Claire believes that the concept of therapy should be positioned as the norm from a young age. Not in the same way as visiting a doctor, which you do when something is wrong, but in the same way that you visit the dentist, just for a check-up; it becomes something that everybody does. You would

learn to talk about yourself and how you're feeling, maybe not one-to-one but in groups, perhaps once or twice a month; *"therapy wouldn't be therapy as such ... it would just be part of everyday life ... like making a cup of tea"*.

"It's just a well-being thing. Not there's something wrong with you, it's just, as they say, you go to the gym to look after your body, but where do you go to look after your head?"

From weakness to strength and the old ingrained default

Starting therapy was the best choice Claire had ever made for herself and she was coping better with her life as a result. Having initially seen therapy as a weakness, she now saw it as a strength. She felt proud to have had therapy, of *"finally having the strength to admit to myself that I needed to get some help from somewhere else"*. Whilst her opinion of seeking therapy had completely turned around and it was now more acceptable in society in general, she was under no illusion that stigma still remained.

"We say that things are changing but, you know, people, even now, sometimes think it's not necessarily a sign that you're mentally unstable if you have counselling, but you know, that you're a bit flaky or something like that, maybe not quite as robust, as reliable as maybe the next man who doesn't, who's able to cope with life on his own without feeling the need to sit in a room and talk to someone about his woes."

Claire was also aware that her old ways of thinking were *"deeply ingrained"* and when caught off guard, she could react automatically and unconsciously and would catch herself being quick to judge. She instantly recognises these old responses and quickly rights herself, saying *"what are you talking about? You know that's not the case"*.

For those who cannot 'right themselves', Claire felt it is they who have the problem, not the person seeking therapy, and their close-minded view was the reason that stigma persists.

“There’s no excuse for it. It’s actually annoying when I hear people come out with ridiculous statements now or say things that are, you know, 20, 30 years out of date, oh really? God! I can’t always be bothered to have an in depth conversation to explain to them why they’re wrong, but yeah, I just find myself thinking, oh god, here we go again. But rather than agreeing with them, whereas I might once have done, or having a laugh with them going, oh yeah, they probably are a bit crazy, or whatever, I find myself thinking, about the person who’s said it, actually, you’re just an idiot or you’re uneducated, or you’re not doing yourself any favours.”

Claire would no longer take these comments personally, she refuted the idea of the snowflake generation that she must be mental, or selfish, or unable to cope. There was no blame now, except perhaps in those rare and fleeting moments when something stirs within her as the *“old ingrained default”* is triggered.

Openness

Although the ingrained default remained, Claire would no longer hide that she had attended therapy. She did not preach about it, but was open with friends and also strangers, if it were to come up in conversation. The more she was open about her experience, the more she found that others reciprocated and this added a new depth to their relationships.

“It’s probably made me more empathetic I suppose, maybe towards other people and to start thinking more about, well I wonder what this person’s story is? You know, even people I have known for a long time, you talk to them about some things, but you don’t necessarily talk to them about how they really feel. You might think you are, you know, even with close friends you might think that you’re being really honest with each other, but I’m not too sure that it always is, sometimes it’s just skimming over stuff isn’t it, you know, you’re not really getting underneath the skin. I’ve certainly found that

where I've been able and willing to open up a bit more about myself, that other people tend to reciprocate. Not all, but some."

When Claire told her mother she was attending therapy, it was initially met with a negative reaction. Her mother thought it was a waste of money and that the therapist would simply tell her it was all her parents' fault. But Claire explained that was not what the therapist was telling her, although that may be part of it, and her persistence eventually led to conversations between them that they may never have had. Her mother began to open up about her own experiences and childhood, and acknowledged that she had shared similar feelings to those that Claire had described.

There was some relief for Claire to hear of these shared experiences with family and friends, as she was no longer so alone with them. But there was also sadness that so many people faced difficulties for which they did not seek help. Instead, many people were just drifting through life feeling *"pretty miserable, most of the time"*, forgetting that we are all human beings, and we all have our flaws.

"In some ways, whilst it's sad, it's also kind of a bit of a relief to know that everybody else is feeling the same way, we're in it together."

Claire's openness was facilitated by the general shift she felt in society over recent years. Prince Harry and high profile footballers' sharing their experiences was encouraging and a helpful way to tackle stigma on a wider level. On a personal level, Claire felt it was important for her to be open because if others had been open with her, she may well have been persuaded to seek help earlier. Beyond that, she was unsure what could be done to address stigma, but was clear that there was a long way to go before mental health was treated in the same way as physical health.

Whilst Claire felt attitudes towards mental health and therapy were improving, she was also aware of an *"epidemic"* of mental health issues among the younger generation. The public way in which young people are forced to lead their lives seemed to be contributing to serious 'depression', suicides, self-harm and eating 'disorders', all of which felt a long way away from her own experience. There was a distinction in her mind between these more serious issues and a more general struggle with angst.

“Obviously there’s mental illness and there are conditions and things that possibly need more specialist help, or therapy, or interventions even, but the majority of the population, most of us are having some sort of angst or another, or thinking, we’re all sitting there thinking we’re the only ones feeling this, when actually, we’re all feeling it to some degree or another.”

Summarising Claire’s experience of stigma

For Claire, stigma created within society and has attached itself to mental health and help-seeking. Stigma comes from a place of naivety and lack of understanding about basic building blocks of human development and how our bodies and minds respond to and manage adverse experiences. Once you understand this, you can no longer accept any form of stigma attached to mental health or help-seeking. People are a product of their environment and experiences, and so therapy becomes about education.

Sarah

Introduction

Sarah is a 48 year old white female. She was born and grew up in the North of England, with her three siblings, but now lives in the South of the country with her husband and their three children. She works as a teacher and also provides pastoral care for pupils at the school. Sarah had a very warm and calm presence and spoke with a gentle and considered voice.

Sarah had attended therapy on two separate occasions. The first was around 20 years ago, when she attended weekly sessions for around nine months. This began with a referral from her GP for eight sessions, which she continued on a private basis with the same therapist. The second occasion ended recently; she had attended weekly sessions for two years with a psychodynamic therapist working in private practice.

Psychotherapy: a dirty little secret

When Sarah engaged in therapy on the first occasion, she had been in a relationship for four months and had begun to doubt whether it was right for her. The long distance relationship felt quite fragile and she was struggling to cope with the anxiety it evoked. In previous relationships Sarah had not wanted to commit and felt that the same was happening here; she wondered if this was connected to her father having passed away when she was young. As she cared deeply for this person she went to seek help from her GP who referred her for therapy. The eight sessions she was offered did not feel like long enough, she felt it opened up some old wounds and was uncomfortable stopping at that point, so she continued on a private basis with the same therapist. Sarah did not disclose that she was attending therapy to anyone.

"I didn't tell anybody that I was going to the doctor, I didn't tell anyone that I'd started therapy and it felt like it was very private, but almost, it was something I couldn't speak about because I felt that people saw me as a capable person, a sociable, happy, positive person. And I think I was very aware there were

issues for me around being vulnerable and ... I think it was about not being acceptable."

"That was a sort of internal battle that I was having, because I did really want to speak to somebody and be able to, not share what was going on in the therapy necessarily, but just ... to be able to sort of say to someone ... that I was feeling vulnerable and that I needed some support. I didn't feel I could."

The second occasion that Sarah engaged in therapy was when it was a requirement of a counselling training course she had begun. Being a requirement was key in her decision to be more open about it, in her mind it instantly became more acceptable.

"In retrospect, I think I wanted to tell people this was part of the course because I wanted to be able to tell people I was having therapy and be able to talk about my experience of it, that it wasn't a dirty little secret ... but it was still only acceptable for me, I thought it would only be acceptable, as something that I had to do."

Messed up or Indulgent

Sarah's initial decision to engage in therapy 20 years ago was a difficult one. She felt therapy was only supposed to be for people who had really big problems, who were "*messed up*", and so she didn't really qualify. This view of therapy was echoed in her concerns over what her family would think of her if she were to engage. She imagined they would think she had lost the plot that she was really in trouble, and they would be worried for her. She also thought they might take another view, which actually concerned her even more:

"What a load of nonsense, what's she doing that for? She's got us, why would she need to spend her money on that? Why would she need to spend her

“time doing that? Why would she think that that is for her? Because actually she’s ok, she’s fine, there’s nothing wrong with her.

This anticipated response left Sarah believing that therapy was an indulgence; to sit and talk about yourself for an hour every week was a bit precious.

“I’d been raised with the idea that the best way to make yourself feel better is to do things for others, the best way to feel happier or to resolve any sense of loneliness, or lack of purpose, or any of those things that I was feeling at the time, was really to reach out to others and do for others, rather than sort of sit and navel gaze.”

Faced with the option of either being seen as messed up or self-indulgent, Sarah was not able to share her experience or indeed that part of herself with anyone; the part that felt vulnerable and unacceptable. She could still clearly recall *“just how lonely that felt”*.

Us and them

Sarah knew her view of therapy, and of herself if she were to attend, was greatly influenced by her upbringing. There was a strong family culture and acceptable *“way of doing things”*.

“There were comments made: all Americans have therapists, you know, they need to start talking to their friends and family, that kind of comment. There were comments about ... I had a friend, it was my boyfriend’s friend actually, who suffered with schizophrenia and they would talk about the madhouse down the road, for the nutters, you know. The word therapy wasn’t used but mental illness was talked of in quite a derogatory way. It wasn’t a case of, you know, we’re all sort of nuts in our own way now and again, because, you know, there’s a bit of being irrational in all of us. It was more, us and them,

you know, the ones who are ok, who get on with their lives, who sort of muddle through, push through, and do normal things like talk to friends, and then there are the others. I suppose there's a split, there's the nutters and the not nutters, and we were in the camp of the not nutters."

There were numerous other examples of these influential statements that came to mind and although Sarah knew they were judgemental, they were usually expressed in a joking way. But the mentality was clear: *"we get on with things, we cope, we manage, and then there are others who don't"*. Sarah considered the culture she grew up in to be a significant factor in this. In the North of England, where her family are from, the general way of thinking is to just get on with things. There are hardships and lots of things go wrong, but you just get on.

There was a moment that encapsulated the depth of this stigma that Sarah felt, when she considered disclosing to her friends the first time she engaged in therapy. She had a close group of friends at the time, and they remain close today. They met through a prayer group. Faith had always been a great inspiration and support to Sarah and as a result, there was a way of life that she and her friends subscribed to. They had strong views about how they were as women, their sexual ethics and the way they wanted relationships to be. When Sarah was having difficulty in committing to relationships she began to consider that long term relationships and marriage may not actually be for her, despite being something that she wanted. Instead, maybe her life would consist of shorter term relationships and companions. Before meeting her husband, Sarah was in a relationship where she contracted a sexually transmitted disease and required regular treatment at a clinic. She was attending these weekly appointments at the same time that she attending weekly therapy.

"What I find interesting is even though there was this huge, for me, there felt like this massive stigma around this young woman who had subscribed to a particular way of life, who now could be exposed as having been experimenting in other ways, that actually, that stigma, although it was very strong, I did end up telling one of my friends about that, but I still never told any of my friends or my boyfriend at the time, about the therapy. So I think that that is quite a telling contrast in a way, because both stigmas were strong, but actually telling people that I was in therapy was even greater for me."

The process of therapy: indulgence became disturbance

Having navigated her way beyond initial feelings of indulgence and allowed herself to engage in therapy, Sarah soon found herself with an additional aspect of stigma that although she was aware of, had not anticipated experiencing it for herself.

“As I went through the therapy it was so deep, reaching very deep into lots of stuff, that I started to feel that ... that I was in trouble, I started to realise that there was a lot there that I hadn’t looked at, and the more I felt that things were unravelling, the more difficult it became to tell people. Because then there was this stigma about, you know, only those who are really mentally ill or very disturbed, need therapy. And I started thinking, maybe I am really disturbed, maybe I am really erm ... I felt that I was struggling, but it made it even more, just all of those sort of societal stigmas, I was sort of buying into them a little bit.”

It was at this point that Sarah felt stigma most acutely. Not only did part of her believe that she was being indulgent, but now part of her also believed that she was messed up. She had bought in to the stigmatising views that had surrounded her growing up, and now she was experiencing them too. She felt like she had entered a pit that she might never come out of.

Sarah made the distinction between societal stigmas and her internalised experience of these. She considered the degree to which this internalisation occurred was related to her predisposition and sensitivities.

“The stigma was certainly there, you know, I don’t have any doubt about that. And the degree to which I felt it, I think was, you know, my particular personality and I suppose the sense of being a bit of a pleaser, wanting people to be happy with me, me caring maybe a bit too much about what people thought of me ... I think there was also an element [of] how people, including myself, might be more robust or less robust in terms of being able to get beyond that stigma and beyond that barrier.”

Sarah understood her difficulties as being connected to the loss of her father at an early age and how her family coped with their grief. She experienced a sense of abandonment and not really knowing where she was.

“Those things, I think, would have played in to me being particularly susceptible to wanting the approval of others and worrying about people disapproving, on the basis of, you know, I’m asking for too much, I’m being self-indulgent, I’m asking for things that really I don’t deserve, you know. I wasn’t aware of it at the time, but I think that those kind of thoughts are, on an unconscious level, much of it.”

Sarah also wondered the feeling of having entered an inescapable pit might be partly connected to the abilities of her therapist. Although she obtained some practical ideas from her first therapist, she did not feel that she moved a great deal in their time together, and that her sense of deeper anxieties and losses remained unresolved. Her second therapist, however, helped guide her through these darkest and most vulnerable places at the bottom of the pit, places that she knew she needed to visit *“before being able to go into the light”*.

No choice but to be more open

Sarah felt that these different experiences of the therapeutic process may have influenced her decision to disclose that she was attending therapy, having only done so on the second occasion. And whilst the main reason that disclosure felt possible was due to therapy being a requirement of her training course, rather than a choice that she had made, there were other additional factors. Sarah had a greater sense of supportive structures around her at this time, stemming from her family, friends and a secure home, and she was also more mature and had greater life experience. Sarah also felt that her living in the South of England rather than the North could also be a significant, as culturally and economically, there were some marked differences.

“In the North where I’m from there’s a lot of unemployment and deprivation, people have difficult lives, there’s not the money, there’s not the money to spend on therapy. Generally you don’t hear of people being in therapy.”

Sarah also felt there was a general shift in society’s perception of stigma over the last 20 years. There wasn’t the same feeling that there must be something really wrong with you to go into therapy, it was acceptable for a number of different issues, not just for those who were *“losing it”*. Sarah also had her own experience of therapy becoming more visible and acceptable. There was a counsellor in the school where she worked and also in her children’s schools, other parents had also spoken of their children having anxiety and attended therapy. In addition, Sarah had seen television programmes related to mental health and of Prince William talking with high profile footballers.

“Although in some of those programmes the actual word therapy, the actual experience of therapy isn’t spoken of explicitly, but just the fact that mental health is being spoken about, I think means that by association, therapy becomes something that is part and parcel of our health offering, you know.”

All these factors contributed to Sarah attending and disclosing her therapy, but there was a clear distinction in her mind about it being acceptable as a training requirement and acceptable because she needed it.

“It took me a good year into therapy to really be honest with anybody about it actually being a need for me, that it was really supporting me. And I say to people now that, you know, I didn’t realise how much I needed it, but it was really helpful for me and I don’t know where I would be without it, having had it, having had that support.”

Sarah’s openness about her need for therapy was prompted by the mounting difficulties her son was having at school, she was very worried about him and it felt like things were falling

to pieces. She felt overwhelmed and was struggling to make difficult decisions; the situation went on for months.

“I think at that point, just any pretence that I had about being ok, just sort of went out the window, I was just brought to a point where I had no choice but to be more open.”

The relief of openness and the strength in vulnerability

Sarah’s openness paved the way for conversations she would never have had before. Friends would enquire as to her experience and ask how they could get support themselves and what they might expect from therapy. The most significant conversation that her openness triggered was one with her mother.

“It’s been a really healing thing for me with my mum who’s now 78 and she said to me, I was really worried when you said to me that you were going into therapy because of that course, because I thought that we’d start having arguments and that you would be telling me everything that I’ve done wrong. And it was a really healing conversation for us to be able to [have], for me to be able to say to her, well you know, I have looked at lots of different things in my experience and let’s be able to talk to each other about what our anxieties and worries are. Because I didn’t know that she was feeling that at the time, that she was feeling really threatened and worried. And she said to me that she was, just really pleased that I had the support.”

This conversation provided a sense of relief for Sarah, although it took some time for her to really understand why that was. She came to the conclusion it was partly due to knowing it wasn’t damaging for her mother to find out that she had been struggling so much, and partly because it didn’t irritate or annoy her, or colour her view of Sarah in a negative way. These were of course, the deeply rooted fears that Sarah had held for many years.

Sarah found that sharing her experiences led to deeper relationships, but she was careful to only share with people who she really trusted. It remained something very private and not something she would band around or talk effortlessly about at the dinner table. Sarah also considered why she had not told her children about her attending therapy

“I’m thinking, why have I not told my children about it? It would be because I wouldn’t want to worry them that their mum might not be as stable, or as together as they need me to be. I think with children it’s slightly different because they do need a mum who’s solid and safe, but that’s interesting. I haven’t even thought about that before, why have I not told my children?”

“Maybe what my conversation with them should be about, is the reason I’m more robust, I’m able to be more robust, is because I’ve had my own therapy and that therapy has helped me. And at some point, that may give them permission themselves to seek out therapy in the future. Because actually if I don’t tell them, and they’re not aware of it, what am I doing? I’m doing the same thing, pretending to be strong and maybe giving them the message that they should be strong and that they don’t need therapy, nobody needs therapy.”

For Sarah, sharing vulnerability is what makes people who they are, it makes them good friends and good parents; she saw “*strength in vulnerability*”. From an early age she always admired people who shared all parts of themselves, who were not too polished and too perfect, but would share the things that were going wrong as well. Sarah felt that sharing this depth of experience was integral in forming a sense of connection, togetherness and belonging.

“Part of it is about being angry, being sad, having difficult experiences is just part of what it is to be human isn’t it, to have those sorts of experiences ... and for my own children, I hope that they understand that that’s part of life and we talk about it, it’s not a mental health issue, it’s just sadness.”

Different therapies and different stigmas

Sarah understood vulnerability as fundamental to establishing deep connections, and that sadness, anger and difficult experiences were an integral part of being human. So the question for her was at what point did these feelings and experiences require more specialist help in order to process them.

This was not a straight forward question however, as Sarah felt different therapies had different stigmas attached to them. For example, she considered Cognitive Behaviour Therapy (CBT) and Neuro Linguistic Programming (NLP) to be viewed as forward thinking, with a focus on getting things sorted out. Sarah knew that CBT was most widely available and offered by the NHS and so was likely to be most familiar to people. She felt people may be unaware that other therapies were available and could potentially be more helpful. Sarah's view of CBT and NLP was that they proposes your thinking controls who you are, and so problems are resolved by changing the way you think. Sarah does not agree with this, and whilst she feels these therapies have a place, they would not have provided the space that she needed to explore and understand her experience. This space was more associated with psychoanalytic or psychodynamic therapies, which came with the stereotypical image of lying on the couch, indulging yourself, talking forever about your problems.

“Because CBT would not, I don’t believe ... have been helpful for me, in fact I think that could have disrupted, it could have been ... well, I don’t know. I think different therapies are good for different situations and for me that could have been more problematic. It could have delayed the progress; it could have interrupted what I needed to do. “

The stigma of engaging in therapy still remains for Sarah, at both a public and an individual level. Although her understanding and view of therapy has changed, if she were to re-engage, the stigma would remain. Sarah had recently opened up a conversation with her husband around them having couples counselling which she felt evoked a different stigma, especially for him.

“I think it would be really good for us, you know. Especially with all of the conflict that we’ve had raising our son and joining our thinking together on that. It’s sort of shown up weaknesses in our relationship, and it’s something that I would like us to do. But there’s also stigma around that, well there certainly is for my husband much more than even for me; you’re really in trouble in your marriage if you start going to therapy ... It’s like admitting that you’re not happy, or you’re not satisfied with each other, or that things are going wrong. Where as my view is, and this is what I say to my husband, my view is that we have the therapy before we get to the point that it’s really difficult to repair. So there’s a different stigma around that.”

Couples therapy was now Sarah’s priority, rather than individual therapy. She saw it as something that was for the good of the whole family, not just for her. She knew she would benefit from it too, but as an investment for the family, it felt less indulgent. Sarah was aware these feelings still remained and she would tell herself, *“if you want it, just have it”*.

Stigma as a motivator

Sarah’s experience of stigma is also a great motivator for her current work. She remembers when she was six years old, after the death of her dad, how valuable the space of openness and acceptance was that a teacher provided for her; a space that she now offers to pupils at her school. She knows the value of early intervention, having experienced how ingrained beliefs and feelings can become without it, and how difficult these can be to overcome. Sarah strives to provide and normalise a therapeutic space for pupils, a space to talk, to share experiences and emotions, and to position this as acceptable rather than indulgent.

Summarising Sarah's experience of stigma

For Sarah, stigma is something that is very subtle but also very powerful. It's about what is acceptable and what is indulgent. Stigma has influenced many important decisions that she has made and feelings that she has had. Despite her own experience, her own training and understanding, stigma is something that remains very alive for her today. Part of her still wants to prove to herself that she can manage without therapy.

"... that I can go on with my normal life without it, and manage ok. I know there's an element of me wanting to show myself that. I think some of the stigma around, 'you should be able to be strong, you should be able to manage without it', is possibly at play."

DISCUSSION

I was fortunate to conduct the interviews with participants in person, as a week or so afterwards, the country entered lockdown due to the Covid-19 pandemic. At the time of writing this discussion, the country is slowly coming out of this lockdown, for what is hoped to be the final time. This has brought numerous challenges and struggles for many, myself included, but it has also brought a focus and acknowledgement of the impact the pandemic has had on the nation's, and the world's, mental health. It feels like a poignant time to be writing about the struggles people face in seeking help when it is desperately needed by so many. The impact of this pandemic on the nation's mental health is set to increase and persist, leading it to be described by the mental health charity Mind, as a "*second pandemic*" (Mind, 2020).

This discussion section is organised around three main themes that I drew from the participants' narratives presented above. I introduce themes at this stage for the purpose described by Bager-Charleson et al. (2018, p.4), "*to push interpretation along and facilitate as a kind of structure to [my] own story, which makes it easier to communicate*". By grouping aspects of the participants' experiences into themes helps organise the narratives, but also to harness their value, as these themes ultimately lead to the development of the core contribution of this research, the 'considerations for therapists', which unfold throughout this discussion section.

The first theme in is titled '**The entanglement of stigma**', which discusses how stigma is experienced as complex and multifaceted, involving both the external and our internal worlds. The second theme, '**The rising crescendo and engaging in therapy**', looks at the participants' experiences leading up to starting therapy and how they navigated their way into, and through it. The final theme is '**A dirty little secret - the dilemma of disclosure and the need for connection**', here I discuss the participants' desire to, and challenges of, disclosing their experiences to others.

Throughout this discussion, I aim to convey the individual experiences with all the complexity that being human brings, and to discuss these within the context of the existing literature and relevant psychological theory. At the end of certain subsections I outline considerations for therapists resulting from the discussion as a way of highlighting specific clinical areas of focus.

The entanglement of stigma - where external and internal worlds collide

Throughout the participants' narratives there was a strong sense of the complexity of stigma and how at times it felt complicated, frustrating, and full of contradiction. Stigma was experienced as an entanglement of external messages, beliefs and implications as well as internal thoughts, emotions and sensations. Sometimes these two worlds aligned, generating a sense of a shared understanding, at other times they collided, resulting in feelings of guilt and shame. It was this collision between the external and internal worlds that I think Andy captured when he described his experience of stigma as a "*strange dichotomy*". At the time, I imagined he might be describing the interaction between 'public stigma' and 'self-stigma' that Corrigan (2004) had identified, and which forms a central tenet of the existing research. But as his narrative unfolded I began to understand the strangeness that he referred to as reflecting the complexity of the interaction between these two worlds, the bidirectional influence operating along many strands and at many levels, and with deep reaching implications.

