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How does psychiatric diagnosis and the language of "disorder" shape humanistic counselling practice? A qualitative reflexive thematic analysis.

ABSTRACT

BACKGROUND: Humanistic approaches to counselling traditionally adopt a non-pathologising stance whereby distress is understood in the context of client subjectivity, rather than standardised diagnostic criteria; yet medicalised language and labels increasingly accompany clients into the counselling room and frame how many people understand their experience. Existing research exploring the influence of psychiatric discourse upon attitudes and approaches of mental health professionals does not include humanistic counselling professionals despite clear tensions between humanistic and psychiatric paradigms. This study sought to address this gap by exploring the interplay between humanistic counselling practice and psychiatric discourse through the lived experience of humanistic counselling professionals in Ireland.

METHOD: Using Reflective Thematic Analysis, this qualitative study conducted semi-structured interviews to explore the attitudes and approaches of (n=7) humanistic counselling professionals in Ireland toward psychiatric discourse, and working with clients given a psychiatric diagnosis. This research was explored through the lens of critical realism.

RESULTS: Four themes are reported in this paper: (i) therapist attitudes, (ii) therapeutic approach, (iii) training, knowledge and understanding, and (iv) therapist resistance to psychiatric discourse. Evidence of incongruent, suspicious, and pessimistic attitudes among participants towards clients presenting with a psychiatric diagnosis were identified within the data. These attitudes may be shaped by stigma and stereotypes associated with a client's diagnosis. Participants described directive and cautious approaches to working with clients diagnosed with a "disorder", and at times appeared to prioritise management over the meaning of "symptoms". Counselling education may play a role in counsellor attitudes and approaches to psychiatric discourse. Attempts to resist the dominance of psychiatric discourse of psychiatry in practice were evident throughout the data.

CONCLUSION: Findings of this study suggest that psychiatric language may threaten the integrity of humanistic counselling practice through incongruent attitudes, focus on "fixing", and pessimism among therapists when clients are viewed in terms of psychiatric "disorder". Results of this paper invite therapists to reflect critically upon their relationship with psychiatric discourse. This includes consideration of the influence of any taken-for-granted knowledge of psychiatric "disorder" and how this may shape their attitudes and approach to counselling practice. Further research might examine the hidden assumptions that therapists hold with regard to psychiatric discourse.

Keywords: psychiatry, counselling and psychotherapy, diagnosis, attitudes, stigma, reflexivity.

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1. Introduction

The humanistic counselling relationship invites clients to explore the personal meaning of their unique experience, free from classifications and explanations by others. In contrast to the psychiatric paradigm, where medical "experts" make reference to standardised lists of "symptoms" in order to diagnose psychiatric "disorder" (American Psychiatric Association, [APA], 2013), humanistic psychologist Carl Rogers claimed that the counselling relationship

facilitates a process of *self*-diagnosis that "goes on in the [phenomenological] experience of the client, rather than in the intellect of the clinician" (1951, p.223).

While counselling and psychotherapy traditionally offer non-medical spaces in which to explore experiences of distress, medicalised language and labels increasingly accompany clients into the counselling room and frame how many people understand their experience (Stein et al., 2022; Isobel, 2023). Many people appear to believe that emotional distress such as persistent low mood is often caused by "chemical imbalances" in the brain (Ang et al., 2022) despite little evidence to support a causal relationship (Moncrieff et al., 2022). Indeed, the Royal College of Psychiatrists in the UK states that antidepressant medications do not address the "cause" but rather the "symptoms" of low mood (2019, p.7).

This influential "disorder" discourse is at odds with humanistic approaches (such as the person centred approach), which regard the client's feelings, thoughts and behaviour as valid responses in the context of their previous and present experience (Person Centred Association, 2023). Yet the general public are encouraged by the state to visit a medical professional as the first port of call for anyone experiencing emotional distress (Health Service Executive, [HSE], 2022a,b) and medical explanations that offer "evidence-based" treatment guidelines and "expert" recommendations may shape public expectations when seeking support. This may present challenges for humanistic counselling professionals working within a society where mainstream responses to emotional distress are organised through the psychiatric paradigm. Furthermore, the literature teems with evidence suggesting that attitudes and approaches of mental health professionals can become stigmatised and lose sight of the individual when working with psychiatric constructs to explain and describe human distress (and is presented below). Yet much of this is quantitative, and to the knowledge of the author there are no studies exploring how psychiatric discourse may shape the practice of humanistic counselling. This is important because there is a risk that this traditionally non-pathologising practice (that places emphasis on the individual's subjective experience) may be compromised by standardised diagnostic criteria in a culture that increasingly medicalises distress. Therefore, t he author was therefore keen to explore how this may play out through the attitudes and approaches of counselling professionals when working with clients given a psychiatric diagnosis.

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1.1 A double-edged sword of diagnosis

Some people report relief and validation upon receiving a psychiatric diagnosis (Cooke et al., 2017, p.24; Sanders & Tolan, 2023, p.12) and a diagnosis may be necessary in order to

access support (Morgan, 2017). Benefits of diagnosis however are often tempered by stigmatised attitudes from others (Dalla Vecchia Pereira & Skovdal, 2022), including the professionals they are seeking support from. Empirical research found within the literature suggests that psychiatric labels may contribute towards stigma, prognostic pessimism and reduction in experience of empathy among nurses, social workers, psychologists and psychiatrists (Lebowitz & Anh, 2014; Magliano et al, 2017; McKenzie et al, 2022; Kolb, Liu & Jackman, 2023). Yet while threats to therapeutic alliances arising from psychiatric conceptualisations of distress are evident in literature exploring other health professionals, the author struggled to identify any empirical research specifically exploring the effects of psychiatric discourse upon humanistic counselling practice.

1.2 Socially constructed and scientifically contested

C oncerns regarding the influence of psychiatric discourse in counselling practice include claims that psychiatric diagnoses are socially constructed categories of "disorder" that are "treated as a positivist empirical construct" (Strong et al., 2012). The classification of homosexuality as a "mental disorder" within the ninth edition of the World Health Organization's International Classification of Diseases (ICD) until 1990 for example, demonstrates how the medical model may be used to pathologise or de-pathologise the lived experience to reflect changes in morality over time (Parker et al., 1995, p.9; Williams, 2023, p.169). As such, socially constructed ideas of "disorder" may jar with the non-pathologising stance of humanistic counselling practice. Yet psychiatric discourse is ubiquitous and can shape what we "know" to be true about emotional distress (Foucault, 1977, p.30); these constructs may then be accepted as empirically sound by client and counsellor.