My discussion of the entanglement of stigma is presented in three subsections. The first section is '**The explicit and the implicit**', which reflects how stigma operates at different levels of experience. The second section is '**The big red flag of certainty and the problem of uncertainty**', which highlights the tendency of mental health to be perceived as something which is very clear cut. The final subsection is titled '**Culture shaping the internal world**', and the participants are presented in sequence in order to focus on the uniqueness of their individual experiences as they consider sources of influence.

The explicit and the implicit

Throughout each of the three narratives there were stories of how, both explicitly and implicitly, people experienced stigma in relation to their mental health and the prospect of seeking therapy. It was clear from their accounts there was a lot at stake in terms of how they would be judged by those around them, and by themselves.

Just saying the words *therapy*, or, *mental health*, out loud, instantly triggers numerous associated thoughts and feelings for me, and presumably for others. Although these associations have changed significantly over the last decade, it's easy to recall my instinct to recoil, the need to distance myself from the words and the feelings they evoked. I wanted to distance myself from the weakness, fragility and sense of inadequacy that I associated with

therapy, considering it to be something reserved for those who cannot cope. I always felt that my response was not a subjective one that existed in isolation, but rather one that I absorbed from the external world around me, just as others did too; it felt as if it was a shared understanding. Having only heard comments that seemed to support these stigmatising views, I had internalised them and began to believe them myself.

The feeling of a shared understanding around mental health and help-seeking that I had experienced also seemed evident in Andy, Claire and Sarah's narratives. They described stigma as something that was located in "*people*", "*society*" and the "*media*", and it was through these channels that stigmatising views were conveyed and reinforced. Claire described how her views on mental health had come from "*hearing people talking ... listening to the adults when I was growing up, from seeing stuff in papers, on TV*". She also emphasised the way in which mental health was spoken about, it was "*the sort of thing that would have been laughed about on TV, in sitcoms and things like that ... it would have been more of a running joke*". There was an explicit message here that Claire had received around mental health and help-seeking, and it came from multiple sources.

The experience of stigma at this explicit level seems to reflect what Corrigan (2004, p.616) referred to as 'public stigma' which he defined as; "*what a naïve public does to the stigmatized group when they endorse the prejudice about that group*". There is a sense of something overt and explicit in this definition, suggesting that stigma was something that was said or done. Corrigan's (2004) definition also positions this form of stigma as something which is located externally, beyond the individual, which is also echoed in Claire's description.

The participants' narratives, however, suggested that the experience of stigma went beyond what was conveyed explicitly, that there was an implicit 'felt sense' (Gendlin, 1982) of it too, as Claire also described:

"You know it's there but it's almost there so obliquely in some ways ... you don't even realise it's there, you don't think about it, it's just understood, it's just something in your, I don't know, I suppose in your defence mechanisms that thinks, hmm, better be careful who knows about this"

Claire's reference to her defence mechanisms could be understood as an attempt to 'cover' herself psychologically, which illustrated Pines' (1990, p.1) description of the process of

experiencing shame, where we *“adapt to, and protect ourselves from, our outer and inner psychic environments, covering and uncovering ourselves”*. Claire's implicit experience of stigma was a powerful one, it posed a threat which she must defend against; it was threat of being shamed.

Andy also spoke of his implicit experience of stigma when he described it as existing *“under the surface”* and as a feeling of wanting to hide, for people not to see him walking in to *“that building”*. Andy's story in particular encapsulated the entanglement of stigma and of the complexity of his explicit and implicit experience. The implicit aspects only began to emerge later in his narrative as we delved deeper into his story. Initially, he located stigma as existing externally in films or in other people, but not in himself; *“I think it's all external, so I think the perception is in the other person, that something is wrong, not in me”*. Andy went as far as to say that that stigma was not really active in his life at all.

“I've never heard anyone really in my peer group say it's a bad thing, or anything against it ... or again in pop culture, on tv, or anywhere ... I can't remember sort of any negative side of it, being portrayed in that way.”

Despite the absence of stigma that Andy was describing, it was still something he felt implicitly, a feeling that was generated within him, of *something* being there. Whilst this apparent incongruence in his experience could be understood as reflecting the way he conceptualised stigma, it is also possible that his implicit experience was not immediately evident to him and only emerged through our inquiry. This implicit experience seemed to hold hidden meaning for Andy, and it was through our dialogue that this was *“brought to the surface”* (Ponterotto, 2005, p.129).

I considered the significance of an implicit 'felt sense' (Gendlin, 1982) in relation to my work as a therapist; how I encourage my clients' awareness of this level of experience, to connect with it and be curious about it. I too am guided by my own implicit experience as I tune into my countertransference and the latent content of clients' narratives, remaining open to that which is communicated unconsciously. The experience of stigma at this embodied level features infrequently in the existing research, presumably as it is so difficult to quantify, but it was at this level that stigma seemed so influential for the participants.

Consideration for therapists – Stigma presenting in the therapy room

A consideration here for therapists is the potential pervasiveness of stigma and how it may be experienced and present itself in therapy, both explicitly and implicitly. Before undertaking this research I gave relatively little thought to stigma when working with clients, despite grappling with my own experience of it throughout my training and personal therapy. I naively assumed that my experience would not be shared by others, as they had chosen to engage in therapy, rather than it being a requirement as it was for me.

I highlight the importance of therapists to remain curious and open to clients' experiences around stigma at an explicit level and to actively invite this into the therapy room. What does attending therapy mean to the client? Do others know they are attending? How did they respond? I also highlight the importance of therapists to remain vigilant to clients' experiences of stigma entering the room at an implicit embodied level as well, as it manifests as shame, especially as this is potentially heightened in the therapeutic encounter (Jacobs, 1996). The embodied 'felt sense' (Gendlin, 1982) of stigma and shame is not always immediately evident for clients and so it is the role of the therapist to help increase awareness through the tracking of sensations and emotions, using techniques such as those found within sensorimotor psychotherapy (Ogden et al., 2006). Therapists who regularly work with the body in this way might also remain open to experiences of stigma being part of this process.

The big red flag of certainty and the problem of uncertainty

Throughout the participants' narratives there was a strong sense of their ongoing struggle to position their experiences, and themselves, within the strict parameters they associated with mental health and help-seeking. At the same time, it seemed important for them to do so, to provide themselves with some certainty rather than having to tolerate the discomfort that came with uncertainty. This discomfort was not being sure if they *were* actually "*unhinged*" or "*really in trouble*", not being sure of *what* they were experiencing or how others might perceive this. Where they were positioned however, was not simply a decision they could make in isolation for themselves, as the influence and perspective of others was not only hugely influential but also unavoidable.

Across the narratives there was a shared perception that the external world viewed mental health issues as very clear cut; you were either 'ill' or you were not. As Claire explained, if you were *"mentally ill, it would be obvious"*, there would be *"visible symptoms"*, or as Sarah described, her family made the distinction between *"the nutters and the not nutters"*. These examples demonstrate how a person's mental health can be defined externally, by others, and with a great deal of certainty. There was no sense of ambiguity here, there was no uncertainty. Casement (1985, p.5) suggests that imposing such certainty is an attempt to lessen the anxiety of not knowing, he described how *"the unknown is treated as if it were already known"*, and can therefore be understood. In an unfamiliar situation, we look for elements that can be seen as familiar and are taken as signs, whether they are of security or of danger, just as Claire and Sarah described.

Furthermore, the participants also described how this degree of certainty about a person's mental health could be applied based simply on their attending therapy. Andy described how therapy could be seen as a *"big red flag"* that something is wrong, or as Claire described, therapy was associated with *"serious mental health issues like psychosis"*. This direct association that Andy and Claire described seemed to illustrate Link's (1987) proposal that therapy was seen as a behavioural cue linked to 'mental illness'. For Andy however, this association was not straight forward as it depended on the context; a person may attend therapy because they were having *"fucked up thoughts"*, or, because their parents were therapists and they had *"always seen that in a really positive light"*.

In highlighting these two possibilities, Andy is describing the potential for uncertainty, that there could be different explanations and motivations behind seeking therapy. This uncertainty brings discomfort for many people who experience anxiety as a result (Casement, 1985). There is a comfort that comes with certainty. It provides us with an understanding of the world, helping us locate ourselves within it and navigate our way through it. If we can be certain of *who* others are, we can either associate ourselves with them or differentiate ourselves from them, helping to create our identity through a sense of belonging (Tajfel et al., 1979). Andy's narrative described the anxiety that uncertainty can bring:

"If you say something like, I go to therapy regularly ... that fills up all that unknown [Chuckles], all that bunch of unknown space in their personality that you don't know about, and that could even go to a place of, I don't know if I want to be alone with that person, like what exactly are they experiencing?"

Certainty provided the participants with a degree of reassurance as none of them considered themselves to have “*serious mental health issues*” and did not appear concerned that anyone would see them this way either, so they were able to distance themselves from “*the nutters*”. At the same time however, this certainty raised a problem when they considered attending therapy themselves, they became uncertain as to how they might be perceived by the external world and how they experienced themselves in their internal worlds. Andy, for example, described how therapy clients could be seen as “*unattractive*”, for Claire they were considered to be “*less robust*” and “*flaky*”, and for Sarah, they were seen as “*weak*” and “*unable to cope*”. By attending therapy without having “*serious mental health issues*”, the participants were blurring the boundary between being ‘ill’ and being well, blurring the ‘us and them’ mentality that mental health seemed to generate. Therapy clients could be obviously unwell, but they could also be quietly suffering, and this meant there could be a bit of ‘them’ in all of ‘us’.

Claire considered herself to have been quietly suffering with her own mental health, but understood this as a general angst that we all experience at one time or another, rather than part of what she described as the “epidemic” amongst young people, whose quiet suffering was resulting in self-harm, eating disorders and even suicide. Despite differentiating her experience in this way, Claire knew she needed help and her story demonstrates the entanglement of stigma, between external and internal worlds, and between certainty and uncertainty. You could have visible signs of being ‘mentally ill’ and therefore needing therapy, but if there weren’t visible signs and you went to therapy, you were either ‘mentally ill’ but kept it hidden and were quietly suffering, or you were just weak and unstable. This ambiguity around clients presenting for therapy throws the doors of possible explanations wide open, removing the certainty that humans are drawn to. This ambiguity could account for the range of different reactions, beliefs and associations that the external world is perceived of holding in relation to those who seek therapy, and also the different ways in which these are internalised and impact at an individual subjective level.

Consideration for therapists – Assisting clients in tolerating uncertainty

The tendency for mental health to be seen as clear cut, that you are either ‘ill’ or ‘not ill’, highlights the importance of therapists to remain open and curious as to how clients conceptualise their mental health. Therapists can assist clients in beginning to challenge this black and white portrayal of mental health and instead begin to consider themselves as

“people with problems, not patients with illnesses” (Longdon and Read, 2017, p.24). This process can be facilitated with psychoeducation around the nature of psychological suffering, increasing understanding and normalising distress. Not only does this potentially reduce internalised stigma, as Longdon and Read (2017) proposed, but may also assist the client in developing self-compassion and greater connection, just as the participants had experienced, whilst simultaneously facilitating the therapeutic relationship and deeper psychological reflection. Therapists are also reminded to avoid making assumptions as to a client’s depth of suffering, holding in mind how ‘quietly’ this can take place.

Culture shaping the internal world

Whilst there were nuanced differences in the participants’ experiencing of stigma as they perceived it in the external world, they shared a relatively similar understanding of it. Where their narratives began to differ more significantly however, was how, by what means, and to what extent, these perceptions influenced and shaped their internal world. The participants’ narratives showed this to be a complex, intersubjective and multifaceted process which was influenced by their familial, social and cultural surroundings, which ultimately shaped their self-perception and subsequent behaviours. The three sections presented below discuss the participants in sequence, unpacking their subjective experiences which have shaped their internal worlds.

Andy – Pandora’s Box, Frasier and Fear

What was significant for Andy in navigating stigma to engage in therapy was his perceived distance from stigmatising views and his proximity to positive ones. Andy felt that stigma did not really feature in his everyday life or *“social sphere”*. He emphasised how his family had been *“super supportive”* of him attending therapy and how fortunate he was not to have to overcome the hurdle of telling them. Andy’s experience is consistent with Vogel et al.’s (2009) proposal that the views of those in our immediate social group were significantly more influential than those of wider society, which might be assumed to be due to the immediacy of the interpersonal dynamic exacerbating the experience of shame. Whilst shame is often

experienced as a great sense of aloneness, it is about social inclusion and acceptance, and where this is most important of course, is with those who are closest to us; reminding us that shame is relational in all its forms (De Young, 2015).

This feeling of support from Andy's family came despite his sister having had a negative experience of therapy, ending after one session, and his father having no intention of ever attending therapy himself, anticipating it to be like opening "*Pandora's Box*". I was curious as to what form this support took, what would it have been like for Andy to engage in therapy whilst at the same time knowing that his father had categorically ruled it out for himself. I imagined how this could easily have been experienced as shaming, that Andy may have experienced what De Young (2015, p.18) described as a "*felt sense of self-disintegrating in relation to a dysregulating other*", in this case, his father. I wondered if Andy's intellectualisation of therapy and his engagement in it may have been significant in addressing the sense of self-disintegration he might have felt. Whilst this is speculative, I also imagined how difficult it might be for Andy to disclose to me that his father's attitude was less than ideal.

Andy positioned himself in opposition to his father by taking up the "*challenge*" of therapy, rather than avoiding it. At the same time however, he also acknowledged that he too had a tendency to avoid his emotional experience, both inside and outside the therapy room; "*I don't really know why that is, I mean maybe it's just the way my head works, maybe I'm more of an engineer than I am a poet*". I wondered about the role of emotion within Andy's family, if, when and how it might be expressed, and whether Andy's assimilating himself to an engineer was an adaptive strategy to accommodate this (Berne, 1974).

Unsurprisingly perhaps, the nature of our interviews followed suit and I frequently felt myself being drawn into Andy's intellectual activity of conceptualising stigma rather than exploring the emotional experience of it. I wondered if this was influenced by the dynamic between us as two men, perhaps unconsciously seeking safer territory that aligned with more traditional gender roles. I have come to consider my pathway into psychotherapy as a form of subversion and have worked through reconceptualising my view of masculinity. Despite having negotiated this over many years, it is an ongoing process and I am aware of inadvertently, and sometimes intentionally, aligning with more traditional gender roles as part of a default protective measure. Researchers have repeatedly found that men are more reluctant to seek help than women (Topkaya, 2014; Gove, 1984) and that gender role conflict plays an integral part in this (Wahto & Swift, 2014; Vogel et al., 2011). I concluded that like me, Andy did not strictly conform to traditional gender roles, at least not sufficiently to deter him from seeking therapy as he made no reference to gender in relation to his

experience, but it was unavoidably there between us. Did I represent the supportive or opposing father? Or perhaps I represented an opportunity for twinship (Kohut, 1971), as someone who would be accepting and validating of his experience? Or was I perhaps, Frasier, from the U.S. TV sitcom, an idealised other (Kohut, 1971)?

The programme Frasier was hugely influential in shaping Andy's perception of therapy. It was centred on a psychiatrist who hosted a call-in show on a talk radio station, and it gave Andy a sense of therapy being for everyone; for those with low level problems as well as those who were "*unstable*". Sarah also referenced therapy as being commonplace in the U.S and generally less stigmatised than in the UK (Havis, 2018), and whilst this was a notable cultural difference for Andy and Sarah it is important to also consider this in a wider context. I wondered if 'low level problems' were perhaps only something that was afforded to white people, especially in the Western world, as we do not have to experience the systemic racism that black people endure. Furthermore, with black people having poorer experiences in therapy than white people, and more likely to be misunderstood by white professionals, the notion of therapy being for 'everyone' is undoubtedly a contested one (Kim et al., 2016; Meyer & Zane, 2013; Gara et al., 2012).

Andy was quite clear in defining the influential factors which shaped his view of therapy, and initially he was clear in identifying stigma as something that was located externally, that "*the perception is in the other person that something is wrong, not in me*". I wondered whether in the early stages of our conversations Andy was keen to locate stigma externally in order to distance himself from the 'bad object', and occupy a position of the 'good object', and consequently, the good participant (Klein et al., 1975). As we progressed however, and began to dig deeper into his experience, he described sharing this view, that attending therapy meant there was "*something wrong with you*". In naming this, Andy seemed a little uncomfortable and was quick to emphasise his dislike for thinking this way and how it conflicted with his beliefs and the positive view that he held of therapy. I wondered whether this was also indicative of ambivalence that he might hold towards his own engagement in therapy which he may still be grappling with but which was difficult to explore further, especially given my position as a therapist. I imagined the aliveness of stigma and shame between us reflected a parallel process that might occur between therapist and client, reflecting the co-constructed, mutually influential nature of relationship (Beebe & Lachmann, 2005).

Despite partially sharing the view that attending therapy was an indication that something was wrong, Andy did not consider this as him being impacted by stigma, he instead described being impacted by a fear of "*becoming someone different*". So rather than feeling

depressed or anxious being a temporary experience that he would pass through, it might actually be a permanent change in his mental state. Although Andy did not describe it this way, I wondered if his fear was of becoming one of ‘them’, a “*nutter*”, rather than being one of ‘us’, a “*not nutter*”? Or as Biddle et al. (2007, p.990) described, he would be crossing the “*threshold*” from “*normal*” to “*real distress*”, a move which was associated with permanence and with engagement in therapy. I also wondered if Andy was describing his fear of being seen as a “*nutter*” when he spoke of his discomfort when attending therapy, walking in to *that* building, how “*some part of you wants to hide and people not see that*”. At that moment, his fear and shame appeared to be very alive, the unease of which was also conveyed in the chuckle that accompanied his words.

Claire – Shame and the Northern Irish way

In contrast to Andy’s experience, Claire’s was more evidently steeped in shame. She had internalised the belief that if you were suffering psychologically, not only were you “*weak*” and “*flaky*” but you were also responsible for having caused your suffering in the first instance. This belief that problems “*were of your own making*”, was so deeply ingrained in Claire’s internal world that the shame it brought felt inescapable. To admit she was struggling psychologically meant she effectively became “*bad-me*” (De Young, 2015, p.27), believing that there was something fundamentally wrong with her.

Claire’s narrative conveyed a lack of sympathy for her suffering as well as feelings of responsibility for having caused it. In my earlier review of the literature I discussed Bathje and Pryor’s (2011) study which highlighted sympathy and responsibility as integral to the internalised experience of stigma, and identified intricate correlations that occurred between them. In my review I highlighted a number of questions that this raised for me; how are these intricate correlations actually experienced in real life? And why do some people feel they are responsible for their difficulties and struggle to feel sympathetic towards them, whilst others do not? In Claire’s narrative we begin to get a flavour of this experience and some answers to these questions.

Claire described how she located her beliefs as stemming from her family, but with awareness that they reflected “*the Northern Irish way of doing things*”, in that “*you just get on with it*”. Problems were there to be sorted out, not complained about, and you should just be grateful for what you have got. Claire described how this message had shaped her internal

world, becoming part of her life script (Berne, 1972); *“I basically carried that through my whole life.”* There was an intergenerational aspect here too, where the sense of hardship and focus on individual responsibility was passed down through generations. Claire referenced her parents as having *“harsh upbringings where there wouldn’t have been very much love or affection or time for talking”*, and she grew up with the message that *“your parents aren’t to blame for everything that’s happened in your life, for the way you’ve turned out”*, reinforcing the idea that problems were of her own making.

Claire is explicit here in her reference to the influence of her Northern Irish culture and how this defined the parameters on how mental health was conceptualised and managed. Her experience reflects the individualistic culture of the West where independence and self-sufficiency are emphasised (Shea and Yeh, 2008; Mojaverian et al., 2013), leaving her with no option but to address her struggles through personal resolve. There are also the cultural and historical implications of Claire and her family living in Northern Ireland and the impact of the ‘Troubles’ that overshadowed parts of the country for decades (McKittrick & McVea, 2012). Now living in the UK, I wondered as to the significance of this change in Claire’s environment and her later engagement in therapy. Given the depth of her ingrained beliefs, her physical distance from where they emanated may have reduced their potency and contributed to making therapy a conceivable option.

When meeting with Claire, I wondered how the differences between us influenced her narrative; I wondered who I might represent for her. At times I felt as though I was an available and accepting other, which enabled her to tell her story in confidence and without judgement. When conveying her early experiences there was a strong sense of how she had taken ownership of them, and as her story unfolded she connected more deeply with the emotion of it, there was a real sense of the anger that she felt which seemed to reflect the confusion and isolation that she experienced as a child. Her cry of *“why are we not told about this?”*, although rhetorical, felt as though it was also directed at me, and in that moment in the transference, I may have been the adult, the parent, who she felt should have been there for her earlier, with an empathic explanation.

During our interview, Claire spoke openly but with a confidence and directness, conveying a sense of her independence and self-sufficiency. She was single and chose to live alone, having secured a career that enabled her to do so financially, and she came across as being in control of her life and taking full responsibility for it. It was not difficult to envisage these traits and her situation as a natural progression of the messages she had received throughout her upbringing and which had shaped her internal world. Claire spoke of the absence of her father growing up and I wondered how this may have contributed to her and

her family's need for independence and self-sufficiency. Perhaps this was also reflected in her apparent distrust of others, especially in the workplace, when it came to considering disclosing her problems, which is something I will discuss later.

To return briefly to Bathje and Pryor's (2011) study and the questions I posed at the beginning of this section. Claire's narrative provides an invaluable contribution to the field, demonstrating the complexity of lived experience in contrast to the distinct and compartmentalised process suggested by Bathje and Pryor (2011). Claire's account gives a flavour of the all-consuming embodied experience of internalised stigma and the complexity of historical, cultural and familial influences that inform it.

Sarah – Indulgence, faith and the North South divide

Family was also influential in shaping Sarah's internal world and how she positioned herself in relation to the external world's view of mental health and help-seeking. Like Claire's experience, Sarah's was also grounded in shame but the message she received from her family was subtly, but significantly, different. It was not so much that you were responsible for your problems, but rather that they should be dealt with by turning to family, or by doing things for others. This positioned both therapy and Sarah, if she were to attend, as "*unacceptable*" and "*indulgent*", and consequently evoked deep feelings of shame.

Sarah's experience can be understood in terms of McLaren's (2010) notion of 'applied shame' which comes from the external world, and 'authentic shame' which comes from our internal world, helping us avoid violating our own and other people's boundaries. Being shamed by others impedes a healthy connection to our 'authentic shame', and instead, shame is 'applied' and we become "*coerced into embodying other people's ideas of right and wrong*" (McLaren's, 2010, p.201). I would argue however, that categorising shame into separate entities in this way can be misleading and overlook the complexity of experience that we begin to see in Sarah's narrative.

As Sarah was unable to attend therapy without being immersed in the shame of her "*indulgence*", the alternative, which was determined by her family, was to turn to others for support. However, this did not feel like an option for her as it would be going against what people perceived, and therefore expected, her to be.

“I felt that people saw me as a capable person, a sociable, happy, positive person. And I think I was very aware there were issues for me around being vulnerable ... I think it was about not being acceptable”.

Sarah seemed to be describing her *“false self”* (Winnicott, 1965, p.140), created from the need for compliance with others’ expectations. She explained in her own words how, at an unconscious level, she would be *“wanting the approval of others and worrying about people disapproving, on the basis of ... I’m asking for too much, I’m being self-indulgent, I’m asking for things that really I don’t deserve”*. Sarah was insightful as to her own process and felt that her fear of vulnerability and need for acceptance were connected to the loss of her father at an early age and how grief had been managed within the family.

Sarah’s experience demonstrates the depth, complexity and significance of stigma. And although it is something that impacts most, if not all of us, in some way, it is at the same time a uniquely subjective experience. In these short excerpts we get a glimpse of how Sarah’s relationship with stigma provides a window into her internal world and to a deeper level of her psychological process.