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Ethical concerns have also been raised by members of the counselling profession regarding the use of psychiatric constructs that lack scientific rigour (Read et al., 2013, p.47; Lynch, 2019, p.145; Watson, 2019, p.233; Caplan, 2020). The APA (2013, p.5) describes the DSM-V as a scientifically reliable means of psychiatric diagnosis and suggests that this iteration of the DSM marks "substantial progress" in its reliability as a diagnostic tool. However, a critique of the DSM-V by Vanheule et al (2014) shows that the intraclass κ-coefficient parameters used to measure reliability of diagnostic categories have been "considerably relaxed" over time, and if the original criteria devised by Spitzer and Fleiss (1974) to assess reliability of previous versions of the DSM were applied to the DSM-V, then most disorder categories tested in the DSM-V field trials would have scored an *unacceptable* rating for reliability.

Furthermore, in their review of the scientific basis for psychiatric classification and research, Uher and Rutter (2012) found “no scientific basis for the validity of the vast majority of mental disorders” classified in the ICD or DSM. The Irish Association of Counselling and Psychotherapy code of ethics (IACP, 2018) states that therapists must only use modalities that are “grounded in research”; clinical psychologist Lucy Johnstone and colleagues claim that it is unethical and scientifically unjustifiable for professionals to “present psychiatric diagnoses as if they were valid statements about people and their difficulties” (2018, p.85). This presents an ethical challenge for therapists when working with psychiatric constructs in their practice - for example where clients may prefer to use or refer to psychiatric ways of viewing their experience.

1.3 Losing sight of the individual

A number of studies reveal concerns among counselling professionals that psychiatric discourse may impact negatively upon clients and the therapeutic relationship. A quantitative exploration of (n=154) counsellor attitudes towards the DSM-IV by Gayle and Raskin (2017) in the United States (US) identified a concern among counsellors that psychiatric labels “distort perceptions of the client” (52.06%), and “obscure individual differences” (60.3%). Another quantitative study of (n=380) counsellors in the US by Mead et al. (1997) found that while some counsellors named “treatment planning”, “case conceptualisation” and “communication” as advantages to psychiatric diagnosis, they named “bias”, “stigma” and “labelling of clients” as disadvantages to diagnosis. These data reveal a tension between standardised diagnostic categories and traditional humanistic values that regard the individual as “utterly unique” (Irish Association of Humanistic and Integrative Psychotherapy, [IAHIP] 2022).

1.4 Alternatives to psychiatric diagnosis

The British Psychological Society’s (BPS) Division of Clinical Psychology (2013, p.1) suggests moving away from diagnostic language of psychiatric “disorder” completely due to its “significant conceptual and empirical limitations”. Non-pathologising alternatives are recommended by the BPS, which describe behaviour and experience in non-medical terms, and “within its personal, interpersonal, social and cultural context” (2015, p.3). An example of this is the The Power Threat Meaning Framework (Johnstone and Boyle, 2018), which seeks to understand *what’s happened to you?* instead of *what’s wrong with you?* Based on the principles of psychological formulation, this may be compatible with counselling approaches that may regard distressing experiences as part of a client’s ongoing process rather than

fixed “disorder” (Martin, 2023, p.63). Gayle and Raskin (2017) found that counsellors responding to their survey were “supportive of the development of alternative [non-pathologising] diagnostic systems” that include “social–interpersonal diagnosis” and “mapping developmental and personal meanings”.

1.5 Psychiatric language may influence experience of empathy

Concerns about the relationship between psychiatric discourse and counselling practice are buttressed by a 2014 study by Lebowitz and Ahn, which examined the effects of biological explanations of client distress upon “mental health” professional’s experience of empathy. Empathy is an important factor in the shaping of a therapeutic alliance between client and counsellor, and is a significant predictor of positive outcomes in psychotherapy (Elliott et al, 2011; Wampold, 2015). A series of two studies measured participant attitudes towards individuals presenting with a range of “symptoms” classified as “obsessive compulsive disorder”, “social phobia”, “depression”, and “schizophrenia”. Vignettes were used to describe client distress using either biological or psychosocial information. Results revealed significant differences in participants’ experience of empathy towards distressed individuals; across all vignettes, biological explanations yielded significantly less empathy than the psychosocial explanation ($P < 0.001$). The terms used to measure empathy each had a Cronbach alpha of >0.87 for all [disorder : explanation] pairs across studies, indicating a high degree of internal reliability (Tavakol and Dennick, 2011). This study also found that biomedical explanations of emotional distress could decrease clinician’s confidence in the effectiveness of non-pharmacological interventions including counselling.

1.6 Stigmatised attitudes within the helping professions

Numerous studies reveal that stigmatised beliefs and assumptions associated with diagnostic categories may shape attitudes and practices among “mental health professionals”. In a 2017 survey of (n=430) GPs in Italy for example, 87.5% of participants agreed that people diagnosed with “schizophrenia” may be “dangerous to others” (Magliano et al., 2017) despite declarations by the APA (2024) that people given this label are no more dangerous or violent than the general population. In their systematic literature review exploring attitudes towards individuals with a diagnosis of “borderline personality disorder” (“BPD”)” McKenzie et al. (2022) found evidence of widespread generalised and negative attitudes towards individuals given a diagnosis of "BPD” among "mental health workers”. The authors highlight a number of adverse implications for individuals living with this label including prognostic pessimism among professionals (Lam et al., 2016 a,b), doctor’s perceptions that people with “BPD” diagnosis are “unpredictable” and “hard to talk to” (Jury,

2014), and reluctance among psychologists and trainees to take on potential clients who had a prior diagnosis of “BPD” (Slaght, 2017). These findings reveal concerns that health professionals may “limit patient opportunities in therapy” as a result of pessimistic attitudes and preconceptions regarding the benefit of therapy for people living with a “BPD” diagnosis and their ability to “engage” (McKenzie et al, 2022).

Person-centred therapist, Pete Sanders (2019, p.28), says that medical diagnosis is akin to “placing judgement on the client” and as such may frame the therapeutic encounter with preconceived notions about the client before they enter the room. Client-centred therapists Rice and Moon (2018, p.130) posit that judgement is the opposite of unconditional positive regard and may therefore compromise the therapeutic foundations of the counselling relationship. Psychotherapist and activist Jo Watson (2019, p.233) questions how therapist engagement and acceptance of pathologising terminology can be considered “ethical, once we understand that the diagnostic model is rarely freely chosen, and has such far-reaching and damaging consequences?”