Another significant influencing factor in shaping Sarah’s internal world was her faith, through which she had made many of her closest friends, and which had been a *“great inspiration and support”* throughout her life. Sarah’s faith had informed her values and ethics as a woman, but she also stated how there had been *“issues with that whole way of thinking”*, as it emphasised the importance of supporting others to such a degree that it reinforced her struggle to acknowledge and accept her own needs. Sarah spoke hesitantly around her faith, acknowledging its importance and also its implications; there was a sense of it impeding the process that she later embarked on in therapy, to *“talk about the really dark spaces ... before being able to go into the light”*.

It was during our second interview that Sarah spoke about the impact of faith on her experiences of stigma, and shared some of the most personal aspects of her story. She described a particularly significant experience of feeling greater stigma around attending therapy than she did around attending a sexual health clinic, even though it was the latter that conflicted most with the way of life that her faith subscribed her to. To share such a personal experience, I felt was testament to the value of repeated interviews. I wondered whether this disclosure in the second interview was only possible because of the development of rapport and trust that we established in the first interview.

Sarah also highlighted the cultural differences between the North of England, where she grew up, and the South, where she now lived. She described how in the North, “*people have difficult lives*” with high levels of unemployment and deprivation, there just wasn’t the money to spend on therapy; this resulted in a “*just get on with it*” attitude. Now living in the South, Sarah wondered whether it was more financially viable and perhaps just more acceptable to turn to therapy here. There is a suggestion that this long standing discrepancy between the North and South of England, in terms of mental health treatment, has begun to change significantly over recent years. Just ten years ago, the North of England saw some of the highest prescribing rates for antidepressants in the UK (Easton, 2012), but in 2020 it had some of the highest numbers of people looking to engage in private therapy (Greedus, 2020). Whilst this may be encouraging, others would argue that the North-South divide is actually getting worse (Burton, 2021).

Participants and ethnicity

It is important to acknowledge the whiteness which encompasses the current study; Andy, Claire, Sarah and I, are all white and British or Northern Irish. As I discussed earlier in the literature review, our whiteness means that we have a very different and privileged experience compared to black people and those from ethnic minority groups. We do not have to endure systemic racism and ‘racial trauma’, and the increased risk this brings to our mental health (Comas-Díaz, 2019; Conner & Brown, 2014). As white people we are less likely to be diagnosed with a ‘mental disorder’ and more likely to be prescribed therapy than medication (Schwartz, 2014; Jaye, 2020). We are more likely to engage in therapy as we have better access to it, face fewer stigmas, and have a more satisfactory experience when we do (Conner & Brown, 2014; Han & Pong, 2015; Masuda & Boone, 2011; Khan, 2000; Dubreucq et al., 2021; Eylem et al., 2020; Kim et al., 2016; Meyer & Zane, 2013). As white people navigating our way into therapy, the participants and I do this from a position of privilege, as Khan (2000) suggests, therapy is currently failing people of colour.

Consideration for therapists – Stigma as the tip of the iceberg

The implication here for therapists is to consider a client's experience and relationship with stigma as being the tip of the iceberg, reflecting the wider context of familial, social and cultural influences. The participants' narratives demonstrate how these factors interact and combine to make stigma a highly complex and subjective experience. Therapists will benefit from considering stigma in relation to cultural difference; maintaining awareness, curiosity and openness to clients' sources of influence, as well as transgenerational factors.

Taking Sarah's experience as an example, if a therapist were to enquire as to how she felt about attending therapy, her response may be that it felt "*indulgent*", or that she had questioned whether it was "*acceptable*" for her to be doing so. These initial feelings associated with stigma are just the tip of the iceberg, reflecting her personal experiences, her family dynamic, cultural background and faith. When we consider Sarah's experience in this context we begin to appreciate how her experience of stigma reflects a much deeper level of her psychological process. In conceptualising stigma this way, therapists are afforded a nonintrusive area of enquiry around a client's thoughts and feelings towards engaging in therapy which may prove very insightful.

Outside of the current study, and across different cultures, numerous other factors may also be integral in shaping clients' views of mental health and help-seeking, such as race, gender, ableness and education, amongst others. Therapists' awareness of their own position, assumptions, biases and privilege is of course a fundamental and integral aspect to this process.

The rising crescendo and engaging in therapy

The participants' experiences discussed so far, demonstrate the entanglement of stigma, which can be understood as featuring both figure and ground (Joyce & Sills, 2018). Stigma resides in the background when perceived and conceptualised externally in the world around us, but begins to move to the fore when experienced subjectively as it influences our internal worlds. Where stigma really comes to the fore, however, is when we directly encounter the threat of exposure that it holds and we consider engaging in therapy? This process of

engagement was significant for each of the three participants and provides the second theme that emerged from the narratives. My discussion of this theme will be split into the following subsections: Therapy as **‘A need or a choice’**, which focuses on the participants’ process of internal negotiation in order to engage in therapy; **‘Entering the pit’** which explores the experience of therapy itself; and **‘The process of change’** which discusses perceived pivotal moments within it.

Stigma is usually researched in relation to its impact prior to entering therapy, in terms of negative attitudes and the barriers this imposes; almost suggesting that this is the only point at which it is relevant. However, as this section will demonstrate, stigma remains very much alive and relevant throughout the process of therapy and beyond, as suggested by Vogel et al. (2007, 2009). My own experience is also testament to this, as having completed the four years of compulsory therapy required for my training, I have not engaged in therapy since. Over the past year, living through the pandemic and sharing the struggles that many others have faced, I have turned once again to personal therapy for support. Even with my previous experience as a client, I was surprised to discover the conflict that this gave rise to within me. Re-engaging in therapy was in the back of my mind for many months as I contemplated what this would mean for me, and with it came a growing sense of shame; that I was failing in my role as therapist to not be able to manage my own struggles whilst attempting to support others with theirs. As I recall this process, I am reminded of Andy’s powerful description of his experiencing mental suffering as a *“rising crescendo”* that continues to build, but never break, which ultimately led him to engage in therapy; an experience which resonated with my own.

My knowledge of the field of psychotherapy means I am able to follow my preferences when looking to engage in therapy, but for many others this is not so easy. I always feel for individuals attempting to reach out for support for the first time, trying to make sense of the swathes of therapists and acronyms that accompany them. There are hundreds of therapies available and various ways to access them, and knowledge of these provides the opportunity to follow any preferences individuals may have, which has been shown to significantly increase the efficacy of therapy (Norcross & Cooper, 2021). Stigma plays a part here too, as Sarah identified feeling that different therapies had different stigmas attached, making the distinction between psychoanalytic therapy and CBT. She considered CBT to be viewed as *“forward thinking”*, a way of getting things *“sorted out”*, and was therefore less indulgent and more acceptable than psychoanalytic therapy which consisted of *“lying on a couch ... talking forever about your problems”*.

Sarah also described how this same feeling of indulgence made the prospect of engaging in couples therapy feel more acceptable than if she were to re-engaging in individual therapy. There was a sense that couples therapy was for the good of her relationship and for the family as a whole, rather than the individual indulgence of personal therapy. These perceptions not only demonstrate how difficult it is for Sarah to acknowledge and be accepting of her needs, but also the value for a therapist to be able to offer a flexible approach which can accommodate client preferences, or at least be able to explore them.

A need or a choice

The way in which participants approached and conceptualised therapy at the time of their engagement appeared to be very significant in shaping their internal experience of stigma, specifically in terms of whether therapy felt like a need or a choice. In individualistic cultures, such as the UK, independence, self-sufficiency, autonomy and agency are often promoted and aspired to; to be self-determining beings in control of our own destinies. Seeking psychological help initially appears to directly contrast with this, as in that moment there is a suggestion that we are dependent on the other, lacking sufficient resources to support ourselves and unable to control and direct our lives in the way we want to. As Claire described:

“I just couldn’t seem to find a way to get myself out of it and it was really messing with my head, not being in control of myself, thinking, that’s what I want to do, I don’t want this, that’s the action I want to take, I want to break away from this, but I can’t, and I just couldn’t understand it, I could not get my head around the fact that I couldn’t do what I wanted to do.”

Claire was describing her desire for a sense of control and autonomy, and this was accompanied with feelings of shame when she felt she had to reach for support. Claire’s experience seemed to reflect a conflict occurring within her emotion-regulation system that Gilbert (2019) identified as underpinning human motivation; that of self-protection and of soothing and contentment. The drive to protect ourselves from exposing our vulnerabilities

and perceived failings means that soothing cannot be easily obtained from an other, in the form of therapy.

Whilst this conflict is likely to persist for anyone who experiences stigma, what seems to influence this process is the way in which therapy is perceived by the individual and also their self-state (Bromberg, 1996) at the time they are seeking it. What emerged as significant in Andy's experience was whether his engagement in therapy felt like a need, or a choice that he was making for himself. Andy described the first occasion that he sought therapy:

"I felt like I was kind of in trouble, like I needed help from someone ... I was so depressed and down that I couldn't approach life in a normal way. I didn't really know how to cope with that."

Andy equated his feeling of need with *"admitting that something was wrong"*, mirroring what Erskine (1995, p.113) described as the life script so often associated with shame, that *"something's wrong with me"*. Claire described a similar experience; *"I just felt I really needed to get some help ... and just didn't seem to be able to do it for myself"*; this left her feeling embarrassed and ashamed, asking herself, *"what's wrong with me?"*.

When Andy engaged in therapy on the second occasion, it was under very different circumstances. He was making an active choice for himself, explaining; *"I don't need it, but it's something that I really want to add to my life"*; on this occasion he was looking forward to it. Where Andy's first experience of engaging in therapy could be understood in terms of the 'cycle of avoidance' proposed by Biddle et al. (2007, p.990), where his need for help saw him cross the threshold from *"normal"* to *"real distress"*, on this second occasion he was crossing the threshold voluntarily. Engaging in therapy in this context resulted in a very different experience for Andy; the shame, feelings of helplessness and the sense that something was wrong were much less active, if at all. Andy had reframed therapy as an *"intellectual activity"*, one which he was choosing to undertake. The use of reframing in this way, to avoid stigma, was also described by Farrimond (2011, p.1), where men reframed help-seeking behaviour to align with an *"action man"* persona rather than the outdated *"Neanderthal man"*, who they associated with avoidance behaviours. Similarly, Prior (2011, p.697) reported how young people adopted a position of *"problem-solver"* in order to avoid stigmatising discourse.

On the first occasion Sarah entered therapy she did not reframe it to avoid stigma, nor did she describe it as something that she needed to do, it was an active and purposeful choice that she made. She was at a “*decision point*” in her life regarding relationships and chose to address the longstanding issues she had faced. Whilst for Andy, positioning therapy as a choice rather than a need was instrumental in alleviating his feeling of shame, for Sarah, this was not the case. Her feelings of shame, of indulgence and unacceptability, remained present and powerful. I wondered if the persistence of such strong feelings could be understood in terms of the “*emotional core*”, the “*affective nature of the psyche*” (West, 2004, p.521), which influences our relationship to reality and our emotional attachment to others.

The second occasion that Sarah entered therapy it was a requirement for her training course, and under these circumstances it felt much easier to engage.

“I thought it would only be acceptable as something that I had to do, I’d been told I had to do ... I wasn’t doing it just because of the self-indulgence, and it wasn’t because I was in such a terrible state that I’d had to take it up”.

Sarah’s experience resonated with my own, as I too was able to sidestep this process of having to navigate stigma before engaging in therapy, I was able to hide behind the requirement. I don’t feel I would have entered therapy otherwise, as even now I’m aware of the conflict inside me as I look to restart sessions. I have undergone a process of reframing therapy as something I can use that helps me to engage in life in its fullness, to connect with myself and with others. The overriding factor is that I feel I owe this to my clients, which of course continues to position it in my mind as a *requirement* rather than my *need*.

Consideration for therapists – Reframing and empowering

The way that therapy is positioned in wider society has a large part to play in influencing whether people perceive it as being a need or a choice. The significance of reframing and empowering are supported, to a degree, by the experiences of the participants in this study, with Andy’s experience in particular demonstrating this process. From his initial experience of therapy being a something he “*needed*”, Andy later reframed this as an “*intellectual*

activity”, a “*challenge*” that he was prepared to take on. This process of reframing resulted in a sense of empowerment, a feeling of taking control and making a purposeful choice.

As I mentioned earlier, the strategies of reframing, empowerment and normalising are widely reported to be effective in reducing the experience of stigma surrounding mental health (Corrigan & Calabrese, 2005; Corrigan, 2004; Rosen, 2003) and help-seeking (Vogel & Wade, 2009). The implication here for therapists is that they also have the opportunity to introduce or reinforce this process once therapy has begun. I often discuss with clients their perception of strength and weakness in relation to their emotional and psychological experience and emphasise the courage required to engage in therapy and attempt to instil a sense of ownership over the process; to borrow Sarah’s words, “*there is strength in vulnerability*”.

Entering the pit

Therapy can provide tremendous support, it can be insightful, empowering and life changing, but it can also be an incredibly challenging process. Sarah described part of her experience of therapy as feeling as though she had “*entered a pit*” that she might never come out of. How people engage with and experience therapy is highly subjective and the participants’ narratives reflect this. Previous research has shown that those who enter therapy with higher levels of stigma are less likely to comply with therapeutic interventions (Fung et al., 2007), are more likely to miss appointments (Vega et al., 2010), and are more prone to early termination of sessions (Sirey et al., 2001). Andy, Claire and Sarah’s experiences all showed a different picture as they either completed the maximum number of sessions available to them, if these were time limited, or remained in therapy for approximately a year. Vogel and Wade (2009) suggested that people’s concerns about help-seeking do not automatically disappear when they engage in therapy and that they continue to evaluate their decision after sessions have begun, and it is this suggestion that will be the focus of this section.

Claire’s concerns about engaging in therapy dissipated quickly once she began sessions, primarily due to feeling that she was not being judged by the therapist; “*after a few sessions I definitely started to feel a relief, from, I suppose, being able to just talk to somebody who I knew wasn’t judging me in anyway whatsoever*”. Claire seemed to experience what Rogers (1957) described as ‘unconditional positive regard’, one of the core conditions for therapeutic change, and it was this feeling of nonjudgement that provided instant relief and quashed

many of her deeply held fears and associated shame. It was interesting to hear Claire speak of the significance of nonjudgement, something which neither Andy nor Sarah made reference to. I understood this to echo the ingrained message from within her family, that problems “*were of your own making*” and not something to complain about but to get on with. There was a strong sense of Claire’s self-awareness and ownership of her vulnerability as she shared her experiences with me, I hope in part at least, due to my provision of this same acceptance and nonjudgement that had been so significant for her.

For Andy, a significant factor relating to stigma during the process of therapy, was not about the process or the relationship itself, or about disclosing his feelings or worries, it was about being seen walking into the building; “*I didn’t feel like a steady drop off of stigma ... there was still something different about walking into that building ... that some part of you wants to hide and people not see that.*” No matter how positive his view or personal experience of therapy was, Andy remained acutely aware of how he might be perceived by others. All the negative judgements and beliefs that he associated with the external world were experienced in that moment, walking into that building. Andy’s experience often seemed contradictory, claiming at times that he did not feel stigma, but also describing moments such as this, where he was aware of becoming self-conscious but stopped short of connecting with his emotional experience of it. His wanting to hide was again reflecting the need to cover ourselves in order to maintain a sense of safety and avoid feelings of shame (Pines, 1990). I considered this contradiction to be a reflection of Andy’s ambivalence around his experience of stigma and also the mixed messages from within his family; supporting one another and the process of therapy whilst also seeming to avoid emotional experience. Andy’s perception of himself as an engineer rather than a poet, and of therapy as an intellectual activity, suggests the use of what McWilliams (2020) described as the higher order defensive process of intellectualisation, in order to isolate affect from intellect as a means of coping. This was also reflected in our interviews, where we had a tendency to grapple intellectually rather than emotionally, with the experience of stigma.

I am aware of how aspects of Andy’s experience, parallel my own, both historically and currently, whilst I am writing. There is a sense of my own ambivalence at times as I strive to remain visible in the study, acknowledging my own process, rather than stepping back and trying to engage intellectually, from a distance. I’m aware of the tension I feel in holding both intellect and affect together and I’m required to regularly *check in* to ensure I maintain this balance.

Sarah's experience was different again. The first occasion that she engaged in therapy, was in accordance with Vogel and Wade's (2009) suggestion that concerns around engaging may actually intensify once sessions had begun. Sarah had navigated her way through her feelings of indulgence and engaged in therapy, but as her sessions progressed she felt things begin to unravel as she started connecting with deeper parts of her experience. She started to feel that she was *"in trouble"*; *"I started thinking, maybe I am really disturbed ... I felt that I was struggling, but it made it even more, just all of those sort of societal kind of stigmas, I was sort of buying into them a little bit"*. At this moment Sarah's external and internal worlds were colliding, becoming increasingly entangled. She experienced her internal world of indulgence, unacceptability and shame, colliding with her perception of the external world view that she had *"really big problems"* and needed to be in therapy. She described feeling as though she had entered a dark pit and was unsure if she would ever find a way out; it took the skill of her second therapist to help her do this. When she did emerge, her self-perception, at least in terms of being in trouble, had abated, but she was left with feeling that therapy remained an indulgence, if she were ever to re-engage again.

Sarah's depictions of entering the *"dark spaces"* in the pit were metaphorical and psychological. They spoke to the loneliness and isolation of her experience in relation to stigma but also at a much deeper level. When Sarah was describing the response she anticipated from her family if she told them she was having therapy, she became upset and tearful; *"I think what I'm feeling at the moment is quite how, well just how lonely that felt. And not being able to share a part of my experience or a part of myself."* In this moment, there was a sense of the loneliness that Sarah had touched upon in relation to losing her father at an early age and the *"sense of abandonment"* she experienced; *"not really knowing where I was"*. There was again a parallel between Sarah's experience of stigma and what was happening for her at a much deeper level of her psychological process.

The process of change

All three participants suggested that their perception of stigma that existed in the external world remained largely unchanged following their engagement in therapy, as Claire stated, *"it remains in their heads"*. Claire and Sarah did however, describe feeling that things were gradually improving over time, that there was greater understanding and acceptance of mental health issues and of seeking therapy. This was attributed to an increase in media

coverage and of high profile figures opening up and publicly sharing their own experiences, as Claire described; *“it’s more out there in the public consciousness”*. There has undoubtedly been an increase in visibility, awareness and conversations around mental health issues over the last few years, such as the Heads Up campaign that Claire and Sarah made reference to (HeadsTogether, 2021), as well as new campaigns launched this year in response to the Covid-19 pandemic, such as Every Mind Matters (2021),

Where significant change did occur however, was in the participants’ relationship with stigma in their internal worlds. The process of change in psychotherapy is uncertain but undoubtedly complex. I understand this process as involving what the Boston Change Process Study Group (BCPSG) (2010, p.30/31) described as *“something more”* than language based knowing; the *something more* being *“Implicit relational knowing”*, which involves procedural representations of interactions with others which are affective and interactive, as well as cognitive. This process was indeed evident in the participants’ experiences of change in relation to stigma, but in very different ways, suggesting once again the complexity and subjectivity of stigma that this study has sought to demonstrate.

For Andy, there was no *“sea change”* moment in therapy, but he experienced a more gradual change over time. He encapsulated this change as a shift in the notion of there being *“something wrong”*, to there being *“something he would like to change”*. This shift reflected work that he had done in therapy around developing self-acceptance and self-compassion, and although speculative, one can imagine this would have occurred intersubjectively between Andy and his therapist, and would have consisted of affective interaction as well as cognition, as BCPSG (2010) had suggested. Whilst I understood this shift to reflect a significant change in how stigma shaped Andy’s internal world, for Andy, this felt like a digression from stigma, which remained firmly located externally rather than internally. I was reminded of Bathje and Pryor’s (2011) research which proposed that sympathy for one’s difficulties correlated with lower ‘self-stigma’, and it seemed as though Andy had developed some of this, which may have accounted for his decision to be more open about his engaging in therapy, on this second occasion.

Andy’s ambivalence remained apparent, as although the shift in his internal world felt like a digression, he remained aware that he still felt impacted by stigma. The result of this impact was a hesitancy to share his experiences of therapy despite wanting to encourage others to engage, believing it would be *“super positive for almost everyone”*. His hesitancy was due to fear of negatively impacting the social dynamic with his peers, that they might act differently towards him. He could understand why they might, because somewhere deep down he knew he would probably do the same.

For Claire, the process of therapy completely changed her relationship with stigma and her perception of herself and her suffering; *“it totally turned my whole head around”*. She no longer considered herself flaky or weak to have had therapy, in fact she was proud to have done so. This change could also be seen as reflecting the correlation identified by Corrigan (2004) between empowerment and the diminishing experience of stigma. What was integral to this process was the book that Claire had been recommended by her therapist, as it provided invaluable insight and understanding into what she was experiencing. She had learned the physiology behind her suffering and begun to view her brain as an operating system, making her realise that *“this isn’t me, there isn’t something wrong with me, this is just a natural process that’s happening in my body and there’s a reason why it’s happening”*. Claire’s new understanding eradicated the blame and shame that had dominated her experience and provided a great sense of relief, enabling her to normalise her distress and to cope better as a consequence.

This significant shift that Claire experienced seemed to encapsulate the same shift that Longdon and Read (2017, p.24) proposed is most effective in reducing stigma, which is framing individuals as *“people with problems, not patients with illnesses”*. Viewing suffering through this lens provides an instant leveller; it is not about us and them, or *“nutters”* and *“not nutters”*, but instead conceptualises mental suffering through a “continuum model” (Longdon & Read 2017, p.27) that involves us all. Claire’s experience also highlights the importance of well-placed, relationally delivered psychoeducation within therapy and just how transformative this can be. Psychoeducation has been shown to positively impact attitudes towards mental health and help-seeking (Gonzalez et al., 2002), as well as assisting clients with a range of presentations (See for example Srivastava & Panday, 2016; Colom & Lam, 2005) and can be affectively integrated across different therapies (Busch & Auchincloss, 2018).

Claire also highlighted the significant role played by her therapist in conjunction with the psychoeducation acquired through the book. There was a sense of how the therapeutic relationship was central in facilitating her understanding.

“It would have taught me something but I don’t think it would have been the same because I wouldn’t have had the follow up conversations and been able to, you know, whatever I’d read in the past week, or whatever, come back and sort of apply it to myself and think, well you know, I can see what’s happening with me now”.

These therapeutic interactions provided deeper reflection and processing of experience, akin to what Stern et al. (1998, p.300) called a *“moment of meeting”*. These moments are integral to the BCPSG’s (2010) theory of change, which updates self-regulating abilities (Beebe and Lachmann, 2005) as well as expanding consciousness to a more coherent and complex state (Tronick et al., 1998); processes which can be seen reflected in Claire’s account.

Sarah’s experience of change also seemed to reflect the notion of *“implicit relational knowing”* (BCPSG, 2010, p.30), as she had described the skill of her therapist in guiding her through the *“really dark spaces ... before being able to go into the light”*. What struck me most about Sarah’s experience was how it compared and contrasted with Claire’s. Initially, they appeared to be similar in many ways, they described similar influencing factors in terms of family, geographical and generational considerations, as well as similar beliefs around public and personal perceptions of mental health and help-seeking. Where they began to differ, was in the evolution of their self-perception during therapy; Claire’s feelings of blame and shame were removed and replaced by anger at the injustice of information not having been shared, whilst Sarah’s self-perception had worsened during therapy and upon completion, had ended up back where she had begun, with her questions around acceptability and her feelings of indulgence.

Claire and Sarah’s contrasting experiences emphasise the subjective nature of stigma, despite its universality, and also suggests that the experiencing of stigma has its foundations at a much deeper level of psychological organisation. This is not perhaps surprising given the breadth and depth of influences the participants identified, and which is also reflected in their contemplation of re-engaging in therapy in the future.

Andy and Claire had both expressed an interest in re-engaging in therapy at some point, feeling as though they would benefit from it; however, both considered it to be a *“luxury”*. For Sarah, the prospect of re-engaging was more complex and required considerable justification if she were to do so. She was aware that stigma was still at play and there was an element of wanting to prove to herself that she can manage without it, to satisfy the thoughts of, *“you should be able to be strong, you should be able to manage”*. Aware of this, she had told herself *“if you want it, just have it”*; the ongoing internal struggle was still very much alive.

Consideration for therapists – The therapeutic relationship, acceptance and attunement

Therapists are well aware of the therapeutic relationship being the most significant common factor in determining the effectiveness of therapy (Asay & Lambert, 2010), and the experiences of the participants in this study provide further support for this. Acceptance, nonjudgement and attunement (Stern, 2005) were all integral to the participants' therapeutic experience. Andy developed greater self-compassion and self-acceptance, which saw a fundamental shift away from his stigmatising view of "*something wrong*", to the empathic view of there being "*something he would like to change*". Nonjudgement from her therapist meant that Claire's concerns about attending soon dissipated, and Sarah also highlighted the importance of having her therapist alongside her as she went to the "*really dark spaces*" where she knew she needed to go. We are reminded then as therapists, of the value of adopting an authentic position (Rowan, 2002), focusing on 'being with' clients, not 'doing to' them; as Buber (1923/1958, p.11) reminds us, "the Thou meets me through grace, it is not found in seeking". We are also reminded of the potential value for clients in receiving appropriate and relationally delivered psychoeducation and how transformative understanding and normalising of experience can be.

A dirty little secret - the dilemma of disclosure and the need for connection

Throughout each of the narratives, disclosure of attending therapy emerged as a significant part of the experience of stigma. The participants had all chosen to disclose at one time or another, for different reasons, but it was clear from their descriptions that they all felt a risk in doing so. Malcolm Pines (1990, p.1) described how we cover and uncover ourselves both physically and psychologically, as part of the "*powerful human rhythm of movement between openness and concealment*". Andy, Claire and Sarah's narratives seemed to reflect this movement, and tension, between openness and concealment; between connection and safety. Stigma threatens both of these; it threatens to expose our failings, both intersubjectively and intrapsychically. Humans are however, wired to connect (Lieberman, 2014), and the deeper connection to self and other that may be found within the therapeutic setting also provides a representation of future possibilities beyond this dyad (Gabbard,

2017). The desire for continued psychological connection and growth is reflected in the subsequent dilemma which clients face, the dilemma of disclosure; if, when and with whom do they disclose? Or, does it remain, as Sarah described, a “*dirty little secret?*” In this section I will discuss the participants in sequence, starting with **Andy**, then **Claire** and finally, **Sarah**, unpacking their subjective experience of this dilemma and how they navigated it.

Whilst this process of managing potentially stigmatising information may not be surprising, it is important to acknowledge that the participants’ experiences are culturally specific. Riessman (2000, p.113) highlights that the assumption that an individual is self-determining, that they have choices and privacy available to them, is a “*product of Western thought*”, and that these luxuries are not necessarily available in other cultures. The dilemma of disclosure would be very different, for example, in South Asian cultures where ‘mental illness’ is more likely to be attributed to a character defect (Mokkarala et al., 2015), or in Latin American cultures where depression is sometimes associated with having a lack of faith (Caplan, 2019). Furthermore, collectivist cultures found in the Eastern world emphasise interdependence and social harmony, where individuals tend to look within the group for support rather than outside of it (Shea and Yeh, 2008; Mojaverian et al., 2013), to disclose attending therapy in these cultures may suggest failure or inadequacy in the family’s support, bringing disgrace and a “*loss of face*” (Zane & Yeh, 2002, p.123).

Andy – “Socially awkward”

Disclosure was central to Andy’s experience of stigma; “*I think where stigma really comes in, is who I would be open with, about doing therapy, and that’s definitely not completely open, like it’s not something I would announce that I was doing.*” Andy’s concern was that by disclosing, he would make things “*socially awkward*”. He would be introducing uncertainty into his relationships and making people feel that he needed to be treated with “*kid gloves*”. There was an indication here again, that attending therapy represented a fragility, that both Andy and the situation would need to be handled with care, and I was reminded of Claire and Sarah’s words, that therapy clients were seen as “*weak*”, “*flaky*”, and as less “*robust*”. This suggestion can again be understood as representing the wider cultural and political emphasis of Western societies, where the focus is on independence, strength and resilience, and how these traits should be developed and prioritised.

Andy went on to describe how in society, interactions were governed by a mutually understood “*social contract*” which determined acceptable responses and reactions to people and situations. By disclosing that you were seeing a therapist, you would introduce an element of uncertainty and the possibility that you were unstable. For Andy, this would mean that the social contract “*goes out the window*”, and would leave people wondering “*how to treat that person?*” or whether they might “*fly off the handle*”. It is this uncertainty however, that Becker and Shalgi (2013) argue, needs to be ‘surrendered to’ in order to facilitate growth and change, both intrapsychically and interpersonally. This process of surrender involves letting go, momentarily, of one’s own sense of self, to break free from the rigidity of certainty, of the social contract that Andy spoke of, and to truly be seen by others. It was Andy’s desire for a more authentic, deeper connection with those closest to him that led him to disclose his attending therapy to them, surrendering in the process. This process of psychological surrender was taken from Ghent’s (1990) work, where he made the distinction between surrender and submission. In this context, surrender is not *giving in* to someone, but *letting go* to be with them.

Andy’s openness however, was polarised. At one end, he shared his experience with those closest to him by way of deepening connection, and because he felt there was minimal chance of the relationship becoming socially awkward; they knew him too well for that to happen. I imagined the social awkwardness that Andy referred to, and was so keen to avoid, as resembling the I-It relationship described by Buber (1923/1958), where a ‘genuine meeting’ between two people gives way to objectification. Andy had described how looking at a dating profile of someone who shared that they were in therapy would alter the lens through which he viewed them, looking out for anything that could be seen as “*unhinged*”. Whilst Buber (1923/1958) suggested that any interaction would consist of both I-Thou and I-It relationships, it becomes problematic when the I-It relationship dominates, which was exactly what Andy feared most; the awkwardness persisting. At the other pole, Andy was also open to sharing his experience with those he knew little of, as there was no relationship as such that could be impacted; he would not be jeopardising any sense of connection. I considered his openness in sharing his experience with me as being a direct reflection of this.

I imagine Andy viewed our meeting as an “*intellectual activity*”, which was how he had viewed therapy, the second time around, and which had made disclosing his engagement significantly easier. I wondered if by approaching therapy and our meeting in this way, Andy provided himself with a freeing ‘psychological buffer’ between his sense of self and his narrative; or as Benjamin (2004) might describe it, an intersubjective space created by surrender. Whilst Becker and Shalgi’s (2013, p.427) notion of surrender also applies

intersubjectively, where, in order to harness its full growth potential, an encounter *“must include the movement between finding each other and losing each other”*, I am drawn instead to Benjamin’s (2004, p.7) notion of an intersubjective space of *“thirdness”*. This thirdness relates to an *“internal mental space”* that is shared by both the self and other, and which is created when both surrender to it. I find this space of thirdness resonates with the feeling of space that was created between Andy and me, which was used to co-create his narrative that emerged from it.

This space within our meeting was seemingly also in Andy’s second experience of therapy, but was perhaps absent from his first. Rather than his first experience being an *“intellectual activity”*, where he was *“an agent helping to shape a co-created reality”* (Benjamin, 2004, p.9), he was instead in a position where he really *“needed help”*. I find Benjamin’s (2004, p.9) view of intersubjectivity helpful again here in understanding how Andy’s feeling of *need* did not allow for a space of thirdness, but instead created a position of *“twoness”*, or *“complementarity”*. In this position, the lack of a shared mental space results in a feeling of being either the *“do-er”*, in this case, Andy’s therapist, or the *“done to”*, in this case, Andy. Feeling ‘done-to’ is perhaps why, on this first occasion, disclosure beyond his immediate family felt completely out of the question.

When describing his process of navigating disclosure, Andy made the distinction between it being cathartic, where he was *“itching to say it”*, and charitable, where he got to experience a *“glow of altruism”*. Andy saw the latter as an opportunity to convey therapy positively and to encourage others to consider it as a viable option; he associated this outlook as being one that came with maturity and a wider perspective on things. By engaging in a conversation about attending therapy he was able to avoid any misunderstandings or people jumping to their own conclusions; he was able to reassure them he wasn’t *“unhinged”*. This again shows Andy’s desire to open an intersubjective space of thirdness, to build connection and as an opportunity for growth, and to avoid a position of ‘complementarity’ and a feeling of being ‘done to’ (Benjamin, 2004).

Andy made a number of comments, like those above, throughout his narrative which reflected his underlying concern of negatively impacting his relationships by changing the way people saw him. I also wondered if his desire for others to attend therapy was a way of potentially continuing to minimise this possibility and also indicative of a desire for twinship (Kohut, 1971); a search for solidarity and continued connection.

Claire – Confidentiality and connection

Not only was confidentiality a key consideration in Claire's process of engaging in therapy in the first instance, it was also prominent in her subsequent disclosure of it. Claire would not have dreamed of accessing therapy via her GP as she would not want it on her medical record, fearing this would affect her medical insurance or her access to a loan in the future. This same reluctance also applied to counselling schemes that were offered through her workplace, she worried who might have access to that information and how it might be used against her. Claire felt very strongly that any psychological suffering "*certainly wouldn't have been appreciated in the workplace*". The stories of her friend's experiences, and her own impressions, made her very apprehensive; turning to colleagues, managers or human resources could quite possibly do more harm than good. The importance of ensuring confidentiality imposed a constraining rigidity on Claire, limiting her opportunity for connection, both with herself, in terms of her emotional experience and vulnerability, and also with others. In the earlier literature review I referenced the role that power plays in the experiencing of stigma and Claire's concerns around confidentiality seem to illustrate this. If attending therapy was "*on her record*", she feared this would result in a loss of power, that she would be handing this to others, whether that be insurers, managers or colleagues. Seeking therapy privately, meant that she was able to maintain the existing balance of power within her workplace.

For Claire, and Sarah, when they did disclose attending therapy, the main positive that came from doing so was a deepening of their relationships; a feeling of greater connection through the sharing of experience. Claire felt relief to hear of others' suffering, realising she had not been alone, but also felt great sadness too, knowing that they and presumably many others had also been through this. Claire was also motivated to disclose in the hope that it might encourage others to attend therapy, that it could be as beneficial to them as it had been for her. She felt strongly about this, knowing that this would have encouraged her to seek help sooner if someone had done the same for her. Claire's strength of feeling seemingly reflecting the desire she felt throughout her life to connect with others, and also the difficulty of doing so when she felt like an "*outsider*".

As Claire began to disclose that she had engaged in therapy, she described a reciprocal process; "*the more people that I opened up to, the more they opened up to me*". In the same way that Benjamin (2004) had emphasised that it was the role of the therapist to *go first*, to surrender to the intersubjective space of thirdness, Claire too was *going first*, surrendering to her vulnerability in order to foster the deeper connection that followed. This was not always

straightforward, however. When Claire disclosed to her mother that she was attending therapy, her initial reaction was that it was a waste of money and that the therapist would tell her it was all her parents' fault. Fortunately, Claire's understanding of her struggles and associated fears had completely turned around by this point so she was not deterred by her mother's response. Her persistence with opening up this conversation did eventually pay off, and they moved from a position of complementarity to one of shared thirdness (Benjamin, 2004) where they were able to talk about both their childhoods and discover that they had shared many similar feelings. This was a very positive experience for Claire and one which brought a deeper sense of connection, healing and growth.

Sarah – Vulnerability and relationships

Sarah's openness around attending therapy was greatly facilitated when it was a requirement of her training course. Despite knowing that she probably needed it and would benefit from it, attending only felt acceptable when she was told she *had* to; it was no longer "*an indulgence*". The unacceptability of therapy, as viewed by her family, was internalised to such an extent that by engaging in it, Sarah felt that she herself would be unacceptable. This was combined with a great sense of guilt, as the message from within her family was that you turn to each other for support, by engaging in therapy, Sarah would be conveying that actually, her family were not enough.

I considered Sarah's, and Claire's, experiencing of stigma that was conveyed and permeated through their family systems as representative of a psychological defense. Taking McWilliams' (2020) definition of defense as the unconscious avoidance or management of a powerful or threatening feeling, and or, the maintenance of self-esteem, the suggestion of the family unit *not* being enough would certainly be something it would want to defend against. Sarah found herself conflicted between maintaining the family's sense of cohesiveness and her need to alleviate her own mental suffering.

There was an additional facilitating factor in Sarah's openness that built upon the foundation of it already being a requirement for her, and that was when her son was going through a very difficult time. Sarah was incredibly worried for him and it felt like things were falling to pieces. It was at that point that any pretence she had about being okay went out the window, she felt she "*had no choice but to be more open*". In this instance, Sarah's desire for concealment was unsustainable and she was forced to disclose. Despite the struggle of this,

it ultimately came with a sense of relief as it enabled her to connect with others rather than “*fall to pieces*”. I understood Sarah to be experiencing the process of managing shame by “*covering and uncovering*” herself, as Pines (1990, p.1) had described, in order to maintain “*equilibrium of safety and coherency in ever changing social and personal worlds*”.

Like Claire, Sarah also began to discuss her experience of therapy with her mother, who initially had a similar reaction to Claire’s; she was worried that she would be told of all the things that she had done wrong. Many clients that I have worked with are often hesitant or averse to directing blame towards their parents for difficulties that they are facing; and this is indeed a tendency often found within psychological theory. I usually adopt a position of attempting to reframe our parent’s influence on our lives as part of a wider intergenerational web in which we, and preceding generations, are caught up in. Both Sarah and Claire’s experiences reflect this initial hesitancy and also how, through persistence, understanding and empathy, it can be navigated.

Neither Sarah nor Claire denied that the attitudes and beliefs within their families were an integral part of shaping their experience, but they also acknowledged that it was not the only factor. Andy’s experience is also testament to this, as even with the very different message that was conveyed within his family, his negative experiences of stigma remained. Sarah described the conversations that she went on to have with her mother as very “*healing*”, especially the great sense of relief that she felt, knowing that it didn’t “*damage*” her to find out that she had been struggling so much, and that it didn’t colour her view of her in any negative way. Just as with Claire’s experience, it was seemingly through a shared space of thirdness that Sarah and her mother had found deeper connection, healing and growth (Benjamin, 2004).

For Sarah, vulnerability had become an important aspect of how she felt connected to people. She had always felt closer to those who were able to share things that were going wrong in their life, as well as things that were going right; therapy had helped her do this too. She had begun to prioritise relationships where she felt this deeper level of connection and distance herself from those where she did not.

When I met with Sarah for the second time, she had been reflecting on our first meeting and how she had spoken about sharing her vulnerability, and why she had not done so with her children. She had wanted to ensure that they felt she was as “*solid and safe*” as they needed her to be, but her thoughts on this had now shifted. She now felt that actually it was important to let her children know that therapy had been instrumental in enabling her to be those things for them. She hoped that by disclosing this, she might be giving them the permission to seek help, which she had not had. This process of reflection demonstrates the

value of multiple interviews for developing deeper and richer narrative. Knowing that we were meeting again had encouraged this reflection, and provided the opportunity to verbalise and integrate this part of her experience. What she seemed to be describing was a shift in her perspective, and a new intention to provide her children with a way out of the intergenerational web in which she had been so caught up in.

Consideration for therapists – Accommodation to the client’s process and momentum

Therapy provides a ‘potential space’ between an individual and their environment (Winnicott, 2005), a space to play and to experiment without the confines of our everyday lives, of which stigma could be considered one, in the physical or observable sense at least. Therapy that provides a deeper connection to self and other is at the same time providing a representation of future possibilities (Gabbard, 2017). Therapists then, have an integral role to play in this process of providing a new blue print for relating and connecting.

Having drawn upon Benjamin’s (2004, p.7/25) notion of “*thirdness*” above, I do so again here in relation to the implication for therapists and the importance of “*accommodation to the other’s rhythm*”. In this context, accommodation proposes that the therapist must lead the way, to surrender, letting go to be with the client and leaving space for them to follow; laying the pathway to connection and growth.

CONCLUSIONS

In this final section I will discuss the conclusions that can be taken from this research. I shall begin by **considering stigma outside of the therapy room**, before summarising the main contribution of this study relating to **stigma in the room: considerations for therapists**. I will end with some **reflections** and my **final thoughts**.

Considering stigma outside of the therapy room

The primary focus of existing research into stigma surrounding psychological therapy is the identification of barriers that impede engagement. The focus of the current study has been to present individual stories of experience to demonstrate the depth and complexity of stigma. Despite stigma being a universal phenomenon (Durkee et al., 2019; Vogel et al., 2017), the experience of it is highly subjective and so addressing it with a 'one size fits all' approach is incredibly challenging. However, I will begin to summarise the experiences of the participants in relation to addressing stigma outside of the therapy room at a wider societal level, and in the context of existing approaches.

Throughout the discussion section I highlighted how the participants' accounts reflected existing approaches to managing stigma, that of reframing negative beliefs (Corrigan & Calabrese, 2005), the normalising of experiences (Rosen, 2003) and of empowerment (Corrigan, 2004), and these will feature in the following section. First, I will consider three further approaches identified by Corrigan and Penn (2015) that have been shown to help reduce stigmatising views; that of protest, education and contact, and consider these in relation to the participants' accounts.

Protest might refer to psychological practitioners challenging the media over inaccurate representations around mental health, given how influential these were in the participants' experiences. Andy for example, made reference to a series of TV advertisements that he felt reinforced the notion of "*something being wrong with you*" if you are suffering with your mental health, and how this contributed to "*public misunderstanding*". Over the past 18 months however, there has been significant increase in conversations, awareness and understanding around mental health due to the impact of Covid-19. This increase has been assisted by public figures speaking out about their struggles, contributing to the apparent shift in society. The second approach of education is aimed at promoting more positive attitudes towards mental health through greater understanding of psychological distress, and

also refers to conveying information relating to the success of treatment, i.e. therapy. Claire's experience demonstrates the potential impact of this, as for her, understanding "*unlocked everything*" and was integral to her positive and life changing experience. Similarly it was for this reason that Claire was also keen to share her experience with others, to pass on this 'education' she had gained. The final approach is contact, which proposes that stigma is reduced when people actually engage with others who experience mental health issues, demystifying and challenging their unfounded beliefs and fears. I was reminded of Sarah describing how her family made the distinction between "*nutters and not-nutters*" and wondered how much contact they might have had with those they were describing.

In addition to these approaches, all three of the participants emphasised the importance of making therapy part of everyday life, so it became, as Claire suggested, as familiar as "*making a cup of tea*". Aware that this would involve a shift in current thinking, Andy proposed how therapy needed to move away from the medical sphere where it currently resided, to the lifestyle sphere, alongside visiting the gym, for example. Claire and Sarah also highlighted the importance of early intervention, reflecting their own experiences, and through her work, Sarah strives to do just that, by providing a therapeutic space for children to share experiences and emotions, making it an "*acceptable*" thing to do.

It's difficult to see these comments from the participants as anything other than helpful in tackling stigma, but there is of course a huge cost implication in achieving them. Therapy is available in the private sector for those who are privileged to afford it, but for those less fortunate, opportunities are limited and waiting lists are significant.

The reduction of stigma at a wider level requires a paradigm shift. We need to humanise mental suffering rather than pathologise it (Davies, 2021). In the current study, I set out to humanise stigma; to present individual stories conveying the depth and complexity of stigma as a lived embodied and affective experience. The aim was to counteract the tendency in the field towards the deconstruction of stigma into disparate parts, resulting in the fragmentation of experience rather than the unearthing of it. Through narrative inquiry I captured the stories of three people who had attended therapy despite feeling there is a stigma that surrounds it, and through my interpretation of these stories I have arrived at a number of considerations for therapists' which I will summarise below.

Stigma in the room: considerations for therapists

Throughout the preceding discussion I highlighted six specific areas of clinical focus, resulting from the participants' experiences, to help inform therapists' understanding and considerations for working with stigma in the therapy room (Figure 1). In this section, I will summarise each of these areas.

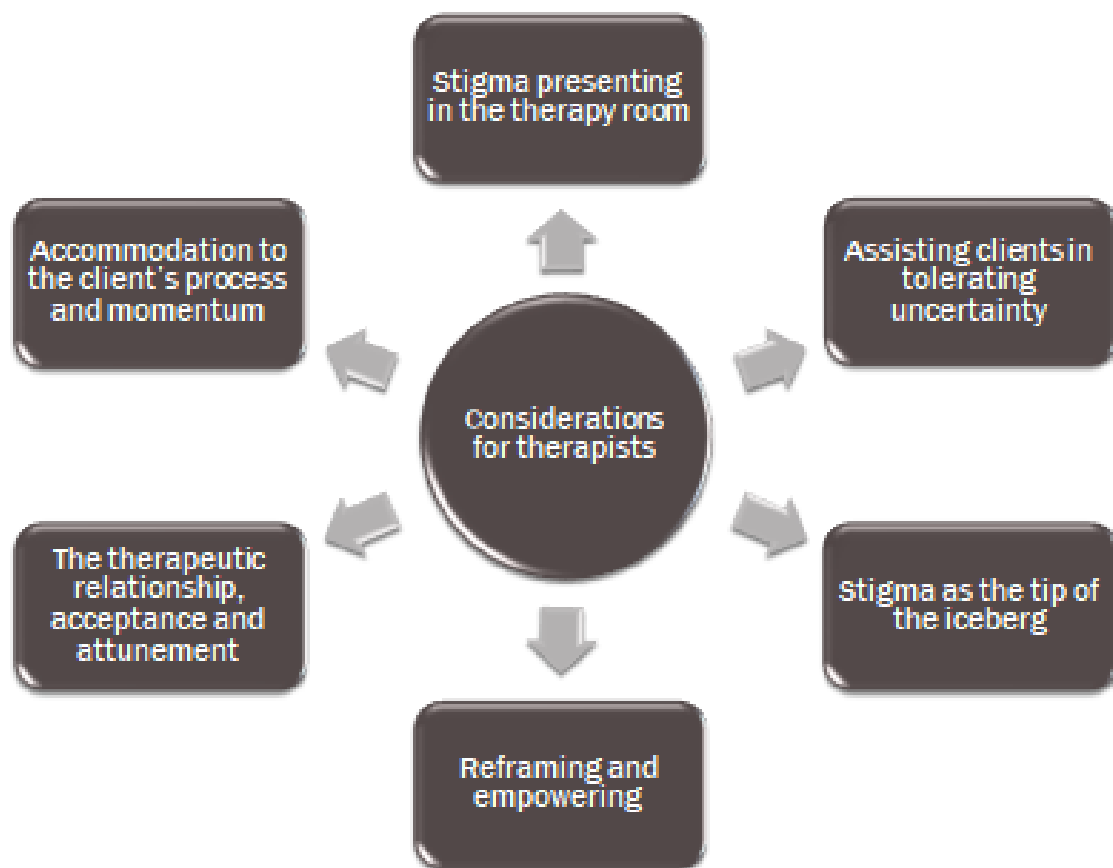


Figure 1 - Considerations for therapists

Stigma presenting in the therapy room

It is important for therapists to consider the potential pervasiveness of stigma and how it may present itself in therapy, both explicitly and implicitly. I encourage therapists to be curious as to clients' experiences of stigma and explicitly invite these into the therapy room, perhaps considering the questions: what does it mean for clients to be in therapy? Do family or friends know they are attending? And how did or might they respond?

I also highlight the importance of therapists to remain vigilant to clients' experiences of stigma at an implicit embodied level, as it might manifest as shame, and help build awareness of this through the tracking of sensations and emotions. For therapists who regularly work with the body in this way might also remain open to experiences of stigma being part of this process.

Assisting clients in tolerating uncertainty

Therapists are encouraged to remain open and curious to how clients conceptualise their mental health, and to consider how 'quietly' they may have been suffering in order to avoid a label. Therapists may ask the questions: how does the client understand their suffering? How do their beliefs impact them and the reactions of those closest to them?