1.7 Considering benefits to psychiatric language in counselling practice

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On the other hand, Gilbert and Orlans (2011, pp.101-102) speak of the potential for diagnostic language to aid “discussion within psychiatric and medical contexts of interdisciplinary work” and urge therapists to become familiar with psychiatric terminology. Evans and Gilbert (2005, p.96), too, suggest that diagnostic criteria can be helpful for counsellors in widening the field of theory available to understand the client’s presenting problems. They point out that the diagnostic criteria used in psychiatry are descriptive rather than causative and so are “compatible” with their “phenomenological approach to psychotherapy”. In her (2017) book “Humanising psychiatry and mental health care” person-centred counsellor and psychiatrist Rachel Freeth (p.82) notes that psychiatry and psychotherapy reflect “two contrasting attitudinal stances”; the person-centred approach for example, places emphasis on “understanding” the client’s subjective experience, whereas psychiatry may be more concerned with “explaining” it. Freeth suggests it is possible for both approaches to complement one another rather than to “stand in opposition” (p.82) when working with clients in distress. Moreover, person-centred therapist Dot Clark (2018, p.238) notes that as human beings we inherently draw upon different bodies of knowledge in order to know ourselves and the Other, using the different “epistemological strategies” of our right and left brain hemispheres. Suggesting that the “fullness of our capacity for knowing” lies in our openness to holding multiple bodies of knowledge, Clark (ibid. p.238-239) cautions

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against dichotomising bodies of knowledge, and gives an example in counselling practice where on one hand the “primacy of the individual’s experience is claimed” and yet on the other hand “Carl Rogers can be quoted as if his word outranks that of others”.

Yet while some therapists are in favour of collaboration between psychiatry and psychotherapy practice, descriptive diagnostic criteria have also been accused of being overly heterogeneous and thus linking back to findings of Gayle and Raskin (2017) diagnosis may “obscure the individual”. Smits et al. (2017) point out that two hundred and fifty six possible combinations of “symptoms” listed in the DSM-V (APA, 2013) for “BPD” may result in the same single diagnosis being made. This raises the question of how helpful diagnostic language may be within humanistic counselling practices that place emphasis on the individual, and to what extent psychiatric language loaded with stereotypes and stigma may shape the therapeutic encounter.

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2. Method

2.1 Aims and objectives

In light of this complex relationship between humanistic and psychiatric paradigms, this study aimed to investigate how psychiatric diagnosis and the language of “disorder” shapes humanistic counselling practice through the views and experiences of humanistic counselling professionals in Ireland.

The objectives of this study were:

- To explore the attitudes, views and experiences of humanistic counselling professionals regarding psychiatric discourse.
- To identify ways in which psychiatric discourse may shape participants’ attitudes and approaches to counselling practice.
- To explore how participants may navigate any tensions arising between their humanistic approach and psychiatric discourse in their counselling practice.

2.2 Ethical approval

This research was authorised by the Research Ethics Committee of Turning Point Institute, University College Cork, on 14 February 2023. Participants were provided with an information sheet and informed consent form to complete prior to interview and this was also discussed verbally with the author at the beginning of each interview. Interview transcripts

were anonymised and stored securely on an encrypted USB drive. Participants were also given a pseudonym, and data that may identify participants was redacted.

2.3 Eligibility criteria

To be eligible for the study, participants were required to:

- Be presently involved in the practice of humanistic or humanistic-integrative counselling and / or psychotherapy, AND
- Hold active accreditation with either the Irish Association for Counselling and Psychotherapy (IACP), the Irish Association of Humanistic and Integrative Psychotherapy (IAHIP), or the Psychological Society of Ireland (PSI), AND
- Hold a minimum of two years' post-accreditation experience in the practice of humanistic counselling practice from which to draw upon during interviews.

2.4 Humanistic p articipants

A sample of seven participants were purposively recruited from across the island of Ireland. Of this sample, (n=2) had completed training at undergraduate level, (n=3) at masters level and (n=2) at doctoral level. All described experiences of counselling education that featured a significant "humanistic" and "person-centred" component; (n=2) participants completed primary training in person-centred counselling (with one completing additional postgraduate training in gestalt therapy and another completing postgraduate training in focussing). The remaining (n=5) participants described a "humanistic-integrative" curriculum to their counselling education.

In addition, all participants referred to the person-centred approach as being integral to their training; while humanistic counselling practice reflects a variety of approaches including Transactional Analysis (Berne, 1958), Gestalt theory, (Perls et al, 1951), and Internal Family Systems (Schwartz, 2023), the person-centred approach (Rogers, 1951) is commonly considered a bedrock of humanistic counselling practice and reflects many of the values shared across other humanistic modalities through its foundational stance towards individual subjectivity and the potential for growth of, every living being.

As such this approach is used as a common reference point when discussing participant's experience of "humanistic counselling" practice throughout this paper unless explicitly otherwise specified.

2.4.1 Inclusion of counselling psychologists

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Given the interest in the study by (n=2) counselling psychologists, a discussion was had between the researcher and his supervisor to determine eligibility, parity of training, and accreditation between participants who identified as “counsellor / psychotherapist” or “counselling psychologist”. A review of the Counselling Psychology Doctorate training syllabus from the institution (n=2) psychology participants trained at declared a “humanistic and person centred baseline” (Trinity College Dublin, 2025) to its curriculum and was deemed theoretically compatible with the humanistic-integrative and person-centred trainings of other participants.

2.5 Data collection

Semi-structured interviews lasting one hour were carried out between each participant and the author and were audio-recorded and transcribed verbatim. An interview schedule consisting of open-ended questions was developed in advance of recruitment. A fictional vignette was used to explore participant attitudes and approaches towards a hypothetical situation regarding working with a client given a diagnosis of “borderline personality disorder”.

2.6 Pilot interview

A pilot interview was carried out with a peer in January 2023 in order to test the flow and feel of the interview schedule. This helped to identify potential bias and unintended consequences of the interview design as suggested by McLeod (2022, pp.101, 147). This revealed that the original number of questions was potentially excessive, which enabled the author to refine and refocus to enable more time for depth of response.

2.7 Data analysis

Reflexive thematic analysis was used for this study. This qualitative method offered a means to explore the views and attitudes of individual participants, while interpreting patterns of meaning across the dataset (Braun and Clarke, 2022, p.40).

2.8 Philosophical foundations

This study was informed by the philosophical position of critical realism (CR) (Bhaskar and Hartwig, 2016). CR adopts a realist ontology by claiming that a real, shared world exists independently of our perceptions, theories, and constructions (Maxwell, 2012, p.5). In terms of epistemology however, CR is relativist and assumes that, while humans may live within a shared reality, our understanding and knowledge of the world is relative to who we are within a dynamic social and cultural context (Bager-Charleson, 2020, p.6). Therefore, this research

sought to explore the views and experiences of participants (counselling professionals) who reside in a shared world, but who hold unique perspectives that may help to address and explore the research question.

2.9 Reflexivity

Having worked as a humanistic-integrative therapist and a mental health nurse, the author has encountered a number of philosophical and ethical tensions arising in his own work with people in distress. Through a process of reflection, supervision, and journaling, throughout the stages of study design, data collection, and analysis of findings, the author attempted to examine any underlying beliefs, values and prior experiences that may bias the research process. For example in his reflective journal he noticed a tension between his 'non-pathologising' values and the sense of apprehension he experienced when clients were described using language such as "schizophrenia". He noticed a shift in these assumptions through naming and discussing these experiences with his supervisor, yet was struck by the potential of these hidden assumptions to shape the research process as well as his own practice. This "bending back on oneself" helped the author to continually question any assumptions that may influence the research journey and his role in it (Braun and Clarke, 2019).

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2.10 Methodological integrity

Levitt et al., (2017) emphasise the importance of methodological integrity of qualitative research as an indicator of quality, and points to the *fidelity* of researchers to the subject matter, and *utility* in terms of how the methodology meets the study aims as guiding concepts that can guide the selection and evaluation of appropriate methods. The author therefore referred back to these concepts and the guidance provided by Levitt et al., (2017) for designing qualitative research, iteratively throughout the research process.

2.11 A note on the use of medicalised language in this article

The author respectfully acknowledges that the epistemic and medicalised foundations of psychiatric discourse are contested and associated with stigma and harm (Sidley, 2019, p.120). To reflect this, terms used to describe distressing experiences and behaviours associated with psychiatric discourse are given in quotation marks, as suggested by the BPS "Guidelines on Language in Relation to Functional Psychiatric Diagnosis" (2013; 2015). This includes medicalised terms that may suggest a biological conceptualisation of distress such as "symptoms", "mental health", "illness", and diagnostic labels of "disorder".

3. Findings

Four themes from the research are reported here: (1) therapist attitudes, (2) therapeutic approach, (3) training, knowledge and understanding, and (4) therapist resistance (to psychiatric discourse). A fifth theme relating to client identity in the original research is not reported here and may form the basis of a follow-on paper.

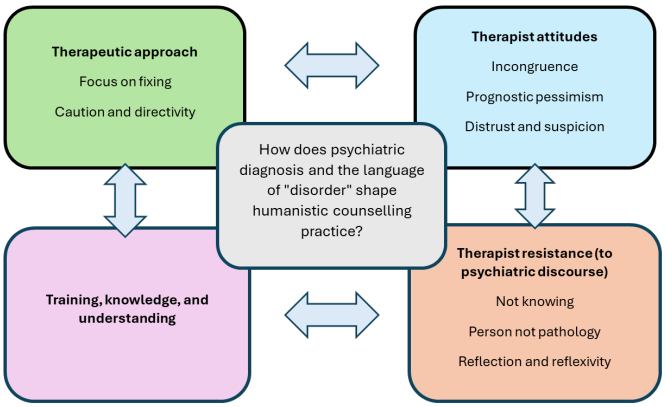

Fig. 1. Themes of the research findings

3.1 Therapist attitudes: Incongruence

While all participants (n=7) commented how the use of psychiatric language may stigmatise the client and obscure their individuality within the counselling process, most (n=6) used psychiatric language at times, to describe their clients and justify counselling interventions that appear incongruent with their stated positions towards psychiatric language. Referring to his humanistic approach to counselling practice, Derek reflected how each of his clients "are unique" and are "the experts on themselves, not me…" Yet as the interview progressed, Derek went on to speak of how:

> "…A borderline [client]… is, habitually, the joke I suppose, in psychotherapeutic circles… you know… it's the 'never ending client', and I guess my experience is yeah, that's been the case."

Geraldine acknowledged that "labels… can be very harming… in terms of the individual…and reputation…" and that "I end up with a lot of borderlines in my… [practice] who have received the official diagnosis and they don't like it…"

Yet throughout the interview Geraldine used the phrase “borderlines” to refer to clients who have been given a diagnosis of “borderline personality disorder” and reflected that:

> “...borderlines are very workable with… like they… they’re very, very emotional and I love working with them… but they’ll fling you around the room…”

Participant attitudes towards psychiatric diagnosis also appeared contradictory at times. Reflecting on psychiatric discourse and diagnosis in counselling practice, Theresa remarked: “The DSM”… “should be burned… I’ve lost the person the minute I just take the label as being who they are… the whole person fails to be seen…”

Yet later, after reflecting on working with “a bipolar woman” Theresa declared that the DSM is: “very useful… [psychiatric] diagnosis is very important”.

Aisling drew attention to the “blunt” and “reductionist” nature of diagnostic categories. Later, she appeared to refer to psychiatric diagnosis to inform and justify her counselling approach:

> “One person said to me, ‘oh, I’ve a war chest… wait till I start’. And… knowing that there was a ‘borderline’ personality… I just felt we just really have to try and [slow the pace of the session]… and now she wasn’t too happy but I really explained to her, it’s about it, not becoming too much… for you…”

3.1.1 Therapist attitudes: Prognostic pessimism

Reflecting on the suitability of counselling for individuals who have been given a diagnosis of “schizophrenia”, Geraldine said, “it would be too dangerous…” and:

> “You could never work with a client like that … you’d unravel them too much, and do way too much harm… and I think you know, the only route is psychiatric care… for a presentation like that…”

When describing a client with a history of “borderline personality disorder” Derek reflected that despite the client spending “the weekend poring over… four folders from her [DBT] course …” and had “...gone and bought me a copy of the DBT textbook as well”, he did not believe the client had made any “...significant change” because:

> “...The slightest little bump that comes out of the wind has her back. Maybe, yeah, she’s quicker to go back and get her tools and quicker to stabilise but… in reality, still very unstable emotionally and nothing has really changed…”

Derek’s example here appeared similar to his earlier stated reflection that people diagnosed with “BPD” are the “never ending client”, suggestive of a pessimistic attitude towards therapy outcomes for people who are given this diagnosis.

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Fear of “unravelling” (Theresa, Geraldine) and “destabilising” (Aisling), “risky” (Sue) clients living with a psychiatric diagnosis as a result of counselling was mentioned by some participants.

Theresa reflected that some therapists “actually avoid any process work with [people with a psychiatric diagnosis]... because they have some unconscious bias that maybe they have a disorder, I’m not going to be very effective here…”

Sue felt that “counselling and psychotherapy isn’t a match for everything either, you know?” and that clients with a psychiatric history may be “chaotic”... “risky”... on a “cocktail of medications” and it can be “hard to know where to begin, or if counselling really is… suitable for a person living with a psychiatric ‘disorder’”.