Therapists have the opportunity to challenge black and white thinking and perceptions of mental health and help-seeking. They can begin to assist clients in tolerating uncertainty, to consider mental health as existing on a continuum, upon which we are all situated and move along throughout our lives; we are *"people with problems, not patients with illnesses"* (Longdon and Read, 2017, p.24). Therapists may facilitate this process with the use of psychoeducation to increase understanding and to normalise psychological distress.

Stigma as the tip of the iceberg

Clients' relationship to stigma can be considered a concentrated reflection of their much broader experience, incorporating familial, social and cultural influences; stigma is the tip of the iceberg. Therapists are encouraged to explore experiences and feelings around stigma sensitively and with awareness and appreciation of difference, remaining curious as to sources of influence, as well as transgenerational factors. Therapists' awareness of their own position, assumptions, biases and privilege is of course a fundamental and integral aspect to this process.

By considering stigma as the tip of the iceberg, practitioners are afforded a nonintrusive area of enquiry around a client's thoughts and feelings towards engaging in therapy which may prove very insightful, providing a window into their internal world and a deeper level of their psychological process.

Reframing and empowering

Stigmatising beliefs, explicit or implicit, may persist long after clients engage in therapy and practitioners might address these beliefs during their work together. Through the approaches of reframing and empowering, therapists have the opportunity to humanise psychological suffering rather than pathologise it (Davies, 2021). They might also, where appropriate, reframe therapy as a choice the client is making rather than a need, to emphasise their engagement in therapy as a purposeful action to regain a sense of control in their lives. Therapists might seek to emphasise and instil a sense of empowerment for clients through agency and autonomy, strength and courage, and consider the questions: how does the client perceive weakness and strength? Why might that be?

The therapeutic relationship, acceptance and attunement

The process of therapy may trigger complex thoughts, feelings and beliefs linked to clients' experiences of stigma. Therapists are reminded of the importance of developing and maintaining a strong therapeutic relationship, founded on acceptance, nonjudgement and moment-to-moment attunement (Stern, 2005), that will assist the tolerating, processing and integrating of these experiences. Furthermore, therapists may help clients reduce stigmatising beliefs through the development of self-compassion and self-acceptance, and are reminded of the value of remaining *alongside* clients, 'being with' them, not 'doing to' them.

Accommodation to the client's process and momentum

Stigma tells us to cover ourselves, to hide our suffering and feelings of weakness and vulnerability. Therapists are reminded of the importance of "*accommodation to the other's rhythm*" (Benjamin, 2004, p.25), letting go to be with the client, leading the way through surrender, and leaving space for them to follow; laying the pathway to connection and growth. Therapists can provide both a physical and psychological space to help clients uncover and integrate experiences of stigma. In providing a deeper level of connection to the self and to an other, clients develop a new blue print for relating and connecting.

The points raised above may be familiar ways of working for many therapists, but my proposal is that stigma is considered an integral and active part of these processes, which can be held in mind and engaged with directly. Exploring clients' experiences and relationship with stigma may also provide insight to a deeper level of their psychological process, and as stigma is an appropriate, and beneficial, conversation to initiate at the start of therapy, this insight is accessible much sooner than it might otherwise be. Once gathered, this information may assist therapists in attuning with clients during initial sessions and developing a therapeutic relationship, providing the necessary foundations for the work that lies ahead.

Reflections

As I reflect on my experience of the research process there a number of points that emerge relating to the study and my learning that I will touch on in this section.

Narrative secrets

I referred earlier to the “*commonplaces of narrative inquiry—temporality, sociality, and place — which specify dimensions of an inquiry space*” (Connelly & Clandinin, 2006, p.479), and these, along with my own interests and agenda, were hugely influential throughout this interpretive process, shaping which stories were ultimately told (Riessman, 1993).

Kermode’s (1980) term, ‘narrative secrets’ acknowledges the stories that were inherent within the participants’ narratives but which were not told, and warrant further investigation. I touch on a couple of these stories below, by way of acknowledgement and also as considerations for future endeavours.

All three of the participants touched on the significance of their **family dynamic** and how this was instrumental in shaping their perceptions and relationship with stigma. Although I discussed these to an extent, the practical limitations and breadth of experience I wanted to cover meant this was somewhat restricted. Sparked perhaps in part by my relationship with my father, I was intrigued by Andy’s relationship with his, how he was “*supportive*” whilst also seeming to distancing himself from the process. It would have been interesting and no doubt insightful, to learn more about their relationship and the wider dynamic of the family; what form did the support take? And where and how did Andy’s attending therapy feature in the family?

The influence of **faith** on Sarah’s experience also remained largely untold and I could have pursued this further. Looking back over the transcripts, Sarah highlighted its significance when she stated: “*my faith has been a great inspiration and support to me, but there have also been issues with that whole way of thinking*”. There was clearly a great deal there to explore, but perhaps the absence of ‘faith’ in my own life led me to move on from this prematurely. I was reminded of the words of du Plock (2010, p.125): “*the angle at which we enter any field of inquiry determines what is illuminated, and also what is thrown into*

shadow". Being more of a sceptic myself, I perhaps inadvertently cast shadow over the influence of faith on Sarah's experience.

The presence and absence of power

Whilst I had made reference to power in this dissertation, it was not until it was highlighted further by one of my readers, that I began to appreciate the complexity and centrality of it, and this is something that I could have expanded upon. I considered power to be most relevant at the wider social, political and economic levels, resulting in discrimination and oppression of those experiencing mental health issues, or seeking help for them, and whilst not immediately evident was of course running throughout. I came to realise that Claire's experience in particular, reflected the significance of power in her concerns around confidentiality, and how vital it was to maintain this. It was following a further discussion with my female supervisor that I began to reflect on the power that I hold as a white, Western, heterosexual male, and how this might have limited my awareness of the significance of power that was at stake, especially for Claire, as a woman in a corporate environment. The power and privilege that I automatically hold means I may have a tendency to overlook its role and when it is at play, and this is clearly something I need to remain mindful of. I do not consider it a coincidence that this oversight was brought to my attention by my female reader and supervisor.

Intergenerational aspect of stigma and life stage

I have also begun to reflect further on the intergenerational aspects of the participants' experiences of stigma that were evident throughout the narratives. The participants all described the influence of the preceding generation in shaping their perceptions and feelings around mental health and help-seeking, and their desire to implement change for the generation that followed. Sarah in particular spoke of wanting things to be different for her children, and how she could play a fundamental role in this by potentially disclosing her engagement in therapy to them.

Claire's experience brought to mind James Hollis' (1993, p.18/19) notion of the psychological experience of the "*middle passage*", when a person becomes obliged to view their life from a depth perspective, rather than a linear succession of years, and begins to ask, "*Who am I*,

apart from my history and the roles I have played?” It is this experience that resonates most with my own. There is something important here about acknowledging and owning one’s position, as part of the wider intergenerational web, and also one’s own agency in finding meaning and purpose in life.

All the participants referenced their life stage or maturity as relevant to their engagement in therapy, and Andy’s experience reflects the significance of this across his two separate experiences of therapy. His proclaimed greater maturity on the second occasion saw him attending therapy, as Wilson (1996, p.13) described, “*willing to engage*” as opposed to the first occasion when he was arguably “*in crisis*”. Engaging in personal therapy again during this past year, provided me with the opportunity to observe and reflect on this process, which I described earlier. Despite my mixed feelings around this, I wondered if the ongoing pandemic, having brought discussions around mental health to the fore, had made this feel more acceptable in my mind, almost giving me permission to do so. Engaging in personal therapy as a therapist, frames the process in a way that is arguably more acceptable, perhaps even expected, and yet I am still aware of my underlying shame in doing so. This demonstrates the power of stigma - I will never truly know how it might feel to engage in therapy from a position not already associated with it, but I can imagine how shameful this might still feel.

Critical reflections

This study focuses on three very personal and unique experiences of the much broader topic of stigma surrounding psychotherapy. It takes a significant step in unearthing the complexity of stigma, and demonstrates the value of doing so. I hope it will spark further interest and research in this area. In this section, I critically reflect on aspects of the study.

I will begin by reflecting on the number of participants involved in the study. I chose not to recruit beyond the three participants who initially came forward, partly due to practical and time constraints associated with the project, but also because this enabled me to focus on capturing the full depth and complexity of subjective experience; the primary aim of narrative inquiry. I interviewed each participant twice, generating approximately eight hours of narrative, overall. By conducting multiple interviews, which were unstructured and open ended, I sought to facilitate the telling of the participant’s stories, inviting any, and all,

aspects of their experience, until they felt this had been exhausted. The value of this was approach was reflected in the richness of experience that was captured.

For some researchers, the minimum number of participants for qualitative research is regarded as five, or until saturation is reached (Dworkin, 2012). Morse (2015, p.587) defines saturation as *“the building of rich data within the process of inquiry, by attending to scope and replication”*. In this context, scope refers to the comprehensiveness of data, and replication refers to the point at which no new or relevant data emerges. Whilst I would argue that both these criteria were met in relation to each of the participant’s individual experiences, I would also suggest that at the same time, the concept of saturation is at odds with the aim of this study. Rather than seeking a conclusive understanding of stigma as a phenomenon, where saturation might arguably be desired, my aim was to unearth complex subjective experiences of stigma; an aim which I believe was achieved.

More qualitative research is certainly needed in order to convey additional experiences of stigma. This must also involve researchers and participants from a variety of backgrounds. I discussed previously, the white, heterosexual, middle class experiences that surrounded, and were captured in, this study (see p.38/96), but the cross-culture differences associated with stigma (see p.16) must also be reflected in the research field via qualitative methods.

I have also considered the dual roles that I hold in this research. I discussed the first of these in the methodology section (see p.36), where, due to my own experiences of stigma and seeking therapy, I am both embedded in the research and remain distanced from it; I occupy the space in between, an *“insider-outsider”* researcher (Dwyer & Buckle, 2009, p.54). In addition, I also occupy the dual role of practitioner-researcher which has further implications for the study. I felt that my experience as a practitioner contributed to my efficacy as a researcher, in particular, my use of empathic attunement and non-judgemental curiosity helped the participants convey such depth of experience, when telling their stories.

These two roles of researcher and practitioner, whilst complimentary, do have fundamentally different aims. My focus as researcher was to elicit stories of experience at an embodied and affective level. As a practitioner, this would also be relevant, but my focus would shift even further towards the client’s process and even deeper levels of meaning. It is here that this dual role might arguably bias the interviews, as my practitioner self probes for meaning beyond the story the client is telling. Whilst this presented a challenge for me at times, to hold in mind the aim of the interviews, I am also in agreement with Frank (1997, p.89), who suggests that, *“the challenge is not to eliminate ‘bias’... but to use it as a focus for more intense insight”*.

To this end, throughout the research process, I maintained a position of critical self-reflection and reflexivity, and incorporated this throughout my discussion section. The ongoing involvement of my supervisor, at every stage of the research process, was integral to this reflection. Not only did this relationship provide me with an invaluable sounding board to consider my biases and assumptions, but it also provided an alternate perspective to highlight aspects outside of my awareness; an example of this being the role of power I discussed above.

In order to avoid unnecessary bias during the interviews, they were left intentionally open. And rather than following a directive interview schedule, I instead focused on three broad areas of experience, pre, during and post therapy: how were the client's experiences of stigma negotiated in order to begin therapy? What were the client's experiences of psychotherapy, in terms of stigma? And what are the client's views/experiences of stigma now? During the interviews, whilst holding these areas in mind, I tried to remain non-directive, and in the same way that I approach a therapy session, I sought only to open up experience rather than lead the conversation. I believe this approach, and its value, was reflected in Sarah's openness during her interviews. There was one moment in particular, where she conveyed the depth of her experience by comparing the stigma she felt around therapy, to that which she felt around sexual ethics and her faith. This was a deep and personal reflection, and one which is unlikely to have emerged through a more directive, structured approach.

As much as I sought a position of openness and acceptance, it is also possible however, that my being a practitioner-researcher may have meant that certain aspects of the participant's experiences felt less acceptable for them to voice. Talking to me, would potentially make sharing negative or critical experiences about therapists, or the profession, somewhat difficult to do.

Final thoughts

The narratives in this study have generated important considerations for therapists, and moved stigma from something that operates solely outside of the therapy room, to something that needs considerable attention within it. Therapists will benefit from an appreciation of the depth and complexity of stigma as well as its pervasiveness, and to recognise they have the opportunity to play an integral role in reducing clients' perception of

stigma during therapy. Not only is this likely to help in the development of a therapeutic relationship, but also to help clients remain engaged in the process.

I commented earlier that throughout the process of this research the world has been navigating its way through a global pandemic, experiencing months of 'lockdown', with our lives being impacted on every level. The interviews themselves were completed before any restrictions were in place and we knew little of what would lie ahead, so were unlikely to have been impacted. The process of transcribing, analysing and writing up has been accompanied from start to finish by the pandemic, and at the time of writing, further restrictions have been put in place. It is difficult to know exactly how this will have impacted what is written here, but it undoubtedly will have. I have tried to honour and convey this in terms of my own process in the reflections throughout the piece, and in the same way that Connelly and Clandinin (2006, p.479) highlighted the "*commonplaces*" of an inquiry space, I consider this to also apply to the writing space, which is specified by "*temporality, sociality, and place*".

Conducting this research has contributed significantly to my own understanding and conceptualising of stigma and has been valuable learning for me as a psychological therapist. In particular, I was struck by the complexity of experience and sources of influence that lay behind stigma, and how the narratives unearthed the depths of this. I was also struck by the uniqueness of experience, how seemingly similar initial conceptions of therapy, such as a weakness or inability to cope, turned out to represent such very different things. Having engaged in therapy myself and navigated my own experiences and relationship with stigma meant that I had first-hand experience of the 'felt sense' (Gendlin, 1982) of this. I emphasised earlier, the importance of lived experience rather than intentions and expectations, and how stigma is most alive when we face it head on and look to engage in therapy. I felt my own experience helped me to connect with the participants, particularly at this implicit level of their experience.

Undergoing this process of research has been significant and invaluable for my personal and professional development, as it has required me to *step into* my capacity as a researcher practitioner, and to fully own this position. This has been an ongoing challenge for me throughout my training, partly due to my own self-belief, but also, as I have come to realise, due to my relationship with stigma. Conducting this research from inception to completion has required me to engage and connect with my experiences, past and present. The realisation that I continue to navigate my own experience of stigma, even now, not only highlights the importance of engaging with clients' experience of this, but also assists me in helping them to do so.

I caught the end of an interview on the television this morning with a man who was walking around the UK to raise money for a charity. He spoke briefly of his struggle with his mental health during the Covid-19 lockdown and was encouraging others to do the same. He described how stigma makes people feel it is a weakness to say they're struggling, when actually it is a strength. Stigma is often summed up in this way, but this study has shown how it is so much more than that. Stigma touches the very core of our being, it is about *who we are*, in our own eyes and, how we perceive to be seen, through the eyes of others.

We need to keep talking, to open up and share our experiences, but we also need to create an environment to facilitate this, an environment where we are not defined by language and labels that then marginalise us, and where our opening up is met with empathy and support. Stigma operates at multiple levels, from the structure of society, through our cultures, social groups and families, permeating our sense of self; it is complex, interwoven, multilayered and multidirectional. Eradicating stigma requires a fundamental shift in our day to day understanding and conceptualisation of what it is to be human. We need to move towards tolerating uncertainty rather than pigeon-holing ourselves or others into being labelled by the current system that conceptualises mental suffering and the language that defines it. If we can consider ourselves to all be on the same continuum of mental health, moving up and down it throughout stages of our lives, then perhaps we can more easily meet one another with greater empathy, openness and acceptance.

“People with problems, not patients with illnesses”

(Longdon & Read, 2017, p.24).

REFERENCES

- Adams, M. (2016). Researching the self and beyond: a virtuous circle. *The Psychotherapist*, 62, 9-10. https://issuu.com/ukcp-publications/docs/the_psychotherapist_spring_web
- Ahmed, S., Birtel, M. D., Pyle, M., & Morrison, A. P. (2020). Stigma towards psychosis: Cross-cultural differences in prejudice, stereotypes, and discrimination in White British and South Asians. *Journal of Community & Applied Social Psychology*, 30(2), 199–213. <https://doi.org/10.1002/casp.2437>
- Allen, M. (2017). *The SAGE Encyclopedia of Communication Research Methods*. Published. <https://doi.org/10.4135/9781483381411.n369>
- Alvidrez, J., Snowden, L. R., Rao, S. M., & Boccellari, A. (2008). Psychoeducation to Address Stigma in Black Adults Referred for Mental Health Treatment: A Randomized Pilot Study. *Community Mental Health Journal*, 45(2), 127–136. <https://doi.org/10.1007/s10597-008-9169-0>
- Anderson, C., & Kirkpatrick, S. (2015). Narrative interviewing. *International Journal of Clinical Pharmacy*. Published. <https://doi.org/10.1007/s11096-015-0222-0>
- Andrews, G. (2000). *Unmet Need in Psychiatry: Problems, Resources, Responses* (1st ed.). Cambridge University Press.
- Andrews, G., Issakidis, C., & Carter, G. (2001). Shortfall in mental health service utilisation. *British Journal of Psychiatry*, 179(5), 417–425. <https://doi.org/10.1192/bjp.179.5.417>
- Arendell, T. 1997. Reflections on the researcher-researched relationship: A woman interviewing men. *Qualitative Sociology* 20: 341-68. <https://doi.org/10.1023/A:1024727316052>
- Asay, T. P. and Lambert, M. J. (2010). The empirical case for the common factors in therapy: Qualitative findings. In M. Hubble, B. L. Duncan, and S. D. Miller (Eds.), *The Heart and Soul of Change: What Works in Therapy*. Washington, DC: American Psychological Association. (p.33–55).

- BACP (2021, October 8). *Attitudes to mental health are changing, our research finds*.
<https://www.bacp.co.uk/news/news-from-bacp/2021/8-october-attitudes-towards-mental-health-are-changing-our-research-finds/>
- Bager-Charleson, S., du Plock, S., & McBeath, A. (2018). Therapists Have a lot to Add to the Field of Research, but Many Don't Make it There: A Narrative Thematic Inquiry into Counsellors' and Psychotherapists' Embodied Engagement with Research. *Language and Psychoanalysis*, 7(1), 4–22. <https://doi.org/10.7565/landp.v7i1.1580>
- Ballinger, C. (2004). Writing up Rigour: Representing and Evaluating Good Scholarship in Qualitative Research. *British Journal of Occupational Therapy*, 67(12), 540–546. <https://doi.org/10.1177/030802260406701204>
- Bathje, G., & Pryor, J. (2011). The Relationships of Public and Self-Stigma to Seeking Mental Health Services. *Journal of Mental Health Counseling*, 33(2), 161–176. <https://doi.org/10.17744/mehc.33.2.g632039274160411>
- Beattie, M., Lenihan, P., Sanderson, C., & Dundas, R. (2018). *Counselling Skills for Working with Gender Diversity and Identity*. Macmillan Publishers.
- Becker, M., & Shalgi, B. (2013). On Being, Disappearing, and Becoming: A Journey of Surrender. *Psychoanalytic Dialogues*, 23(4), 426–438. <https://doi.org/10.1080/10481885.2013.810499>
- Beebe, B., & Lachmann, F. M. (2005). *Infant Research and Adult Treatment* (1st ed.). Routledge.
- Benjamin, J. (2004). Beyond Doer and Done To: an Intersubjective View of Thirdness. *The Psychoanalytic Quarterly*, 73(1), 5–46. <https://doi.org/10.1002/j.2167-4086.2004.tb00151.x>
- Berne, E. (1972) *What Do You Say After You Say Hello*. New York. Grove Press.
- Berne, E. (1974). *T/A, Transactional Analysis in Psychotherapy*. Ballantine.
- Biddle, L., Donovan, J., Sharp, D., & Gunnell, D. (2007). Explaining non-help-seeking amongst young adults with mental distress: a dynamic interpretive model of illness

- behaviour. *Sociology of Health & Illness*, 29(7), 983–1002.
<https://doi.org/10.1111/j.1467-9566.2007.01030.x>
- Birt, L., Scott, S., Cavers, D., Campbell, C., & Walter, F. (2016). Member Checking. *Qualitative Health Research*, 26(13), 1802–1811.
<https://doi.org/10.1177/1049732316654870>
- Bowlby, J. (1979). *The Making and Breaking of Affectional Bonds*. Tavistock Publications.
- Braud, W. G., & Anderson, R. (1998). *Transpersonal Research Methods for the Social Sciences: Honoring Human Experience (Progress in Neural Processing; 7)*. SAGE Publications, Inc.
- British Psychological Society. (2009) *Code of Ethics and Conduct*.
<https://www.bps.org.uk/files/code-ethics-and-conduct-2009pdf>
- Bromberg, P. M. (1996). Standing in the Spaces. *Contemporary Psychoanalysis*, 32(4), 509–535. <https://doi.org/10.1080/00107530.1996.10746334>
- Buber, M. (1958). *I And Thou*. (R. G. Smith, Trans.) Charles Scribner and Sons. (original work published 1923).
- Burr, V. (2015). Social Constructionism. *International Encyclopedia of the Social & Behavioral Sciences*, 222–227. <https://doi.org/10.1016/b978-0-08-097086-8.24049-x>
- Busch, F. N., & Auchincloss, E. L. (2018). The Role of Psychoeducation in Psychodynamic Psychotherapy. *Psychodynamic Psychiatry*, 46(1), 145–163.
<https://doi.org/10.1521/pdps.2018.46.1.145>
- Burton, K. (2021, May 5). *A country divided: Why England's North–South divide is getting worse* - *Geographical Magazine*. Geographical.Co.Uk.
<https://geographical.co.uk/uk/item/3906-a-country-divided-why-england-s-north-south-divide-is-getting-worse>
- Caplan, S. (2019). Intersection of Cultural and Religious Beliefs About Mental Health: Latinos in the Faith-Based Setting. *Hispanic Health Care International*, 17(1), 4–10.
<https://doi.org/10.1177/1540415319828265>

- Casement, P. (1985). *On learning from the patient*. Tavistock Publications.
- Cepeda-Benito, A., & Short, P. (1998). Self-concealment, avoidance of psychological services, and perceived likelihood of seeking professional help. *Journal of Counseling Psychology*, 45(1), 58–64. <https://doi.org/10.1037/0022-0167.45.1.58>
- Cheon, B. K., & Chiao, J. Y. (2012). Cultural Variation in Implicit Mental Illness Stigma. *Journal of Cross-Cultural Psychology*, 43(7), 1058–1062. <https://doi.org/10.1177/0022022112455457>
- Clandinin, J. D., & Connelly, M. F. (2000). *Narrative Inquiry: Experience and Story in Qualitative Research* (1st ed.). Jossey-Bass.
- Clandinin, D. J., Pushor, D., & Orr, A. M. (2007). Navigating Sites for Narrative Inquiry. *Journal of Teacher Education*, 58(1), 21–35. <https://doi.org/10.1177/0022487106296218>
- Clement, S., Schauman, O., Graham, T., Maggioni, F., Evans-Lacko, S., Bezborodovs, N., Morgan, C., Rüsch, N., Brown, J. S. L., & Thornicroft, G. (2014). What is the impact of mental health-related stigma on help-seeking? A systematic review of quantitative and qualitative studies. *Psychological Medicine*, 45(1), 11–27. <https://doi.org/10.1017/s0033291714000129>
- Clement, S., Brohan, E., Jeffery, D., Henderson, C., Hatch, S. L., & Thornicroft, G. (2012). Development and psychometric properties the Barriers to Access to Care Evaluation scale (BACE) related to people with mental ill health. *BMC Psychiatry*, 12(1). <https://doi.org/10.1186/1471-244x-12-36>
- Colom, F., & Lam, D. (2005). Psychoeducation: improving outcomes in bipolar disorder. *European Psychiatry*, 20(5–6), 359–364. <https://doi.org/10.1016/j.eurpsy.2005.06.002>
- Comas-Díaz, L., Hall, G. N., & Neville, H. A. (2019). Racial trauma: Theory, research, and healing: Introduction to the special issue. *American Psychologist*, 74(1), 1–5. <https://doi.org/10.1037/amp0000442>
- Connelly, F. M., & Clandinin, D. J. (1990). Stories of Experience and Narrative Inquiry. *Educational Researcher*, 19(5), 2–14. <https://doi.org/10.3102/0013189x019005002>

- Connelly, F. M., & Clandinin, D. J. (2006). Narrative inquiry. In J. L. Green, G. Camilli, & P. Elmore (Eds.), *Handbook of complementary methods in education research* (3rd ed., pp. 477–487). Mahwah, NJ: Lawrence Erlbaum.
- Conner, K., & Brown, C. (2014). Attitudes and beliefs about mental health treatment among African American older adults suffering from depression: The Impact of Stigma. *The American Journal of Geriatric Psychiatry*, 22(3), S88–S89.
<https://doi.org/10.1016/j.jagp.2013.12.102>
- Corrigan, P. (2004). How stigma interferes with mental health care. *American Psychologist*, 59(7), 614–625. <https://doi.org/10.1037/0003-066x.59.7.614>
- Corrigan, P. W., & Calabrese, J. D. (2005). *Strategies for Assessing and Diminishing Self-Stigma*. In P. W. Corrigan (Ed.), *On the stigma of mental illness: Practical strategies for research and social change* (p. 239–256). American Psychological Association. <https://doi.org/10.1037/10887-011>
- Corrigan, P. W., & Penn, D. L. (2015). Lessons from social psychology on discrediting psychiatric stigma. *Stigma and Health*, 1(S), 2–17. <https://doi.org/10.1037/2376-6972.1.s.2>
- Corrigan, P. W., & Rao, D. (2012). On the Self-Stigma of Mental Illness: Stages, Disclosure, and Strategies for Change. *The Canadian Journal of Psychiatry*, 57(8), 464–469.
<https://doi.org/10.1177/070674371205700804>
- Corrigan, P. W., Watson, A. C., & Barr, L. (2006). The Self–Stigma of Mental Illness: Implications for Self–Esteem and Self–Efficacy. *Journal of Social and Clinical Psychology*, 25(8), 875–884. <https://doi.org/10.1521/jscp.2006.25.8.875>
- Cozolino, L. (2010). *The Neuroscience of Psychotherapy: Healing the Social Brain* (The Norton Series on Interpersonal Neurobiology) (Second ed.). W. W. Norton & Company.
- Creswell, J. W. (2013). *Qualitative Inquiry and Research Design: Choosing Among Five Approaches* (Third ed.). SAGE Publications, Inc.
- Creswell, J. W., & Poth, C. N. (2017). *Qualitative Inquiry and Research Design: Choosing Among Five Approaches* (4th ed.). SAGE Publications, Inc.

- Crisp, A. H., Gelder, M. G., Rix, S., Meltzer, H. I., & Rowlands, O. J. (2000). Stigmatisation of people with mental illnesses. *British Journal of Psychiatry*, 177(1), 4–7.
<https://doi.org/10.1192/bjp.177.1.4>
- Cronin, P., Ryan, F., & Coughlan, M. (2008). Undertaking a literature review: a step-by-step approach. *British Journal of Nursing*, 17(1), 38–43.
<https://doi.org/10.12968/bjon.2008.17.1.28059>
- Davies, J. (2014) *Cracked: Why Psychiatry is Doing More Harm Than Good*. Icon Books Ltd.
- Davies, J. [@JDaviesPhD]. (2021, April 29). *It's 'normal' for everyone to suffer emotionally at some point in their lives (often at multiple times & sometimes acutely). Yet, from a wider historical perspective, what seems to me to be 'abnormal' (& ideological) is to pathologise that widespread suffering as 'mental illness'* [Tweet]. Twitter.
<https://twitter.com/JDaviesPhD/status/1387656645065412610>
- Denzin, N. K., & Lincoln, Y. S. (2017). *The SAGE Handbook of Qualitative Research* (Fifth ed.). SAGE Publications, Inc.
- DeYoung, P. A. (2015). *Understanding and Treating Chronic Shame: A Relational/Neurobiological Approach* (1st ed.). Routledge.
- du Plock, S. (2010). The vulnerable researcher. In S. Bager-Charleson (Ed.), *Reflective practice in counselling and psychotherapy* (pp. 121–135). Learning matters Ltd.
- Dubreucq, J., Plasse, J., & Franck, N. (2021). Self-stigma in Serious Mental Illness: A Systematic Review of Frequency, Correlates, and Consequences. *Schizophrenia Bulletin*. Published. <https://doi.org/10.1093/schbul/sbaa181>
- Dudley, J. R. (2000). Confronting Stigma within the Services System. *Social Work*, 45(5), 449–455. <https://doi.org/10.1093/sw/45.5.449>
- Durkee, P. K., Lukaszewski, A. W., & Buss, D. M. (2019). Pride and shame: Key components of a culturally universal status management system. *Evolution and Human Behavior*, 40(5), 470–478.
<https://doi.org/10.1016/j.evolhumbehav.2019.06.004>
- Durkheim, E. (1982). *Rules of Sociological Method* (2nd printing ed.). Free Press.

- Dworkin, S. L. (2012). Sample Size Policy for Qualitative Studies Using In-Depth Interviews. *Archives of Sexual Behavior*, 41(6), 1319–1320. <https://doi.org/10.1007/s10508-012-0016-6>
- Dwyer, S. C., & Buckle, J. L. (2009). The Space Between: On Being an Insider-Outsider in Qualitative Research. *International Journal of Qualitative Methods*, 54–63. <https://doi.org/10.1177/160940690900800105>
- Easton, M. (2012, August 2). *The north/south divide on antidepressants*. BBC News. <https://www.bbc.co.uk/news/uk-19076219>
- Elliott, R., Fischer, C. T., & Rennie, D. L. (1999). Evolving guidelines for publication of qualitative research studies in psychology and related fields. *British Journal of Clinical Psychology*, 38(3), 215–229. <https://doi.org/10.1348/014466599162782>
- Erskine, R. G. (1995). A Gestalt therapy approach to shame and self-righteousness: Theory and methods. *British Gestalt Journal*, 4(2), 108–117. <https://www.britishgestaltjournal.com/shop/volume-4-2-1995>
- Etherington, K. (2004). *Becoming a Reflexive Researcher - Using Our Selves in Research* (1st ed.). Jessica Kingsley Publishers.
- Every Mind Matters*. (2021, June 7). Nhs.Uk. <https://www.nhs.uk/every-mind-matters/>
- Eylem, O., de Wit, L., van Straten, A., Steubl, L., Melissourgaki, Z., Danişman, G. T., de Vries, R., Kerkhof, A. J. F. M., Bhui, K., & Cuijpers, P. (2020). Stigma for common mental disorders in racial minorities and majorities a systematic review and meta-analysis. *BMC Public Health*, 20(1). <https://doi.org/10.1186/s12889-020-08964-3>
- Farrimond, H. (2011). Beyond the caveman: Rethinking masculinity in relation to men's help-seeking. *Health: An Interdisciplinary Journal for the Social Study of Health, Illness and Medicine*, 16(2), 208–225. <https://doi.org/10.1177/1363459311403943>
- Fay, B. (1996). *Contemporary Philosophy of Social Science: A Multicultural Approach* (1st ed.). Wiley-Blackwell.
- Festinger, L. (2021). *A Theory of Cognitive Dissonance* (Anniversary ed.). Stanford University Press.

- Fine, C. (2010). *Delusions of gender: The real science behind sex differences*. London: Icon Books.
- Finlay, L. (2016). Being a therapist-researcher: Doing relational-reflexive research. *The Psychotherapist*, 62. https://issuu.com/ukcp-publications/docs/the_psychotherapist_spring_web
- Finlay, L., & Gough, B. (2003). *Reflexivity: A Practical Guide for Researchers in Health and Social Sciences* (1st ed.). Wiley-Blackwell.
- Frank, G. (1997). Is there life after categories? Reflexivity in qualitative research. *Occupational Therapy Journal of Research*, 17, 84-98.
- Furukawa, E., Tangney, J., & Higashibara, F. (2012). Cross-cultural Continuities and Discontinuities in Shame, Guilt, and Pride: A Study of Children Residing in Japan, Korea and the USA. *Self and Identity*, 11(1), 90–113.
<https://doi.org/10.1080/15298868.2010.512748>
- Fung, K. M., Tsang, H. W., Corrigan, P. W., Lam, C. S., & Cheng, W. M. (2007). Measuring Self-Stigma of Mental Illness in China and Its Implications for Recovery. *International Journal of Social Psychiatry*, 53(5), 408–418.
<https://doi.org/10.1177/0020764007078342>
- Gabbard, G. O. (2017). *Long-Term Psychodynamic Psychotherapy: A Basic Text* (3rd ed.). American Psychiatric Association Publishing.
- Gara, M. A., Vega, W. A., Arndt, S., Escamilla, M., Fleck, D. E., Lawson, W. B., Lesser, I., Neighbors, H. W., Wilson, D. R., Arnold, L. M., & Strakowski, S. M. (2012). Influence of Patient Race and Ethnicity on Clinical Assessment in Patients With Affective Disorders. *Archives of General Psychiatry*, 69(6).
<https://doi.org/10.1001/archgenpsychiatry.2011.2040>
- Ghent, E. (1990). Masochism, Submission, Surrender. *Contemporary Psychoanalysis*, 26(1), 108–136. <https://doi.org/10.1080/00107530.1990.10746643>
- Gendlin, E. T. (1982). *Focusing* (2nd (revised) ed.). Bantam.

- Gilbert, P. (2019). *The Compassionate Mind (Compassion Focused Therapy)* (Re-issue ed.). Robinson.
- Gilbert, M. and Orlans, V. (2011). *Integrative Therapy (100 Key Points)* (1st ed.). Routledge.
- Glaser, B., & Strauss, A. (1999). *The Discovery of Grounded Theory: Strategies for Qualitative Research*. Routledge.
- Goffman, E. (1963). *Stigma; Notes on the management of spoiled identity (A Spectrum book)*. Prentice-Hall.
- Gonzalez, J. M., Tinsley, H. E. A., & Kreuder, K. R. (2002). Effects of psychoeducational interventions on opinions of mental illness, attitudes toward help seeking, and expectations about psychotherapy in college students. *Journal of College Student Development*, 43(1), 51–63. <https://psycnet.apa.org/record/2002-17954-004>
- Gove, W. R. (1984). Gender differences in mental and physical illness: The effects of fixed roles and nurturant roles. *Social Science & Medicine*, 19(2), 77–84. [https://doi.org/10.1016/0277-9536\(84\)90273-9](https://doi.org/10.1016/0277-9536(84)90273-9)
- Greedus, A. (2020, July 23). *Revealed: The UK cities with the highest percentage of individuals looking for private therapy* [Press release]. <https://memiah.co.uk/2020/07/23/uk-cities-with-the-highest-percentage-of-individuals-looking-for-private-therapy/>
- Griffiths, K. M., Nakane, Y., Christensen, H., Yoshioka, K., Jorm, A. F., & Nakane, H. (2006). Stigma in response to mental disorders: a comparison of Australia and Japan. *BMC Psychiatry*, 6(1). <https://doi.org/10.1186/1471-244x-6-21>
- Gubrium, J. E., and J. A. Holstein. 2002. *Handbook of interview research: Context and method*. Thousand Oaks, CA: Sage.
- Han, M., & Pong, H. (2015). Mental Health Help-Seeking Behaviors Among Asian American Community College Students: The Effect of Stigma, Cultural Barriers, and Acculturation. *Journal of College Student Development*, 56(1), 1–14. <https://doi.org/10.1353/csd.2015.0001>

- Havis, R. J. (2018, September 28). *The US Versus UK: Comparing Mental Health Care and Stigma*. Talkspace. <https://www.talkspace.com/blog/us-versus-uk-comparing-mental-health-care-stigma/>
- He, T., & Williams, M. J. (2021). Interdependence and reflected failure: Cultural differences in stigma by association. *Journal of Experimental Social Psychology*, 95, 104130. <https://doi.org/10.1016/j.jesp.2021.104130>
- Heads Together. (2019, May 20) *A Royal Team Talk-Tackling Mental Health* [Video]. YouTube. Retrieved September 30, 2022, from https://www.youtube.com/watch?v=Yn_shQZz5tw
- HeadsTogether. (2021, May 11). *Heads Up*. <https://www.headstogether.org.uk/heads-up/>
- Held, P., & Owens, G. P. (2013). Stigmas and attitudes toward seeking mental health treatment in a sample of veterans and active duty service members. *Traumatology*, 19(2), 136–143. <https://doi.org/10.1177/1534765612455227>
- Hennink, M., & Kaiser, B. N. (2022). Sample sizes for saturation in qualitative research: A systematic review of empirical tests. *Social Science & Medicine*, 292, 114523. <https://doi.org/10.1016/j.socscimed.2021.114523>
- Henwood, K. L., & Pidgeon, N. F. (1992). Qualitative research and psychological theorizing. *British journal of psychology (London, England: 1953)*, 83 (Pt 1), 97–111. <https://doi.org/10.1111/j.2044-8295.1992.tb02426.x>
- Hilpern, K. (2014, July 24). Britons are going to therapy in record numbers. *The Independent*. <https://www.independent.co.uk/life-style/health-and-families/features/britons-are-going-therapy-record-numbers-9593217.html>
- Hinshaw, S. P. (2009). *The Mark of Shame: Stigma of Mental Illness and an Agenda for Change* (1st ed.). Oxford University Press.
- Hollis, J. (1993). *The Middle Passage: From misery to meaning in midlife*. Inner City Books.
- Hoffmann, E. A. (2007). Open-Ended Interviews, Power, and Emotional Labor. *Journal of Contemporary Ethnography*, 36(3), 318–346. <https://doi.org/10.1177/0891241606293134>

- Houle, J., Mishara, B. L., & Chagnon, F. (2008). An empirical test of a mediation model of the impact of the traditional male gender role on suicidal behavior in men. *Journal of Affective Disorders*, 107(1–3), 37–43. <https://doi.org/10.1016/j.jad.2007.07.016>
- Jacobs, L. (1996). Shame in the therapeutic dialogue. In R. Lee & G. Wheeler (Eds.), *Voice of shame*. Jossey-Bass.
- Jaye, L. (2020, August 12). *Why race matters when it comes to mental health*. BBC Future. <https://www.bbc.com/future/article/20200804-black-lives-matter-protests-race-mental-health-therapy>
- Jovchelovitch, S., & Bauer, M. W. (2000). Narrative interviewing. In M. W. Bauer & G. Gaskell (Eds.), *Qualitative Researching With Text, Image and Sound : a Practical Handbook* (pp. 55–74). SAGE Publications.
- Johnstone, L., & Boyle, M. (2018). The Power Threat Meaning Framework: An Alternative Nondiagnostic Conceptual System. *Journal of Humanistic Psychology*, 002216781879328. <https://doi.org/10.1177/0022167818793289>
- Jorm, A. F., & Wright, A. (2008). Influences on young people's stigmatising attitudes towards peers with mental disorders: National survey of young Australians and their parents. *British Journal of Psychiatry*, 192(2), 144–149. <https://doi.org/10.1192/bjp.bp.107.039404>
- Josselson, R. (2013). *Interviewing for Qualitative Inquiry: A Relational Approach* (1st ed.). The Guilford Press.
- Josselson, R. (2016, February 24). The Psychotherapist issue 62: Spring 2016. *Issuu*. https://issuu.com/ukcp-publications/docs/the_psychotherapist_spring_web
- Joyce, P., & Sills, C. (2018). *Skills in Gestalt Counselling & Psychotherapy (Skills in Counselling & Psychotherapy Series)* (4th ed.). SAGE Publications Ltd.
- Kermode, F. (1980). Secrets and Narrative Sequence. *Critical Inquiry*, 7(1), 83–101. <https://doi.org/10.1086/448089>

- Kessler, R. C., Berglund, P. A., Bruce, M. L., Koch, R., Laska, E. M., & Leaf, P. J. (2001). The prevalence and correlates of untreated serious mental illness. *Health Services Research, 36*, 987–1007. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1089274/>
- Khan, C. (2020, February 10). 'I thought I was a lost cause': how therapy is failing people of colour. *The Guardian*. <https://www.theguardian.com/lifeandstyle/2020/feb/10/therapy-failing-bme-patients-mental-health-counselling>
- Klein, M., Strachey, A., & Thorner, H. A. (1975). *The Psychoanalysis of Children* (Revised ed.). Delacorte Press/Seymour Lawrence.
- Kim, J. E., Park, S. S., La, A., Chang, J., & Zane, N. (2016). Counseling services for Asian, Latino/a, and White American students: Initial severity, session attendance, and outcome. *Cultural Diversity and Ethnic Minority Psychology, 22*(3), 299–310. <https://doi.org/10.1037/cdp0000069>
- Kohut, H. (1971). *The Analysis of the Self: A Systematic Approach to the Psychoanalytic Treatment of Narcissistic Personality Disorders by Heinz Kohut (1971–06-03)*. Intl Universities Pr Inc.
- Komiya, N., Good, G. E., & Sherrod, N. B. (2000). Emotional openness as a predictor of college students' attitudes toward seeking psychological help. *Journal of Counseling Psychology, 47*(1), 138–143. <https://doi.org/10.1037/0022-0167.47.1.138>
- Kranke, D. A., Floersch, J., Kranke, B. O., & Munson, M. R. (2011). A Qualitative Investigation of Self-Stigma Among Adolescents Taking Psychiatric Medication. *Psychiatric Services, 62*(8), 893–899. https://doi.org/10.1176/ps.62.8.pss6208_0893
- Kumar, A., Haque Nizamie, S., & Srivastava, N. K. (2013). Violence against women and mental health. *Mental Health & Prevention, 1*(1), 4–10. <https://doi.org/10.1016/j.mhp.2013.06.002>
- Lannin, D. G., Vogel, D. L., Brenner, R. E., & Tucker, J. R. (2014). Predicting Self-Esteem and Intentions to Seek Counseling. *The Counseling Psychologist, 43*(1), 64–93. <https://doi.org/10.1177/0011000014541550>
- Lewis, H. B. (1987). Shame and the narcissistic personality. In D. L. Nathanson (Ed.), *The many faces of shame* (pp. 93-132). New York: Guilford Press.

- Lieberman, M. D. (2014). *Social: Why Our Brains Are Wired to Connect* (Illustrated ed.). Crown.
- Lincoln, Y. S., & Guba, E. (1985). *Naturalistic Inquiry* (1st ed.). SAGE Publications.
- Link, B. G., Cullen, F. T., Frank, J., & Wozniak, J. F. (1987). The Social Rejection of Former Mental Patients: Understanding Why Labels Matter. *American Journal of Sociology*, 92(6), 1461–1500. <https://doi.org/10.1086/228672>
- Link, B. G. (1987). Understanding Labeling Effects in the Area of Mental Disorders: An Assessment of the Effects of Expectations of Rejection. *American Sociological Review*, 52(1), 96. <https://doi.org/10.2307/2095395>
- Link, B. G., & Phelan, J. C. (2001). Conceptualizing Stigma. *Annual Review of Sociology*, 27(1), 363–385. <https://doi.org/10.1146/annurev.soc.27.1.363>
- Link, B. G., Cullen, F. T., Struening, E., Shrout, P. E., & Dohrenwend, B. P. (1989). A Modified Labeling Theory Approach to Mental Disorders: An Empirical Assessment. *American Sociological Review*, 54(3), 400. <https://doi.org/10.2307/2095613>
- Link, B. G., Struening, E. L., Neese-Todd, S., Asmussen, S., & Phelan, J. C. (2001). Stigma as a Barrier to Recovery: The Consequences of Stigma for the Self-Esteem of People With Mental Illnesses. *Psychiatric Services*, 52(12), 1621–1626. <https://doi.org/10.1176/appi.ps.52.12.1621>
- Longdon, E., & Read, J. (2017). People with Problems, Not Patients with Illnesses: Using Psychosocial Frameworks to Reduce the Stigma of Psychosis. *The Israel journal of psychiatry and related sciences*, 54(1), 24–28.
- Ludwikowski, W. M. A., Vogel, D., & Armstrong, P. I. (2009). Attitudes toward career counseling: The role of public and self-stigma. *Journal of Counseling Psychology*, 56(3), 408–416. <https://doi.org/10.1037/a0016180>
- Manen T, M. (1990). *Research Lived Experience* (1st ed.). Routledge.
- Manos, R. C., Rusch, L. C., Kanter, J. W., & Clifford, L. M. (2009). Depression Self-Stigma as a Mediator of the Relationship Between Depression Severity and Avoidance. *Journal of Social and Clinical Psychology*, 28(9), 1128–1143. <https://doi.org/10.1521/jscp.2009.28.9.1128>

- Masuda, A., & Boone, M. S. (2011). Mental Health Stigma, Self-Concealment, and Help-Seeking Attitudes among Asian American and European American College Students with No Help-Seeking Experience. *International Journal for the Advancement of Counselling*, 33(4), 266–279. <https://doi.org/10.1007/s10447-011-9129-1>
- McKittrick, D., & McVea, D. (2012). *Making Sense of the Troubles: The Story of the Conflict in Northern Ireland*. Viking.
- McLaren, K. (2010). *The Language of Emotions*. Sounds True.
- McManus, S., Meltzer, H., Brugha, T., Bebbington, P., & Jenkins, R. (2009, January). *Adult psychiatric morbidity in England, 2007: Results of a household survey*. <https://doi.org/10.13140/2.1.1563.5205>
- McManus, S., Bebbington, P., Jenkins, R., & Brugha, T. (2016, September). *Mental health and wellbeing in England: Adult psychiatric morbidity survey*. <https://digital.nhs.uk/data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/adult-psychiatric-morbidity-survey-survey-of-mental-health-and-wellbeing-england-2014>
- McWilliams, N. (2020). *Psychoanalytic Diagnosis, Second Edition: Understanding Personality Structure in the Clinical Process* (Second ed.). The Guilford Press.
- Mellor, D., Carne, L., Shen, Y. C., McCabe, M., & Wang, L. (2012). Stigma Toward Mental Illness. *Journal of Cross-Cultural Psychology*, 44(3), 352–364. <https://doi.org/10.1177/0022022112451052>
- Meltzer, H., Bebbington, P., Brugha, T., Farrell, M., Jenkins, R., & Lewis, G. (2003). The reluctance to seek treatment for neurotic disorders. *International Review of Psychiatry*, 15(1–2), 123–128. <https://doi.org/10.1080/0954026021000046038>
- Meltzoff, A. (1990). Foundations for developing a concept of self: the role of imitation in relating self to other and the value of social mirroring, social modelling and self practice in infancy. In D. Cicchetti and M. Beeghly (Eds) *The self in transition: Infancy to childhood* (pp.139-164). University of Chicago Press.