Some (n=3) participants expressed concerns regarding the suitability of counselling for clients who are prescribed psychiatric drugs. For example, Derek said he would be “wary of how capable someone would be of major change being on heavy meds…” and Geraldine reflected that if a client was on medication, it may be a “numbing agent” which may mean they “can’t do the deeper dive…”

While these findings reflect a degree of pessimism towards working with or counselling outcomes for clients given a psychiatric diagnosis, it is also possible that they reveal concerns about working outside of their scope of practice which may also be influenced by the training they received regarding psychiatric discourse and diagnosis (see section 3.3).

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3.1.2 Therapist attitudes: Distrust and suspicion

A pattern of distrust of clients with a psychiatric diagnosis was noticed in the data, with all participants describing instances where clients may be viewed with suspicion as a result of their psychiatric diagnosis:

“...You hear, they have just burned through every intervention…” (Aisling).

Some clients “...Might take the position of being a victim” and “use [therapy] not for change… but as a way not to have to do anything” (Derek).

[It may be necessary to] “strap in the seatbelt” (when working with a client given a label of “borderline personality disorder”) (Terri).

Some clients can be “very quick to attract a diagnosis” and may: “hold on to their ‘symptomology’ until a litigated case is resolved…” (Geraldine).

“Nowadays there’s quite a lot of people using labels for secondary gain… I remember a young person said ‘well I get away with more... since I have the [diagnosis]” (Theresa)

Mark felt that there is a tendency for professionals to adopt a “hyper cautious” attitude towards clients presenting with psychiatric “disorder” in counselling settings.

Three participants described a sense of suspicion towards clients who may disagree with their psychiatric diagnosis. Derek suggested that there was a risk associated with affirming the client's position and that it was important to:

> "...Tread very carefully… not to tread on somebody else's toes, I don't want to say anything that's gonna go back somewhere else and hang me, and maybe hang somebody else, as well… you know, I'm only hearing one version of things… I guess there's, just there's just that general caution that's there, erm…"

Similarly, Theresa said that, while she would want to believe the client "...The doctor sees something that I have to respect there as well" and might suggest: "well wouldn't it be good to give… to work both ways… can we work hand in hand, with [the medical advice]...can you manage to hold both?"

3.2 Therapeutic approach

Results of this study suggest that psychiatric discourse may inform participant decision making and approaches to working with clients.

3.2.1 Therapeutic approach: Focus on "fixing"

When reflecting on her work with bereaved clients, Sue suggested that psychiatric guidelines for the treatment of "prolonged grief disorder" ("PGD") would "completely inform" how she would work with a client if they were given this diagnosis.

Terri felt "anxious about admitting…" that in her early years as a counselling psychologist there were times when "there was so much preoccupation with the labels, and how are we gonna work with these obsessive thoughts…" adding that:

> "I often find they [psychiatric diagnoses]…put… those blinkers on where I'm looking for… what I'm being told is… presenting for this client… and I lose sight of other possibilities of what's happening for this person…"

Mark reflected that since treatment guidelines for people with a diagnosis of "borderline personality disorder" recommend DBT, there is an assumption that:

> "...Because they suffer with these kinds of emotional distress 'symptoms' they can't do the relationship piece… let's just give them DBT … so that they learn all these skills…"

But that if:

"...There's this highly atomised, and individualised approach [to "symptoms"]… through medication or looking at self-harm… like, these individual experiences…it's like… we never quite get to the important piece of the work…"

3.2.2 Therapeutic approach: Caution and directivity

During interviews, most (n=5) participants appeared to describe a sense of caution when working with clients living with a psychiatric "disorder"; this seemed to inform therapist directivity, decisions regarding client suitability for counselling, and consideration of psychiatric opinion.

When working with a client who had received a diagnosis of "borderline personality disorder", Aisling explained how she would be more directive in her approach with:

"...My foot on the accelerator or brake…" and yet "this is really interesting because this wouldn't have been my training…"

Sue described how it would be important to consider how "stable" a potential client was before working with someone with a diagnosis of "borderline personality disorder" because it can be "very hard to process"... "if you're highly dysregulated"...

When reflecting on the clients she may work with and the therapeutic approach she may take, Geraldine suggested that she would be "reluctant" to work with "autistic" clients "because I'm not a huge lover of CBT or solutions focussed work" and so **"**I found it very difficult, working when somebody had come with a diagnosis like that."

Participants (n=4) also mentioned the importance of consulting the psychiatrist's opinion before working with a client who has received a form of psychiatric "treatment" or diagnosis. Derek said it is important to "cover my ass" because "this is a person I've never met and I don't know anything about".

Commented [15]: Added in response to comment R2 #3

3.3 Training, knowledge and understanding

Most participants (n=5) reported limited engagement with psychiatric discourse during their training and appeared to display varied and limited understanding regarding the epistemological debates regarding the nature of "disorder". Sue reflected that her training was focussed towards supporting "mainly the person who was, mainly unwell, but not in need of psychiatric… you know?" and noted that:

Commented [16]: Noticed I used 'p5' instead of pseudonym so have replaced for consistency

"...We didn't get any specific training on anything that needed specialised care… medical especially, or the psychiatric side...you know psychiatric … it was all bunched over there, er, in a 'disorder' level…"

This was echoed across the other participants with a primary training in counselling and psychotherapy (Aisling, Derek, Theresa, Geraldine). Derek added that there was little time given to psychiatric discourse within his counselling training and:

> "I think it was almost a decision that that stuff can take care of itself or something, right? Our work is a bit different… and yes the DSM's kinda handy in theory, but in practice, you know, we won't be using that much of whatever, you know?..."

Participants who appeared less critically engaged with the debates around psychiatric discourse and "disorder" (n=5) seemed to refer to psychiatric diagnosis implicitly or explicitly as epistemic fact. Geraldine appeared to associate the inclusion of a "disorder" within the DSM with a level of epistemic validity. For example, when referring to "premenstrual dysphoric disorder" ("PMDD") she suggested that this was a "very valid" form of "disorder" *because* it "was added to the DSM-V recently".

When asked about their understanding of the term "psychiatric disorder", the two participants who completed counselling psychology doctoral training both referred to the "socially constructed" nature of psychiatric diagnosis and suggested a belief that "symptoms" of "disorder" are a reflection of "what isn't working in society" (Terri). Mark described the concept of psychiatric "disorder", "as a capitalist frame for 'you're not behaving as we wish you would'... and I think the language is there to preserve the status quo…". Similarly, Terri suggested that diagnosis might be used to indicate "bad behaviour" and a "form of keeping people in order".

3.4 Therapist Resistance (to psychiatric discourse)

3.4.1 Not knowing

All seven participants gave examples of how they may suspend attempts to "know" their client's experiences, as a means of resisting "the epistemic rigidity that diagnosis brings" (Mark). Aisling and Terri referred to the importance of "holding lightly" any theories that claim to know or explain the lived experience and (Aisling, Theresa and Terri) each likened theories of the mind to "maps", for which the territory is very different.