- Meyer, O. L., & Zane, N. (2013). The influence of race and ethnicity in clients' experiences of mental health treatment. *Journal of Community Psychology*, 41(7), 884–901.
<https://doi.org/10.1002/jcop.21580>
- Mind, the Mental Health Charity - Help for Mental Health Problems. (2020, November 13). *Mind warns of “second pandemic” as it reveals more people in mental health crisis than ever recorded and helpline calls soar*. <https://www.mind.org.uk/news-campaigns/news/mind-warns-of-second-pandemic-as-it-reveals-more-people-in-mental-health-crisis-than-ever-recorded-and-helpline-calls-soar/>
- Mishler, E. G. (1991). *Research Interviewing: Context and Narrative*. Harvard University Press.
- Mojtabai, R., Olfson, M., Sampson, N. A., Jin, R., Druss, B., Wang, P. S., Wells, K. B., Pincus, H. A., & Kessler, R. C. (2010). Barriers to mental health treatment: results from the National Comorbidity Survey Replication. *Psychological Medicine*, 41(8), 1751–1761. <https://doi.org/10.1017/s0033291710002291>
- Mojaverian, T., Hashimoto, T., & Kim, H. S. (2013). Cultural Differences in Professional Help Seeking: A Comparison of Japan and the U.S. *Frontiers in Psychology*, 3.
<https://doi.org/10.3389/fpsyg.2012.00615>
- Mokkarala, S., O'Brien, E. K., & Siegel, J. T. (2015). The relationship between shame and perceived biological origins of mental illness among South Asian and white American young adults. *Psychology, Health & Medicine*, 21(4), 448–459.
<https://doi.org/10.1080/13548506.2015.1090615>
- Morris, J. (2006). *Conundrum (New York Review Books Classics)* (New York Review Books Classics ed.). NYRB Classics.
- Morse, J. M. (2015). “Data Were Saturated . . .” *Qualitative Health Research*, 25(5), 587–588. <https://doi.org/10.1177/1049732315576699>
- Morrow, S. L. (2005). Quality and trustworthiness in qualitative research in counseling psychology. *Journal of Counseling Psychology*, 52(2), 250–260.
<https://doi.org/10.1037/0022-0167.52.2.250>

- National Institute of Mental Health (NIMH) (2003). *Real men. Real depression*. Washington, DC: Author.
- Newell, R., & Burnard, P. (2006) *Research for Evidence-Based Practice*. Blackwell Publishing, Oxford
- Norcross, J. C., & Cooper, M. (2021). *Personalizing Psychotherapy: Assessing and Accommodating Patient Preferences* (1st ed.). American Psychological Association.
- Oakley, L. D., Kanter, J. W., Taylor, J. Y., & Duguid, M. (2011). The self-stigma of depression for women. *International Journal of Social Psychiatry*, 58(5), 512–520. <https://doi.org/10.1177/0020764011409820>
- O'Brien, R., Hunt, K., & Hart, G. (2005). 'It's caveman stuff, but that is to a certain extent how guys still operate': men's accounts of masculinity and help seeking. *Social Science & Medicine*, 61(3), 503–516. <https://doi.org/10.1016/j.socscimed.2004.12.008>
- Ogden, P., Minton, K., Pain, C., Siegel, D. J., & van der Kolk, B. (2006). *Trauma and the Body: A Sensorimotor Approach to Psychotherapy* (Norton Series on Interpersonal Neurobiology) (Illustrated ed.). W. W. Norton & Company.
- Oliver, M. I., Pearson, N., Coe, N., & Gunnell, D. (2005). Help-seeking behaviour in men and women with common mental health problems: cross-sectional study. *British Journal of Psychiatry*, 186(4), 297–301. <https://doi.org/10.1192/bjp.186.4.297>
- O'Neil, J. M. (1981). Patterns of Gender Role Conflict and Strain: Sexism and Fear of Femininity in Men's Lives. *The Personnel and Guidance Journal*, 60(4), 203–210. <https://doi.org/10.1002/j.2164-4918.1981.tb00282.x>
- ONS. (1998, June). *Psychiatric morbidity among prisoners: Summary report*. The Stationary Office. https://www.researchgate.net/publication/260226998_Psychiatric_Morbidity_Among_Prisoners_Summary_Report
- ONS. (2021, September) *Suicides in the UK: 2019 registrations*. <https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/datasets/suicidesintheunitedkingdomreferencetables>

- Oram S, Khalifeh H, Howard L. Violence against women and mental health. *Lancet Psychiatry* 2016; published online Nov 14. [http://dx.doi.org/10.1016/S2215-0366\(16\)30261-9](http://dx.doi.org/10.1016/S2215-0366(16)30261-9).
- Orange, D. M. (2008) Whose Shame is it Anyway? *Contemporary Psychoanalysis*, 44:1, 83-100, DOI: [10.1080/00107530.2008.10745952](https://doi.org/10.1080/00107530.2008.10745952)
- Owen, J., Thomas, L., & Rodolfa, E. (2012). Stigma for Seeking Therapy. *The Counseling Psychologist*, 41(6), 857–880. <https://doi.org/10.1177/0011000012459365>
- Pederson, E. L., & Vogel, D. L. (2007). Male gender role conflict and willingness to seek counseling: Testing a mediation model on college-aged men. *Journal of Counseling Psychology*, 54(4), 373–384. <https://doi.org/10.1037/0022-0167.54.4.373>
- Pettit, S., Qureshi, A., Lee, W., Stirzaker, A., Gibson, A., Henley, W., & Byng, R. (2017). Variation in referral and access to new psychological therapy services by age: an empirical quantitative study. *British Journal of General Practice*, 67(660), e453–e459. <https://doi.org/10.3399/bjgp17x691361>
- Pines, M. (1990, February 2-3). *The Universality of Shame: A Psychoanalytic Approach*. [Conference session]. University College London.
- Plummer, K. (1983). *Documents of Life: An Introduction to the Problems and Literature of a Humanistic Method (Contemporary Social Research Series, 7)*. Unwin Hyman.
- Ponterotto, J. G. (2005). Qualitative research in counseling psychology: A primer on research paradigms and philosophy of science. *Journal of Counseling Psychology*, 52(2), 126–136. <https://doi.org/10.1037/0022-0167.52.2.126>
- Prior, S. (2011). Overcoming stigma: how young people position themselves as counselling service users. *Sociology of Health & Illness*, 34(5), 697–713. <https://doi.org/10.1111/j.1467-9566.2011.01430.x>
- Priory Group (2021) *How the pandemic has shifted attitudes towards mental health*. Retrieved August 3, 2022, from <https://www.priorygroup.com/media-centre/how-the-pandemic-has-shifted-attitudes-towards-mental-health>

- Reed, E. E. (2014). Man Up: Young Men's Lived Experiences and Reflections on Counseling. *Journal of Counseling & Development*, 92(4), 428–437.
<https://doi.org/10.1002/j.1556-6676.2014.00169.x>
- Riessman, C. K. (1993). *Narrative Analysis (Qualitative Research Methods)* (1st ed.). SAGE Publications, Inc.
- Riessman, C. K. (2000). Stigma and Everyday Resistance Practices. *Gender & Society*, 14(1), 111–135. <https://doi.org/10.1177/089124300014001007>
- Riessman, C. K. (2008). *Narrative Methods for the Human Sciences* (First ed.). SAGE Publications, Inc.
- Richards, C., & Barker, M. (2013). *Sexuality and Gender for Mental Health Professionals: A Practical Guide* (1st ed.). SAGE Publications Ltd.
- Robbins, C. (1989). Sex Differences in Psychosocial Consequences of Alcohol and Drug Abuse. *Journal of Health and Social Behavior*, 30(1), 117.
<https://doi.org/10.2307/2136917>
- Robson, C. (2002). *Real World Research: A Resource for Social Scientists and Practitioner-Researchers* (2nd ed.). Wiley-Blackwell.
- Rochlen, A. B., McKelley, R. A., & Pituch, K. A. (2006). A preliminary examination of the "Real Men. Real Depression" campaign. *Psychology of Men & Masculinity*, 7(1), 1–13. <https://doi.org/10.1037/1524-9220.7.1.1>
- Rochlen, A. B., & Hoyer, W. D. (2005). Marketing mental health to men: Theoretical and practical considerations. *Journal of Clinical Psychology*, 61(6), 675–684.
<https://doi.org/10.1002/jclp.20102>
- Rogers, C. R. (1957). The necessary and sufficient conditions of therapeutic personality change. *Journal of Consulting Psychology*, 21(2), 95–103.
<https://doi.org/10.1037/h0045357>

- Rosen, A. (2003). What developed countries can learn from developing countries in challenging psychiatric stigma. *Australian Psychiatry*. Published.
<https://www.tandfonline.com/doi/ref/10.1046/j.1038-5282.2003.02021.x?scroll=top>
- Rosenfield, S., & Smith, D. (2009). Gender and Mental Health: Do Men and Women Have Different Amounts or Types of Problems? In T. Scheid & T. Brown (Eds.), *A Handbook for the Study of Mental Health: Social Contexts, Theories, and Systems* (pp. 256-267). Cambridge: Cambridge University Press.
doi:10.1017/CBO9780511984945.017
- Ross, W. D. (Ed.). (1924). *Aristotle's Metaphysics* (Vol. 1). Oxford University Press.
<https://doi.org/10.1093/actrade/9780198847762.book.1>
- Rowan, J. (2002). *The Therapist's Use of Self* (1st ed.). Open University Press.
- Rudestam, K. E., & Newton, R. R. (2014). *Surviving Your Dissertation: A Comprehensive Guide to Content and Process* (4th ed.). SAGE Publications, Inc.
- Satcher, D. (1999). *Mental Health: A Report of the Surgeon General*. Washington D.C.: Department of Health and Human Services.
- Savin-Baden, M., & Niekerk, L. V. (2007). Narrative Inquiry: Theory and Practice. *Journal of Geography in Higher Education*, 31(3), 459–472.
<https://doi.org/10.1080/03098260601071324>
- Schore, A. N. (1998). Early shame experiences and infant brain development. In P. Gilbert & B. Andrews (Eds.), *Shame: Interpersonal behavior, psychopathology, and culture* (pp. 57–77). Oxford University Press. <https://micpp.org/wp-content/uploads/2016/02/early-shame-experiences-and-infant-brain-development.pdf>
- Schore, A.N. (2003). *Affect Dysregulation and Disorders of the Self* (1st ed.). W. W. Norton & Company.
- Schore, A. N. (2005). Back to Basics: Attachment, Affect Regulation, and the Developing Right Brain: Linking Developmental Neuroscience to Pediatrics. *Pediatrics in Review*, 26(6), 204–217. <https://doi.org/10.1542/pir.26-6-204>

- Schulze, B., & Angermeyer, M. C. (2003). Subjective experiences of stigma. A focus group study of schizophrenic patients, their relatives and mental health professionals. *Social Science & Medicine*, 56(2), 299–312. [https://doi.org/10.1016/s0277-9536\(02\)00028-x](https://doi.org/10.1016/s0277-9536(02)00028-x)
- Schwalbe, M. L., & Wolkomir, M. (2002). Interviewing men. In J. F. Gubrium & J. A. Holstein (Eds.), *Handbook of interview research* (pp. 203–219). Thousand Oaks.
- Schwartz, R. C. (2014). Racial disparities in psychotic disorder diagnosis: A review of empirical literature. *World Journal of Psychiatry*, 4(4), 133. <https://doi.org/10.5498/wjp.v4.i4.133>
- Seavey, C. A., Katz, P. A., & Zalk, S. R. (1975). Baby X. *Sex Roles*, 1(2), 103–109. <https://doi.org/10.1007/bf00288004>
- Shea, M., & Yeh, C. (2008). Asian American Students' Cultural Values, Stigma, and Relational Self-construal: Correlates of Attitudes Toward Professional Help Seeking. *Journal of Mental Health Counseling*, 30(2), 157–172. <https://doi.org/10.17744/mehc.30.2.g662g5l2r1352198>
- Sibicky, M., & Dovidio, J. F. (1986). Stigma of psychological therapy: Stereotypes, interpersonal reactions, and the self-fulfilling prophecy. *Journal of Counseling Psychology*, 33(2), 148–154. <https://doi.org/10.1037/0022-0167.33.2.148>
- Siegel, D. J. (2012). *The Developing Mind, Second Edition: How Relationships and the Brain Interact to Shape Who We Are* (2nd ed.). The Guilford Press.
- Sirey, J. A., Bruce, M. L., Alexopoulos, G. S., Perlick, D. A., Raue, P., Friedman, S. J., & Meyers, B. S. (2001). Perceived Stigma as a Predictor of Treatment Discontinuation in Young and Older Outpatients With Depression. *American Journal of Psychiatry*, 158(3), 479–481. <https://doi.org/10.1176/appi.ajp.158.3.479>
- Smith, J. A., Flowers, P., & Larkin, M. (2009). *Interpretative Phenomenological Analysis: Theory, Method and Research*. SAGE Publications Ltd.
- Speedy, J. (2008). *Narrative Inquiry and Psychotherapy*. Palgrave Macmillan.

- Spence, D. P. (1986). Narrative smoothing and clinical wisdom. In T. R. Sarbin (Ed.), *Narrative psychology: The storied nature of human conduct* (pp. 211–232). Praeger Publishers/Greenwood Publishing Group.
- Squire, C. (2008). Experience-centred and culturally-oriented approaches to narrative. In Andrews, M., Squire, C. and Tamboukou, M. (Eds.), *Doing Narrative Research (Chapter 2)*. Sage Publications. <https://doi.org/10.4135/9780857024992.d4>
- Srivastava, P., & Panday, R. (2016). Psychoeducation an effective tool as treatment modality in mental health. *The International Journal of Indian Psychology*, 4(1), 123-130. https://www.researchgate.net/profile/Rishi-Panday/publication/318461551_Psychoeducation_an_Effective_Tool_as_Treatment_Modality_in_Mental_Health/links/596c6c32458515e9afb1da95/Psychoeducation-an-Effective-Tool-as-Treatment-Modality-in-Mental-Health.pdf
- Stangor, C., & Crandall, C. S. (2000). Threat and the social construction of stigma. In T. F. Heatherton, R. E. Kleck, M. R. Hebl, & J. G. Hull (Eds.), *The social psychology of stigma* (pp. 62–87). Guilford Press.
- Stern, D. N. (2000). *The Interpersonal World Of The Infant: A View from Psychoanalysis and Developmental Psychology*. Basic Books.
- Stern, D. N., Bruschweiler-Stern, N., Harrison, A. M., Lyons-Ruth, K., Morgan, A. C., Nahum, J. P., Sander, L., & Tronick, E. Z. (1998). The process of therapeutic change involving implicit knowledge: Some implications of developmental observations for adult psychotherapy. *Infant Mental Health Journal*, 19(3), 300–308. [https://doi.org/10.1002/\(sici\)1097-0355\(199823\)](https://doi.org/10.1002/(sici)1097-0355(199823))
- Stolorow, R. D., & Atwood, G. E. (2014). *Contexts of Being*. Taylor & Francis.
- Stuart, H., Arboleda-Florez, J., & Sartorius, N. (2012). *Paradigms Lost: Fighting Stigma and the Lessons Learned* (1st ed.). Oxford University Press.
- Stuart, H. (2017). Stigma: Mark of shame or complex social process? *Issue of Visions Journal*, 13(1), 5–8. <https://www.heretohelp.bc.ca/sites/default/files/visions-stigma-and-inclusion-vol13.pdf>

- Tangney, J. P. (1994). The mixed legacy of the superego: Adaptive and maladaptive aspects of shame and guilt. In J. M. Masling & R. F. Borenstein (Eds.), *Empirical perspectiveness on object relations theory* (pp.1-28). Washington, DC: American Psychological Association.
- Tajfel, H., Turner, J. C., Austin, W. G., & Worchel, S. (1979). An integrative theory of intergroup conflict. *Organizational identity: A reader*, 56-65.
- Time to Change Impact report 2016–21*. (2022, March). Turtl.Co. Retrieved August 3, 2022, from <https://time-to-change.turtl.co/story/impact-report-2016-21/page/2/1>
- Today, J. (2013, March 1). *Normal behavior in Japan, taboo abroad*. Japan Today. <https://japantoday.com/category/features/lifestyle/normal-behavior-in-japan-taboo-abroad>
- Topkaya, N. (2014). Gender, Self-stigma, and Public Stigma in Predicting Attitudes toward Psychological Help-seeking. *Educational Sciences: Theory & Practice*. Published. <https://doi.org/10.12738/estp.2014.2.1799>
- Tronick, E. Z., Bruschiweiler-Stern, N., Harrison, A. M., Lyons-Ruth, K., Morgan, A. C., Nahum, J. P., Sander, L., & Stern, D. N. (1998). Dyadically expanded states of consciousness and the process of therapeutic change. *Infant Mental Health Journal*, 19(3), 290–299. [https://doi.org/10.1002/\(sici\)1097-0355\(199823](https://doi.org/10.1002/(sici)1097-0355(199823)
- Tucker, J. R., Hammer, J. H., Vogel, D. L., Bitman, R. L., Wade, N. G., & Maier, E. J. (2013). Disentangling self-stigma: Are mental illness and help-seeking self-stigmas different? *Journal of Counseling Psychology*, 60(4), 520–531. <https://doi.org/10.1037/a0033555>
- Turner, D. (2021). *Intersections of Privilege and Otherness in Counselling and Psychotherapy* (1st ed.). Routledge.
- Vega, W. A., Rodriguez, M. A., & Ang, A. (2010). Addressing stigma of depression in Latino primary care patients. *General Hospital Psychiatry*, 32(2), 182–191. <https://doi.org/10.1016/j.genhosppsych.2009.10.008>
- Vogel, D. L., Bitman, R. L., Hammer, J. H., & Wade, N. G. (2013). Is stigma internalized? The longitudinal impact of public stigma on self-stigma. *Journal of Counseling Psychology*, 60(2), 311–316. <https://doi.org/10.1037/a0031889>

- Vogel, D. L., Shechtman, Z., & Wade, N. G. (2010). The Role of Public and Self-Stigma in Predicting Attitudes Toward Group Counseling. *The Counseling Psychologist*, 38(7), 904–922. <https://doi.org/10.1177/0011000010368297>
- Vogel, D. L., Wade, N. G., & Haake, S. (2006). Measuring the self-stigma associated with seeking psychological help. *Journal of Counseling Psychology*, 53(3), 325–337. <https://doi.org/10.1037/0022-0167.53.3.325>
- Vogel, D. L., Wade, N. G., & Aschman, P. L. (2009). Measuring perceptions of stigmatization by others for seeking psychological help: Reliability and validity of a new stigma scale with college students. *Journal of Counseling Psychology*, 56(2), 301–308. <https://doi.org/10.1037/a0014903>
- Vogel, D. L., Wade, N. G., & Hackler, A. H. (2007). Perceived public stigma and the willingness to seek counseling: The mediating roles of self-stigma and attitudes toward counseling. *Journal of Counseling Psychology*, 54(1), 40–50. <https://doi.org/10.1037/0022-0167.54.1.40>
- Vogel, D. L. and Wade, N. G. (2009) Stigma and help-seeking. *The Psychologist*, 22, 20–23.
- Vogel, D. L., Armstrong, P. I., Tsai, P. C., Wade, N. G., Hammer, J. H., Efstathiou, G., Holtham, E., Kouvaraki, E., Liao, H. Y., Shechtman, Z., & Topkaya, N. (2013). Cross-cultural validity of the Self-Stigma of Seeking Help (SSOSH) scale: Examination across six nations. *Journal of Counseling Psychology*, 60(2), 303–310. <https://doi.org/10.1037/a0032055>
- Vogel, D. L., Heimerdinger-Edwards, S. R., Hammer, J. H., & Hubbard, A. (2011). “Boys don’t cry”: Examination of the links between endorsement of masculine norms, self-stigma, and help-seeking attitudes for men from diverse backgrounds. *Journal of Counseling Psychology*, 58(3), 368–382. <https://doi.org/10.1037/a0023688>
- Vogel, D. L., Strass, H. A., Heath, P. J., Al-Darmaki, F. R., Armstrong, P. I., Baptista, M. N., Brenner, R. E., Gonçalves, M., Lannin, D. G., Liao, H. Y., Mackenzie, C. S., Mak, W. W. S., Rubin, M., Topkaya, N., Wade, N. G., Wang, Y. F., & Zlati, A. (2017). Stigma of Seeking Psychological Services: Examining College Students Across Ten Countries/Regions. *The Counseling Psychologist*, 45(2), 170–192. <https://doi.org/10.1177/0011000016671411>

- Wahto, R., & Swift, J. K. (2014). Labels, Gender-Role Conflict, Stigma, and Attitudes Toward Seeking Psychological Help in Men. *American Journal of Men's Health*, 10(3), 181–191. <https://doi.org/10.1177/1557988314561491>
- Wallin, D. J. (2015). *Attachment in Psychotherapy*. Guilford Publications.
- Wang, P. S., Aguilar-Gaxiola, S., Alonso, J., Angermeyer, M. C., Borges, G., Bromet, E. J., Bruffaerts, R., de Girolamo, G., de Graaf, R., Gureje, O., Haro, J. M., Karam, E. G., Kessler, R. C., Kovess, V., Lane, M. C., Lee, S., Levinson, D., Ono, Y., Petukhova, M., . . . Wells, J. E. (2007). Use of mental health services for anxiety, mood, and substance disorders in 17 countries in the WHO world mental health surveys. *The Lancet*, 370(9590), 841–850. [https://doi.org/10.1016/s0140-6736\(07\)61414-7](https://doi.org/10.1016/s0140-6736(07)61414-7)
- West, M. (2004). Identity, narcissism and the emotional core. *Journal of Analytical Psychology*, 49(4), 521–551. <https://doi.org/10.1111/j.0021-8774.2004.00482.x>
- Williams, D. R. (2018). Stress and the Mental Health of Populations of Color: Advancing Our Understanding of Race-related Stressors. *Journal of Health and Social Behavior*, 59(4), 466–485. <https://doi.org/10.1177/0022146518814251>
- Willig, C. (2013). *Introducing Qualitative Research in Psychology Third Edition* (Revised ed.). Open University Press.
- Wilson, E. J. (1996). *Time-conscious Psychological Therapy* (1st ed.). Routledge.
- Winkler, P., Csémy, L., Janoušková, M., Mladá, K., Bankovská Motlová, L., & Evans-Lacko, S. (2015). Reported and Intended Behaviour Towards Those With Mental Health Problems in the Czech Republic and England. *European Psychiatry*, 30(6), 801–806. <https://doi.org/10.1016/j.eurpsy.2015.05.003>
- Winnicott, D. W. (1960). Ego distortion in terms of true and false self. The Maturation Process and the Facilitating Environment: Studies in the Theory of Emotional Development. *International Universities Press*, 140–57. <https://icpla.edu/wp-content/uploads/2017/11/Winnicott-D.-Ego-Distortion-in-Terms-of-True-and-False-Self.pdf>
- Winnicott, D. W. (2005). *Playing and Reality (Routledge Classics)* (2nd ed.). Routledge.

Zane, N., & Yeh, M. (2002). The Use of Culturally-Based Variables in Assessment: Studies on Loss of Face. In K. S. Kurasaki, S. Okazaki, & S. Sue (Eds.), *Asian American mental health: Assessment methods and theories* (pp. 123–138). Kluwer Academic Publishers.

Ziebland, S., & McPherson, A. (2006). Making sense of qualitative data analysis: an introduction with illustrations from DIPEX (personal experiences of health and illness). *Medical Education*, 40(5), 405–414. <https://doi.org/10.1111/j.1365-2929.2006.02467.x>

APPENDICES

Appendix A: Example of line-by-line analysis

commit for different reasons (R: Mmm). And I started to wonder whether it was something linked to, erm, losing my dad at a young age, I could sort of see that there was some kind of link but I couldn't quite work out what it was (R: Mmm). So erm, so I'd got to a point in this new relationship which was a few months, where I really cared about the person, who is now my husband (Chuckles) erm, but I was sort of having some questions about whether it was right for me, whether he really loved me, whether I really could, erm, cope with the anxiety of the long distance relationship, all sorts of different things (R: Mmm). But I sort of sensed it was some abandonment issues and there was something linked with losing my dad when I was very young, erm so..... At that point, because I realised that the relationship was feeling quite fragile and I was feeling very unsure about myself and different things, I decide to get in touch with a therapist. No, I went to my GP (R: Mm hmm), and the GP erm, said that I could have 8 sessions with a therapist. It didn't feel like long enough, it felt like it opened up erm, some difficulties, some wounds and I felt that, very shaky about getting that far and then having to stop (R: Mm hmm). So it was the same therapist that I went to see in her private practice (R: Ah ok). I didn't tell anybody that I was going to the doctor. I didn't tell anyone that I'd started therapy and it felt like it was a very erm, a sort of.... private, but almost erm, it was something I couldn't speak about because (R: Mmm), erm, I felt that people saw me as a capable person, erm, a sociable, happy, positive person erm..... and I think I was very aware.... there were issues for me around being vulnerable and erm..... (Pause - becoming tearful) just ignore me if this happens. I'm ok but I might get a bit upset now and again (R: Mmm). So really, I think it was about not being acceptable. If I wasn't happy and together and all those things (R: Mmm), I think it's something that maybe a lot of people feel, but I felt it quite acutely, that it couldn't be spoken about. And that was a sort of internal sort of battle that I was having, because I did really want to speak to somebody. And to be able to, not share what was going on in the therapy necessarily, but just..... to be able to sort of say to someone..... that I was feeling vulnerable, yeah erm, and that I needed some support (R: Mmm). I didn't feel I could.

but not wanted to
commit. - link to losing
Dad? Young age.