> "...[Diagnosis will] never be the full story. One of my favourite words Ashley, is ineffable… and this idea that we might not know at all… this idea that there's an unknowable piece." (Aisling)

Terri noted that it has taken “a lot of self-trust” to resist the influence of psychiatric discourse in her practice - such as choosing not to read some of the psychiatric collateral sent to her:

> “...Because again, it’s like, an expert in another discipline has told you that this is their professional, and clinical opinion, and I’ve decided to park that… you know, and … and … as an early career psychologist, sometimes, it’s hard to hold… you know ‘how about we just give space to this person?’ You know, and let them tell their story?”

3.4.2 Reflection and reflexivity as resistance

Most participants (n=6) referred to the role of reflection and reflexivity in counselling practice when tensions arise between humanistic counselling practice and psychiatric discourse. For example:

“We say humanistic and seeing the person as a whole, but we don’t always do it, so, I think it’s just to be mindful of that…” (Theresa)

Geraldine reflected that a diagnosis can obscure the person and the “real core issue”, citing an example where a diagnostic label “really, really threw me”. Describing how supervision helped the participant to work through this and meet “[the client] in a different place… the label just kinda dissipated and we carried on working as I would with any other client...”

When reflecting on a fictional vignette describing a client living with a diagnosis of “borderline personality disorder” Terri noticed herself suggesting it may be important to strap "in the seatbelt…” and to be aware of “any breaks or endings” coming up when working with clients given this diagnosis. However after “sitting back” to reflect on her position, the participant reflected that she was actually “drawing on what I’ve been told this person should look like….” and “...yet when they’re sitting in front of me, it’s not what I see…”.

3.4.3 Person not pathology

All participants spoke of the importance of curiosity towards the client and their unique experience, and a recognition that they are “more than a diagnosis” (Sue). Most participants (n=6) referred to the importance of “meeting the person as a whole” (Theresa), and at times appeared to reframe “symptoms” of “pathology” as adaptive survival strategies. Terri commented that “everybody’s story makes sense . . . if we take the time to listen to that story…”

Another common sentiment shared by all participants is that the “client is the expert” (Derek) in their life. Aisling said “my approach isn’t to pathologise… but to be utterly curious”

and “the person knows themselves better than anyone else…” Similarly, Sue stated, “if a client has a really strong sense of ‘no that doesn’t describe me’, I always go with the client because they are the expert in their eyes… you know what I mean?”

4. Discussion

4.1 Incongruence

This study reveals evidence of incongruent attitudes among counselling professionals towards psychiatric discourse and towards clients given a psychiatric diagnosis. On one hand, most participants appeared to suggest that psychiatric diagnosis may serve as reductive and even harmful constructs in counselling; on the other, most appeared to embrace diagnosis as an epistemic vantage point that is used to inform attitudes and approaches to practice. These results are in keeping with Foucault's (1977, p.30) ideas about the unspoken power of psychiatric discourse to shape the “taken for granted” knowledge among research participants of this study despite holding a primary training in a counselling practice that is underpinned by humanistic philosophy , and despite many participant’s expression of values and perspectives that appear to be at odds with a “disorder” discourse of distress.

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During interviews most participants (n=5) appeared to describe a limited training, understanding and critical engagement around the scientific and philosophical foundations of psychiatry and yet, appeared to draw on psychiatric discourse to shape decisions around their practice. It is therefore possible that the attitudes of participants in this study may be influenced by a dominant discourse that seeks to position psychiatry as the source of “expert” knowledge, and alternative possibilities as inferior (Foucault, 1977, p.30). This position may be reinforced by a lack of critical training in counselling education that might otherwise examine the basis of psychiatric discourse, its dominance in society, and how it may jar with humanistic approaches to emotional distress.

This evidence of incongruence does not appear to be reflected in any of the qualitative data identified in the literature review; it is possible that the presence and use of psychiatric language in the counselling room may threaten the integrity of humanistic counselling practice since therapist congruence has been found to be an important ‘way of being’ within the therapy relationship (Rogers, 1965; Kolden et al, 2011).

Commented [17]: Added in response to R1#7

Commented [18]: Changed in response to feedback on plain language / tone R2 #4 C

Commented [19]: Re-worded as per R1#4 (c) suggestion on plain language

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4.2 Pessimism and suspicion

Drawing parallels with the findings of Lebowitz and Ahn (2014) and McKenzie et al. (2022), most participants of this study described instances where they have either felt pessimistic or suspicious when working with clients who present with a variety of psychiatric “disorders”. Analysis of data also suggests a sense of distrust among participants towards the client’s frame of reference when they present with a psychiatric diagnosis, despite a unanimous acknowledgment among the sample that the client is the “expert” in their lives. This draws parallels with evidence in the literature of the stigmatised attitudes and generalisations associated with diagnosis that may be held by professionals (Magliano et al., 2017; McKenzie et al., 2022). In his work on stigma, Goffman (1963, p.138) described labels of “mental illness” as “blemishes of character” that communicate an “attribute that is deeply discrediting”, and thus carries harmful consequences for individuals associated with stereotyping, status loss, and separation from those deemed “normal” (Link and Phelan, 2001).

While most participants appeared reluctant to eschew diagnosis completely - even if the client disagreed with a diagnosis they had been given - it is possible that these findings reflect attempts by participants to embrace the complementary potential of different bodies of knowledge, as suggested earlier by Freeth (2017, p.82) and Clark (2018, p.238). However, the broader findings of this research suggest that psychiatric constructs were at times afforded greater influence in shaping the counselling process than the client’s subjective experience or preferences. As such, it is possible that drawing on psychiatric constructs in counselling may compromise the integrity of humanistic approaches if not carefully managed.

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Reluctance to believe the client’s understanding of their distress over the psychiatrist, and beliefs that clients may seek diagnosis for secondary gain found in this study may be evidence of such stigmatising effects of diagnosis, and adds to the wider literature demonstrating the potential for psychiatric diagnosis to harm clients through stigmatised attitudes of professionals supporting them. As such, these findings jar with the IACP (2018) code of ethics which is founded upon the principle of non-maleficence and the therapist’s duty to avoid harm to any client.

Concerns of some participants that psychiatric drugs may render clients unsuitable for counselling appear to be unsupported by literature, as are concerns that humanistic forms of counselling may “unravel” clients with diagnoses of “borderline personality disorder”, “bipolar

disorder", and "schizophrenia". These findings are in keeping with the "myths" highlighted in the literature around the inappropriateness of humanistic counselling for people who may be experiencing states of distress deemed "severe" or "enduring", despite numerous studies suggesting that person-centred and humanistic counselling may be helpful to people given these labels (Sommerbeck, 2014, p.159, Rundle, 2023, pp.115-126; Sanders, 2023, p.75).

Interestingly, findings also indicate that the two counselling psychology participants (Terri, Mark) appeared more comfortable with "parking" (Terri) psychiatric opinion, and affirming the client if they happened to disagree with the diagnosis they had been given. This may be evidence of an increased confidence among these participants to critique the role of psychiatric discourse in their practice, which may coincide with evidence suggesting greater critical engagement regarding the contested nature of psychiatry during their counselling education and current practice.

4.3 Therapist attitudes towards diagnosis may shape the counselling relationship

Incongruent attitudes among participants regarding the use and effect of psychiatric discourse in counselling practice, and feelings of suspicion and pessimism towards working with clients presenting with a psychiatric diagnosis appear to be at odds with three of Rogers' (1957) relational conditions that underpin the humanistic therapeutic process. Incongruent attitudes held by counsellors may result in the client not experiencing them as genuine - which Rogers says is fundamental in the creation of the "psychological climate" where therapeutic change may occur (Rogers, 1959, p.214). Feelings of pessimism and distrust towards the client's diagnosis and their engagement in counselling may correspond with judgments being made upon the client, which Rice and Moon (2018, p.130) claim is "the opposite of unconditional regard". The potential for harm to clients arising from such attitudes pose ethical challenges for counselling practice.

Participant attitudes and positions presented here may also impair an empathic attunement towards the client's frame of reference, in favour of psychiatric explanations that are entangled with stigmatised generalisations and psychiatric identities (Roberts, 2005). These findings may therefore indicate significant implications for the therapeutic relationship between client and therapist, and the phenomenological process that humanistic counselling seeks to facilitate "in the experience of the client" (Rogers, 1951, p.223).

4.4 Focus on "fixing"

Psychotherapists (across modalities) and psychiatrists generally agree that "symptoms" are meaningful in some way. Yet in humanistic psychotherapy "symptoms" are considered to be subjectively meaningful, rather than standardised in the context of DSM criteria. Moreover, Rogers (1951, p.222-223) placed emphasis on the client's accurate understanding of their experiences (or symptoms) as a central mechanism of change in psychotherapy, rather than adopting the curative stance of physical medicine - which Rogers claimed "have no real analogy" in counselling practice (1951, p.222). Yet while all participants appeared committed to exploring the meaning and impact of the symptom for the individual client, these findings also indicate that participants may at times focus on the "treatment" and relief of psychiatric "symptoms" at the expense of the client's frame of reference. Ladd (2013) suggests that this psychiatric informed approach to distress may result in clients becoming "standardised" while their "experience becomes marginalised". Psychiatrist and psychologist Viktor Frankl (2011, p.68) suggests that the unique value of humanistic psychology may lie in the exploration of the client's personal meaning of their experience, which may otherwise be "castrated" from "mechanistic" interventions that target relief of "symptoms". This reflects one of the key philosophical differences between psychiatry that seeks to "treat" an intrapsychic "disorder", and humanistic psychology, which recognises the client's distress as a valid response to their past and present experience.

4.5 Cautious approach to counselling for people living with a "disorder"

Most participants made reference to caution and risk when working with clients living with a psychiatric "disorder". This appeared to inform therapist directivity and deference to psychiatric authority. The potential for psychiatric labels to divert therapists from their humanistic training may also indicate a lack of confidence in the sufficiency of their approach to working with individuals who are described in terms of "disorder". Person-centred therapist Lisbeth Sommerbeck (2003, p.33) suggests however that the conditions deemed "necessary and sufficient" for facilitating the clients' "most constructive potentials… are to be trusted to be the same for everybody, irrespective of diagnosis" rather than determining suitability and eligibility for counselling on the basis of a psychiatric label. Yet the caution evident among participants of this study may be reinforced by implicit messages received during training that there may be some clients with psychiatric "disorder" who may be unsuitable for counselling. This is perhaps unsurprising in a culture of medicalised approaches to mental health where the psychiatrist holds ultimate responsibility for coordination of state-run "mental health services" and the "treatment" of individuals entering this system (Department of Health, 2020, p.44).

Commented [22]: Changed in response to R1#10

4.6 Uncritical acceptance of psychiatric discourse in counselling education

What appears to be a low level of critical engagement with psychiatric discourse in most participant's humanistic counselling education and practice may be informed by Rogers' claims that "the pursuit of an objective and pathological source of emotional distress is a concern of the scientific paradigm" and not a concern for the counselling space (1951, p.220). Yet the findings of this study suggest that the influence of psychiatric discourse is a real concern for the counselling profession and that it may undermine the integrity of the therapeutic relationship, from which much of the value and efficacy of counselling draws heavily. Counselling tutors Taper and Tipping (2019, p.193), claim that widespread uncritical acceptance of psychiatric "disorder" within counselling education may contribute to therapist beliefs that clients given a psychiatric diagnosis are "outside the competency level of the counselling profession". This may account for some of the caution or pessimism identified in this research.

Commented [23]: Text added in response to feedback: R1#11

Interestingly the two counselling psychologists who took part in the study appeared more critically engaged with the debates around psychiatric discourse and also appeared more comfortable with resisting the influence of psychiatric opinion upon their practice. Person centred therapist and psychiatrist Rachel Freeth (2023, p.130) suggests that it is important for all counselling professionals to follow suit and actively reflect on their understanding of this contested discourse, encouraging the profession to consider "what we know and how we know it" – rather than taking medicalised perspectives for granted. This may go some way to ameliorating the dominance of psychiatric discourse within counselling practice and may include examining the conceptualisation of distress as "disorder" including the socially constructed roots of diagnostic categories versus other causal explanations.

4.7 Therapist Resistance (to psychiatric discourse)

4.7.1 Not knowing

All participants described efforts to hold theory "lightly" and suspend attempts to "know" or "understand" their clients through psychiatric taxonomy, since this may have the effect of obscuring the client's own view of themselves. Resisting influential sources of "knowledge" such as psychiatry in the counselling profession by "not knowing" may preserve the philosophical integrity of humanistic counselling practice (Spinelli, 1997; Larner, 1999, p.40), yet may be easier said than done.

Appearing to recognise the subjective experience of receiving a psychiatric diagnosis, all (n=7) participants spoke ubiquitously of the importance of “following the client” (Derek) in order to explore the personal experience and meaning of diagnosis for each client. At face value this approach appears compatible with participants’ broad consensus that the client is the “expert”, and may reflect a person-centred position that resists psychiatric explanation. However, given the influence of psychiatric discourse to shape what we “know” to be “true”**,** Larner (1999, p.43) suggests that it may be difficult to “unpick the discursive contexts [such as psychiatric constructs] within which shape the client’s inner experience”.