This new relationship
(now husband). - began
to question it.

sensed abandonment
issues. - losing Dad.

Relationship = fragile, unsure
Went to GP - 8 sessions
- not long enough
- "opened up" "wounds"

Continued in PP.

Didn't tell anyone about
GP or Th.
"Private" "Couldn't speak
about" because?
- capable, happy, positive
- issues around being
vulnerable.
- "about not being
acceptable"

something a lot of
people feel - "I felt it
quite acutely!"
"it couldn't be spoken
about."

Internal battle.

- wanting to share she
was feeling vulnerable.
and needed some
support

"I didn't feel I could"

R3: That was the hardest part, it sounds like.

CR3: It was.

R4: Wanting to be able to just share how you were feeling, really.

CR4: Yeah. Yeah.

R5: But that came with a whole, kind of, sense of whether that was ok, was it acceptable to be even feeling that way.

CR5: Yes, exactly. And erm, I also felt that erm, if I told family or friends, it would be a case of, *are we not enough for you? why do you have to go and see a therapist?* Erm, *Can't you just talk to us about it like most people do?* (R: Mmm) Erm, if, I also had the sense that

therapy was sort of seen as a bit of an *indulgence* (R: Mm hmm), erm, that really err, you know, to sit and talk about yourself for an hour every week, erm, my family would be seen as erm, rather

indulgent (a bit precious, a little bit erm, sort of..... because I'd been sort of raised with the idea that erm, the *best way to make yourself*

feel better is to do things for others (R: Mmm), erm, the best way to sort of feel happier or to resolve, erm, any sense of loneliness or...

lack of purpose, or any of those things, some of things that I was feeling at the time, was really to *reach out to others*, erm, and do for others, rather than sort of *sit and naval gaze*. So, this is part of the sort of family kind of..... way of doing things, I suppose (R: Right). I'd

been raised that way, my friends had sort of..... well my.... that's another thing altogether. My friends that I'd surrounded myself with were very good friends actually and they're still very good friends

erm, but I'd met them through sort of..... err prayer group, Christian Union erm, things like that. And they were really very good to me and

my faith has been a great inspiration and support to me, but there have also been issues with that whole way of thinking erm, and my friends, erm, experienced me as someone who was a support to them, erm, and they were a support to me as well.... I don't know where I'm going really with all this, but err. It was also a way of life that we'er, that we sort of... subscribed to I suppose.

R6: And when you say we?

● If disclosed Th:

Th as an "Indulgence".
"sit and talk about yourself for an hour every week".

Family see this as "Indulgent" "a bit precious"

"Best way.... do things for others".... "reach out to others" → to resolve loneliness, or lack of purpose. - rather than "naval gaze"

● "Been raised that way."

Friends through prayer group / Christian Union.

- Faith as inspiration and support. - but also issues with that way of thinking....?

- Support to and from friends....

● Way of life we subscribed to.

R7: Mmm

CR7: Err.... and I had known, I'd known all through my life that I felt strange and I felt like an outsider and all the usual sort of erm, sort of things, and I knew there were obviously psychological and developmental reasons for it, but I didn't know how to find out about those things and I always shied away from it because, I suppose because of the stigma and because I was worried that.... if people thought that I was looking for any sort of help for mental issues, shall we say (R: Uh huh), and that's not so much, I don't know, I don't know whether I've ever suffered from depression, I suspect I probably have, but I've certainly never sought any, erm, help, I've never talked to my doctor or anything like that, and even though there were times, there have been plenty of times in my life where I have really felt that I should, I never did, and I know the reason for that was because I was embarrassed and ashamed and... erm I suppose as well, I come from erm, Ireland from..... well both my mum and dad would of had very harsh upbringings where there wouldn't have been very much love or affection or time for talking about erm, problems of that sort of kind, so.

"throughout my life"
longevity of difficulties.
'strange' / 'outsider'
Awareness of psych. dev. reasons
Didn't know how to find out more 'shied away'.
Stigma.
People's thoughts if help for 'mental issues'
Q of depression? label.
but never sought help via doctor. -
times when she 'should'
"embarrassed" + "ashamed"
Context: Ireland. +
parents 'harsh upbringings'
"not much love, affection or time for talking."

R8: So do you think that plays a part in it.....

CR8: yeah, very much so....

R9: how you felt about being open?

CR9: very much so, yeah. When I was growing up it was very much; you just get on with it, you don't, you don't cry about things, you just get on with it (R: Uh huh). And I basically carried that through my whole life. Erm... and any sort of approaches that I've ever made to talk to family or my mum about things that happened in the past never ended well (Chuckles)... erm. But since I started having the therapy, erm again, I didn't, I didn't look to do that through my GP, I erm chose to do that privately, again, partly because I wanted to see someone quickly and partly because I sort of didn't want it on my medical record, erm..... and I don't know why, but (R: Mmm) you read things here and there about, you know, it can affect insurance and all kinds of things, erm, if you ever need to make a, a claim on

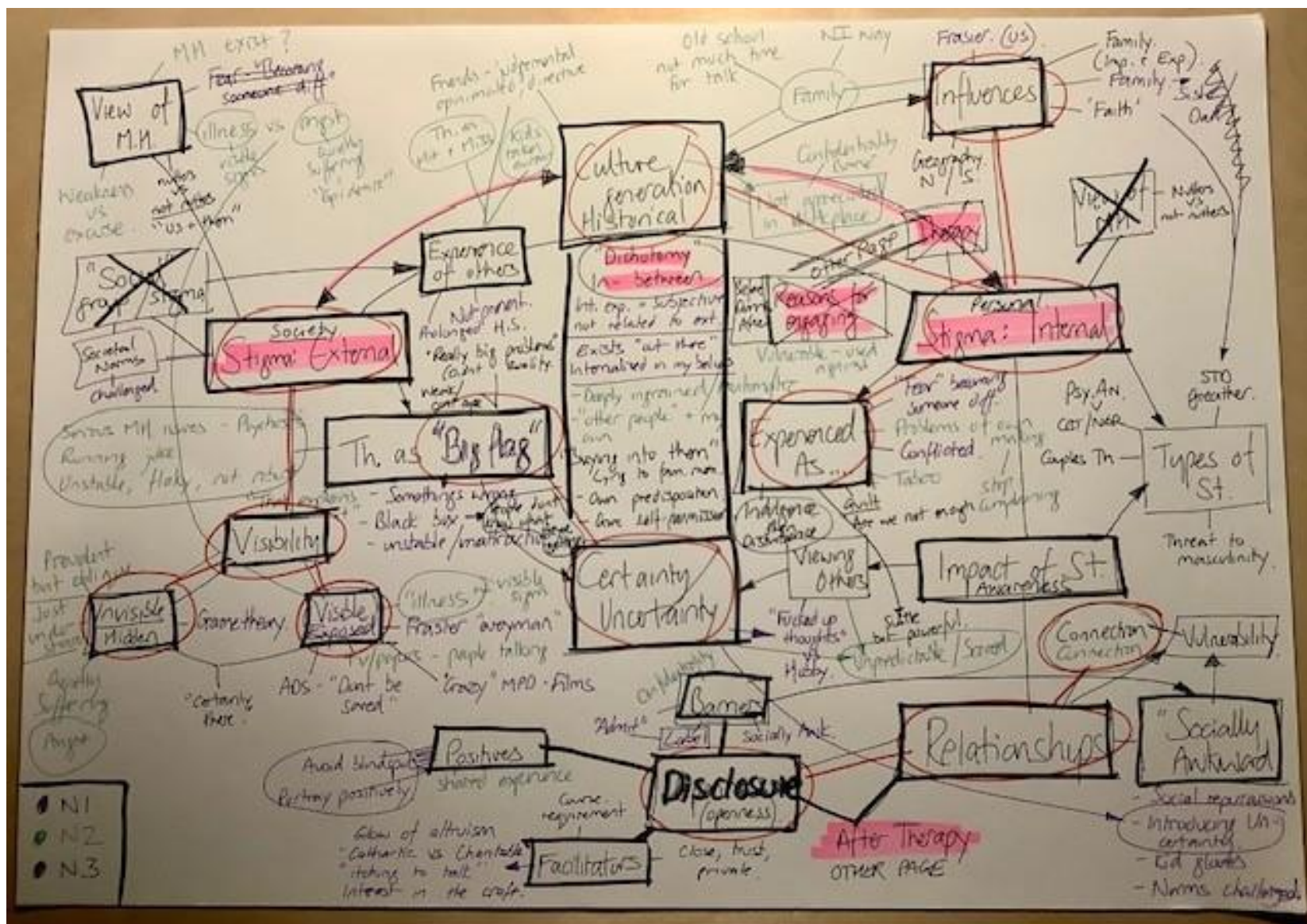
message
"growing up":
"just get on with it"
"Don't cry about things"
carried thru whole life.
Difficulties talking with family "never ended well."
Th. privately not via GP.
- quickly.
- avoid medical record.
↓
affect insurance...?

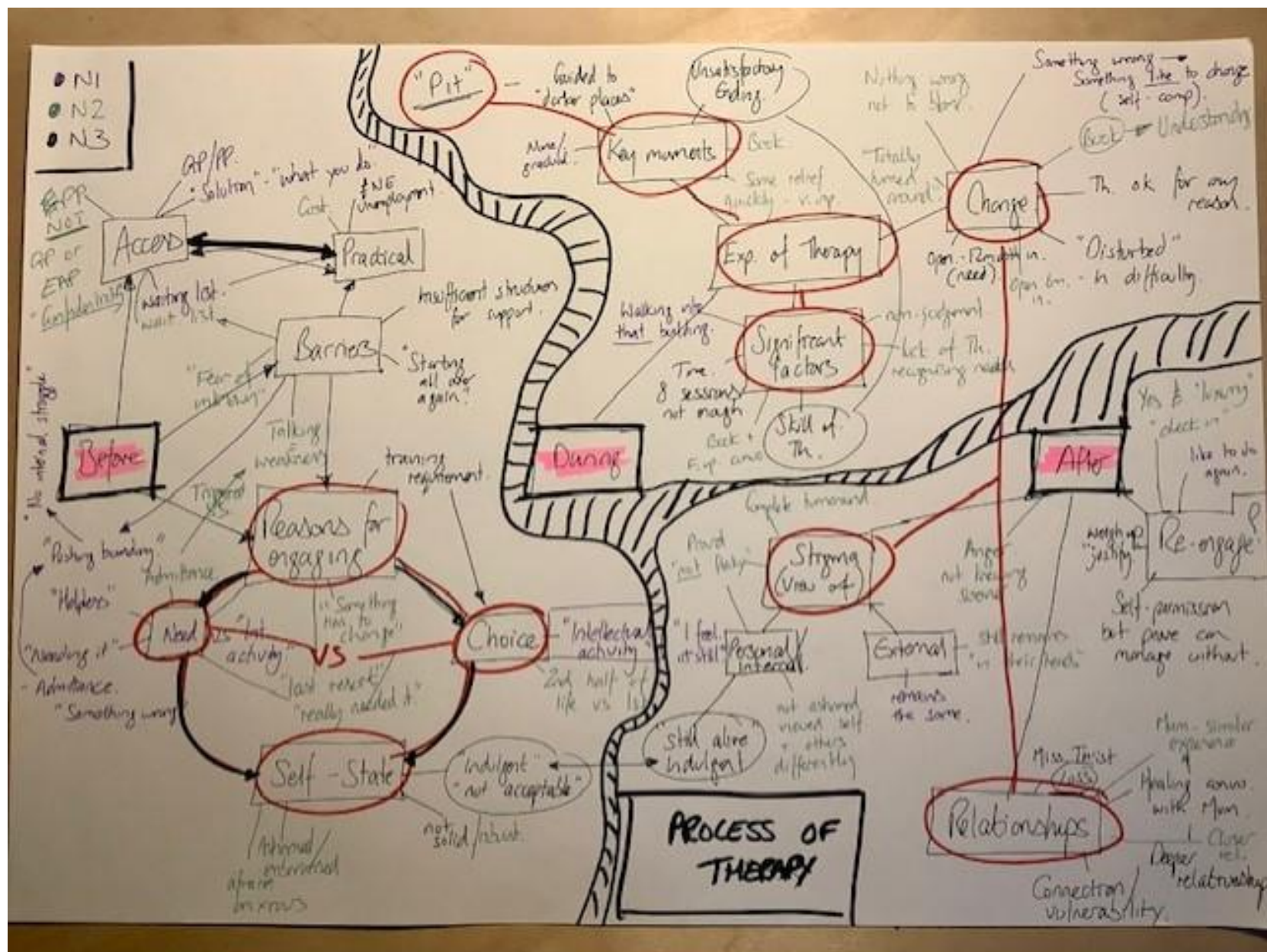
(Probed to expand)

Appendix B: Example summary of coding

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Appendix C: 'OSOP' (one sheet of paper) organising of themes





Appendix D: Excerpts from research notes

Reflections on interview: 1:1. 10-10-19

right angles less imposing?

* Seating

- Setting the scene with my own exp. of Th. and acknowledgment of stigma was well received - A sense of shared experience/understanding. seemed important and settling - for him and also me!
- Had clearly spent considerable time thinking about topic - especially in terms of how it was conceptualised and why that might be - Noticed myself drawn into this intrigued by it (* perhaps more comfortable for both of us ... ??)
- ↓ Then aware of this - noticed some anxiety → Need good data!!
- Once or twice caught myself trying too hard to "get on track" - what I thought he should be describing. - One or two leading q's as a result.

→ Two exp. of Th. - provided interesting contrast.

VS.

- "In need of help"
- "Intellectual activity"

→ Dichotomy of Mind vs Body.

→ Stigma located externally

→ Sense of us grappling with experience of stigma - "under the surface" - Hard to pin down.

- A felt sense of it something that is there at an embodied level.
- Diff. for us to speak of this, staying much more "heady" instead.

↓

* Two men talking ?

Aware of my role, researcher vs therapist - noticed wanting to explore more, go to the emotion, but staying with C's story.

↓

Q - Where does the line sit? facilitate exploration of experience without too much deviation.

Interview 1:2

31-11-19

- Real sense of rapport following on from 1st meeting.
- * Support for value of this.

Although "heady" aspect still ardent.
Sense of deeper personal reflection.
- more room available for this.

- Interesting dynamic in family - Dad.
Considered my role/position - who am I?
- Seemed to provide opp. to explore / talk of what opp. is not possible elsewhere ... hesitation / discomfort of doing so.
(father - support vs. reluctance / avoidance?)

* Embodiment.
"Engineer not a poet"

"Socially awkward".
Key implication - where does this originate?

Little talk of Th. process - of self-comp.
* re-framing

Thoughts,

- Ps desire to tell their story - ownership - parallel with desire to tell others about Th. - Why??

Is it, authentically? or more than that → Contact, connection
- "wired to connect"

- Th. as template - taken elsewhere and repeated.

→ Talking to me as another opp. and self-reassurance / reflection.

- Reflection in/on action (Ephun).

Second interview v. helpful.

Value of talking this exp. -
- N2 - realisation of "how much stigma was 'in her head'".

- N3 - reflection on not telling children - thoughts changed - be person I need to be because of Th.

- * → N3 exp. resonates with my own - side step stigma as "requirement".
- unacceptable / indulgence.

↓ Shame

- My own avoidance now?
- Struggle to re-engage...

Call for research participants

Research title: The stigma of psychotherapy: Clients' accounts



Have you attended psychotherapy despite feeling that there is a stigma surrounding it?
If so, it would be great to hear your story.

Stigma is often considered the main reason that stops people attending psychotherapy, yet there are many people who do attend. This research aims to better understand different attitudes towards psychotherapy and how the stigma that surrounds it can be reduced, both in and outside the therapy room.

My research is focusing on how the stigma of psychotherapy is experienced before, during and after attending psychotherapy.

The criteria to be included in the research are that:

- You have attended psychotherapy and feel there is a stigma surrounding it
- You have finished working with your therapist within the last 6 months
- You participated in at least 12 sessions of psychotherapy on a weekly basis
- You are willing to talk freely about your experience of stigma and psychotherapy

Participating in this research will give you the chance to reflect on your experiences, whilst contributing to the understanding of different attitudes towards psychotherapy, with a view to reducing the stigma that surrounds it.

For more information, please contact Richard Webster: richard.webster@metanoia.ac.uk / 07949 592336. Or Dr Camilla Stack, the research supervisor: camillastack@gmail.com

Appendix F: Participant information sheet



PARTICIPANT INFORMATION SHEET V.1

March 2019



You are being invited to take part in a research study. Before you decide whether or not to take part it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Please ask us if there is anything that is not clear or if you would like more information.

Title of project: The stigma of psychotherapy: Clients' accounts

Name of researcher: Richard Webster

What is the purpose of the research?

The purpose of this research is to investigate what the experience of psychotherapy has been like for people who feel there is a stigma that surrounds it.

Stigma is often seen as the main reason that stops people from attending psychotherapy. However, there are many people that do attend and see it as a way of taking action and control in their lives. It is hoped that the results of this research will help to better understand these different attitudes towards psychotherapy and how the stigma that surrounds it can be reduced, both in and outside of the therapy room. The ultimate aim is to encourage more people to seek psychotherapy and to benefit from the insight and empowerment that it can often provide.

The research is likely to be completed within the next twelve months.

Why have I been asked to participate?

You have been asked to participate because you have completed at least 12 weeks of psychotherapy within the last 6 months, and have now finished working with your therapist.

A total of between 3 and 5 participants will be taking part in the study.

Do I have to take part?

Taking part in this research is entirely voluntary. If you decide you would like to take part, then you will be asked to sign a consent form which you will be given a copy of to keep. If

during the study you decide that you no longer wish to take part, you are free to withdraw at any time and without giving a reason. In the event of this happening, you can decide what happens to any of the data you have provided.

How will I be involved if I take part?

You will initially be asked to speak on the phone with the researcher to discuss the research process and to confirm your suitability and willingness to talk in depth about your experiences. Following this, your involvement will entail talking freely about your experience of stigma and psychotherapy in two interviews, which will take place several weeks apart. There is no set time limit to each interview, although a guide would be of approximately an hour. This is to allow time for you to talk about your experiences and to give you the opportunity reflect upon and add to your account during the second interview.

The interviews will be conducted by the researcher who will ask you questions during your account. The interviews will take place at a suitable location close to you, perhaps your home or a local community/public space. The interview will be recorded and then transcribed. You will have the opportunity to read the transcript in order to check that you are happy with what is written. At a later stage, the transcript will be analysed and interpreted by the researcher, who may contact you to ask for clarification on parts of the interviews. You may also be asked for your thoughts on the analysis and interpretations offered, and you will have the opportunity to review sections of your account to be included in the study.

What will I have to do?

Taking part in this study entails your willingness to talk openly about your experiences of stigma and psychotherapy in two recorded interviews. It also requires your willingness to be contacted subsequently during the research period as outlined above.

What are the possible disadvantages and risks of taking part?

It is possible that talking about your experiences of stigma and psychotherapy might take you back to places of vulnerability and might reawaken painful feelings. It is recommended that you are willing to make contact with a therapist following your participation, if you feel you require further support. The researcher can give you information about other sources of support, some of which are listed below.

What are the possible benefits of taking part?

It is hoped that participating in the study will be of interest to you, and provide an opportunity to reflect on your experience of therapy. It is also hoped that the information gained from your participation, along with others, will contribute to understanding the stigma of psychotherapy, and ultimately help to find ways to encourage more people to seek help. However, due to the nature of this kind of research, such outcomes cannot be guaranteed.

Will my taking part in this study be kept confidential?

All information that is collected about you during the course of the research will be kept strictly confidential. Any information which is used will have your name and personal details removed so that you cannot be recognised from it. All data will be stored, analysed and reported in compliance with UK Data Protection legislation.

What will happen to the results of the research study?

The results of this research study will be published as a doctoral thesis. It is also possible that articles based on the research will be published in academic and practitioner journals, or as a book chapter/book. The researcher can tell you where you can obtain a copy of the published results. You will not be identified in the thesis or any article/publication.

Who has reviewed the study?

This study has been reviewed by the Metanoia Research Ethics Committee.

What if I have a question?

If you have any questions at all regarding the research, at any point, these are most welcome and you are encouraged to contact the researcher or research supervisor without hesitation. The contact details are below.

Contact details for further information

Researcher contact details:

Richard Webster: richard.webster@metanoia.ac.uk

Research supervisor contact details:

Dr Camilla Stack: camilla.stack@gmail.com

Metanoia Institute
13 North Common Road
Ealing, London
W5 2QB

020 8579 2505
www.metanoia.ac.uk

Sources of support

Samaritans

Telephone: 116 123

Email: jo@samaritans.org

Website: samaritans.org

SANeline

Telephone: 0300 304 7000

Email: info@sane.org.uk

Website: sane.org.uk

Mind

Telephone: 0300 123 3393

Email: info@mind.org.uk

Website: mind.org.uk

Ealing Abbey Counselling Service (EACS)

Reduced cost general counselling service

1A Montpelier Avenue

Ealing

London

W5 2XP

Telephone: 020 8998 3361

Email: counselling@eacs.org.uk

Website: eacs.org.uk

British Association for Counselling and Psychotherapy (BACP)

Find a therapist database

Telephone: 0870 443 5252

Website: itsgoodtotalk.org.uk

UK Council for Psychotherapy (UKCP)

Find a therapist database

Telephone: 020 7014 9955

Website: psychotherapy.org.uk/find-a-therapist

Thank you for your interest in this study.

Appendix G: Participant consent form



CONSENT FORM



Participant Identification Number:

Research Title: The stigma of psychotherapy: Clients' accounts

Name of researcher: Richard Webster

Please initial box

- | | |
|---|--------------------------|
| 1. I confirm that I have read and understand the participant information sheet dated March 2019 for the above study. | ☐ |
| 2. I have had the opportunity to ask any questions that I may have. | ☐ |
| 3. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason. If I choose to withdraw, I can decide what happens to any data I have provided. | ☐ |
| 4. I understand that my interview will be recorded and then transcribed. | ☐ |
| 5. I agree to take part in the above study. | ☐ |
| 6. I agree that this form that bears my name and signature may be seen by a designated auditor. | ☐ |

Name of participant

Date

Signature

Name of researcher

Date

Signature

1 copy for participant; 1 copy for researcher

Appendix H: Letter of ethical approval



13 Gunnersbury Avenue
Ealing, London W5 3XD
Telephone: 020 8579 2505
Facsimile: 020 8832 3070
www.metanoia.ac.uk

Richard Webster
Doctorate in Counselling Psychology and Psychotherapy by Professional Studies (DCPsych)
Metanoia Institute

6th January 2022
Ref: 9/18-19/version2

Dear Richard,

Re: Unearthing the complexity of stigma: A narrative inquiry into clients' experiences of stigma and psychotherapy

I am pleased to let you know that the recent minor amendment of a change of name to your ethically approved project has been approved by Metanoia Research Ethics Committee. If in the course of carrying out the project there are any new developments that may have ethical implications, please inform me as research ethics representative for the DCPsych programme.

Yours sincerely,



Dr Joel Vos
Senior Researcher & Senior Lecturer DCPsych
Faculty of Research and Doctoral Programmes

On behalf of Metanoia Research Ethics Committee

Registered in England at the
above address No. 2918520

Registered Charity No. 1050175

Appendix I: Research Supervisor Confirmation of Consent



Research Supervisor Confirmation of Consent

Name of student: RICHARD WASSER

Name of research project: UNEARTHING THE COMPLEXITY OF STIGMA!

A NARRATIVE INQUIRY INTO CLIENTS' EXPERIENCE OF STIGMA AND
This is to verify that as Research Supervisor for the above research project I have personally
seen proof that appropriate consent has been obtained from the participants used in
the project.

Supervisor's name: CAMILLA STACE

Signature: 

Date: 30.11.21