Caution may therefore be warranted when engaging with psychiatric constructs in humanistic counselling practices that traditionally positions the client’s internal frame of reference as the focus of the therapeutic gaze. It is possible that “following the client” along a path of internalised psychiatric discourse may result in both counsellor and client overlooking aspects of the client that lie beyond linguistic and psychiatric attempts to apprehend and articulate their inner world.

4.7.2 Reflective and reflexive forms of resistance

The importance of reflection and reflexivity as acts of resistance to the dominance of psychiatry is echoed among critical perspectives towards psychiatry in psychotherapy found in the literature. Madigan, (1999, p.153) suggests that asking reflexive questions can help to consider the discursive restraints of one’s own training and how they may shape (or limit) counselling conversations. Sanders (2023, p.75) urges counsellors to reflect on their stance towards the medical model in counselling practice and perhaps develop a personal statement that may articulate their position towards psychiatric discourse, rather than regurgitating “trite soundbites”... “on the fly”. Appearing to recognise a wider need for epistemological and ontological reflexivity in counselling practice and education, Professor of Psychology at City, University of London, Carla Willig (2019) suggests it is important that therapists “recognise their ontological and epistemological positions as positions that they are taking (rather than perceiving them to be self-evident truths)”.

4.7.3 Person not pathology

While participants described moments where they may become more directive and symptom-oriented in their work with clients living with a psychiatric diagnosis, all participants of this study spoke of the importance of taking a holistic approach to counselling practice that looks beyond labels. Most (n=6) participants appeared to agree that “symptoms” of psychiatric “disorder” may in fact reflect survival strategies and adaptations that the client

has made in response to their lived experience. This may represent another form of resistance to psychiatric explanations that may otherwise "locate the problem in the person" and frame client experiences as "disorder" (Proctor, 2006, p.69; Mac Gabhann, 2014, p.28).

5. Conclusion

While psychotherapy and psychiatry reflect different epistemological and philosophical assumptions regarding the nature of emotional distress, it may be difficult to separate psychiatric discourse from counselling conversations in a world that draws heavily on medicalised language. Yet findings of this study suggest that psychiatric language may threaten the integrity of humanistic counselling practice through increased stigma, reduced empathy, and pessimism among therapists when clients are viewed in terms of psychiatric "disorder".

These findings are therefore suggestive of the potential to harm the client and counselling process, which raise ethical questions for counselling professionals. Attitudes indicative of suspicion, pessimism, caution, and incongruence identified among participant transcripts may deprioritise the client's frame of reference and may represent a threat to the core conditions of unconditional positive regard, empathic understanding, and genuineness, which are the cornerstones of humanistic counselling practice. These findings appear to support existing evidence in this area and speak to the gap in research specifically concerned with the effect of psychiatric discourse upon the attitudes and practice of counselling professionals.

This research also suggests that therapists may adopt a more directive approach to working with clients living with a psychiatric diagnosis which may focus on "fixing" or "managing" "symptoms". Acceptance of influential and dominant psychiatric discourse as empirically sound within counselling education and practice may account for some of these findings.

Acts of therapist resistance identified in this research appear to be helpful in managing the influence that psychiatric discourse may have upon counselling practice and include uncertainty, reflexivity and looking beyond labels. However, the broader findings of this study suggest that these efforts to resist the harmful effects of psychiatric discourse may be inadequate unless they are underpinned with critical engagement and understanding regarding the contested nature of psychiatric discourse that may otherwise threaten humanistic counselling practice.

5.1 Further research

Further research might examine the hidden assumptions that therapists hold with regard to their engagement with psychiatric discourse, and how these may shape their attitudes and approaches to working with clients living with a psychiatric diagnosis. This might explore the role of critical engagement with the debates around psychiatry within different forms of counselling education, and whether this has any effect on levels of congruence and confidence to grapple with the effects of psychiatric discourse upon their humanistic counselling practice. Research involving counselling clients who have been given a psychiatric diagnosis may also help to understand how these findings may relate to (and shape) their counselling experiences.

Commented [24]: Changed in response to feedback on plain language / tone R2 #4 C

5.2 Recommendations for practice

Given the prevalence of psychiatric discourse in society and the potential for psychiatric language to shape how many people understand their experience, counselling professionals are urged to reflect on any hidden assumptions regarding psychiatric discourse and how these may shape their attitudes and approaches to working with clients who may be given a psychiatric diagnosis. This includes consideration of the ethical tensions and risk of harm that exist when working across humanistic and psychiatric paradigms within their practice with individual clients. Professionals are also encouraged to reflexively examine what they know about psychiatric "disorder" and how they know it. In her chapter on "incorporating demedicalised therapy into training and continuing professional development", psychiatrist and person-centred therapist Rachel Freeth (2023, p.126) poses a series of reflective questions for practitioners to explore their attitudes and beliefs regarding psychiatric diagnosis and the intersection with counselling practice. Critical reflection of this nature may also help practitioners to adopt positions that are more congruent with their beliefs around psychiatric discourse.

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5.3 Limitations of this research

When conducting participant interviews a fictional vignette was used alongside a list of open-ended questions in order to elicit participant attitudes towards working with a fictional client who had been diagnosed with "borderline personality disorder". This scenario made reference to a range of factors such as previous history of self-injury, and history of inpatient admission to a psychiatric hospital (see appendix 1). While vignettes can provide an effective platform for discussion when researching topics where participants may be reluctant to share sensitive real-life experiences (Murphy et al, 2023), it may be difficult to draw conclusions about the specific impact of the psychiatric diagnosis upon participant attitudes or approaches to working with the fictional client as distinct from the additional

variables described. The scenario could have been simplified or an open-ended question asked such as “how might you feel about working with a client who had a diagnosis of ‘borderline personality disorder’”?

Appendix 1: Fictional client scenario used during semi-structured interviews with research participants

Commented [26]: text added in response to comment by R2 #2 (B)

Sam is 23 years old and has contacted you looking for some counselling. They explain that they have a diagnosis of ‘borderline personality disorder’ and that they have previously been admitted to St Pat’s Hospital after a self-harm experience - but are currently not self harming. They have been prescribed ‘sodium valproate’, and ‘aripiprazole’ and Sam says these are ‘mood stabilisers’. They also see a psychiatrist once every couple of months for a medication review. Sam was told that they may not be suitable for some types of counselling and does not agree with this. Sam would like to work in a person-centred way.

Could you share any thoughts you might have about working with Sam?

Optional follow up: Would you envisage any challenges or limitations to working in a humanistic or person-centred way with Sam?

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