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CURRENT COUNSELLING VIEWS AND THE MEDICAL MODEL: AN EXPLORATION OF THE TENSION

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Abstract

The field of psychotherapy has been influenced by several ideologies and models. Among these, the medical model is the most influential and dominant. There is great tension between the philosophical foundation on which psychotherapy was built and how it is practiced today. Having a comprehensive understanding of this tension and its impact on students of counselling is imperative for the future of psychotherapy. I used Interpretive Phenomenological Analysis to answer the research question: What impact does the tension between the medical model and the humanistic approach to counselling have on students in a Master of Counselling in a psychology program? I interviewed four participants who shared their experiences regarding this tension. Five themes emerged from the analysis and will be discussed. The themes highlighted the importance of education and training for students so that they can evolve with the growing demands of psychotherapy.

Keywords: Humanistic Approach, Medical Model, Counselling/Psychotherapy, Education, Training, Students

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Chapter 1. Significance of the Problem

Humanistic Approach to Psychotherapy

The humanistic approach to psychotherapy is characterized by an emphasis on the client's subjectivity and an increased awareness of understanding behaviour. This perspective is resistance against views that see a client as an object ignoring their existential reality (Greenberg & Rice, 1997). Prominent philosophers in the humanistic approach such as Soren Kierkegaard (1813-1955) and Jean-Paul Sartre (1905-1980) held the belief that both the objective and subjective reality of the client must be respected to gain a deeper understanding of their reality. European philosophers such as Edmund Husserl (1859-1938), Martin Heidegger (1889-1976), Karl Jaspers (1883-1969), and Gabriel Marcel (1889-1973) were all influential in extending this view. Many prominent figures have built the humanistic approach into various branches such as Carl Rogers's client-centered approach, Fritz Perls' gestalt approach, and Rollo May and Irvin Yalom's existential approach (as cited in Greenberg & Rice, 1997, p. 97). Tageson (1982) provided a comprehensive overview of the core characteristics of a humanistic approach to psychotherapy including: (a) commitment to a belief that humans have a unique capacity for reflecting on their consciousness which can lead to freedom and self-determination; (b) a belief that all human beings strive towards growth and development; and (c) person-centeredness where a client's subjective experience is central importance to therapy (Tageson, 1982; Greenberg & Rice, 1997).

The Medical Model as a Profession

The term medical model was first coined by Ronald Laing (1971) in one of his published essays titled, *The Politics of Family and Other Essays*. Elkins (2009) defined the medical model in psychotherapy as a "descriptive schema borrowed from the practice of medicine and superimposed on the practice of psychotherapy" (Elkins, 2009 p. 67). In the medical model a doctor diagnoses a patient on the bases of biological symptoms and then administer treatment to cure the patient's illness (Elkins, 2009). This alludes to Foucault's (1973/1994) concept of the medical gaze presented in his work *The Birth of the Clinic*. Foucault (1973/1994) said that doctors view a human with a medical gaze – a set of organs such as kidneys, heart, or lungs instead of as a human in its whole entity. Foucault addresses this view as dehumanizing the individual leading to an abusive power structure (Misselbrook, 2013; Foucault, 1973/1994). Despite the critiques and the cautions against the use of the medical model, it remains dominant in psychology to this day.

History of The Medical Model

The concept of medicalization and the relationship between a doctor and a patient in modern medicine has been in practice since the 1800s. I will outline the history of the medical model considering depression as an example. One of the earliest recorded accounts of depression is from the times of Greek civilization. According to Thase et al. (2002), the biological bases and treatment of depression began with the Greek model of health. They considered good health to be the balance of four bodily fluids called humours which included blood, phlegm, black bile, and yellow bile. Having depression, also known as melancholia to the Greeks, meant that the humour was out of balance with

the person having excessive black bile. To regain good health, one must work towards balancing humours through fasting or purging (Thase et al., 2002).

Electroconvulsive Therapy

Electroconvulsive Therapy (ECT) for depression started in the 1940s. Despite having a clear understanding of biological bases of depression, the results showed that ECT seemed to have helped people with severe depression (Taylor 2007; Frost, 2012). However, ECT was deemed an inhumane treatment that gave rise to the "anti-psychiatry" movement coined by David Cooper in 1967 (as cited in Brayton, 2017). The anti-psychiatry movement was led and carried by prominent figures in the discipline such as David Cooper, Thomas Szasz, Theodore Lidz, Michel Foucault, and Wolfgang Huber among others. These leaders were discontent with the biological explanations for mental illness and collectively argued that treatments such as ECT and psychotropic drugs were abusive and unnecessary. They reminded the public of the foundational discipline of counselling psychology. They alluded to exploring people struggling with a mental health crisis based on their social changes and economic struggles rather than solely relying on a biological bases for their crisis (Brayton, 2017). The influence of the medical model did not seem to slow down. In fact, the introduction of anti-depressants and the powerful effect of advertisements for these medications only led to strengthening the influence of the medical model in the mental health community. David Healy (1997) called this an "anti-depressant era" because big pharmaceutical companies started promoting that depression was caused by chemical imbalance which could be treated by anti-depressants.

Chemical Imbalance Theory

A psychiatrist named Roland Khun (1912-2005) discovered the antidepressant effect of imipramine during the 1950s (Frost, 2012). This discovery caused the rise of the chemical imbalance theory of depression. By 1960s, many scientists were working on three major neurotransmitters: serotonin, norepinephrine, and dopamine (Frost, 2012). According to Leo and Lacasse (2008) successful research with neurotransmitters led to the development of Selective Serotonin Reuptake Inhibitors (SSRI). Still unclear about why the chemical changes were present in people with depression, the belief was that changes meant that a person with depression was deficient in serotonin neurotransmitter. This era transformed two important sectors of the healthcare system including the psychiatry and the pharmaceutical industry because of the seemingly promising results from medications. Antidepressants such as Prozac and Paxil were the most prescribed drugs in the United States from 2002 to 2007. Leo and Lacasse (2008) reported that patients spent about $123 billion dollars on psychotropic drugs while a fraction of that was spent in advertisement of drugs by the companies. In 2005, doctors wrote 31 million prescriptions for antidepressants (Leo & Lacasse, 2008). Greenberg (2016) cautioned that the relationship between selling drugs while simultaneously producing scientifically demonstrable benefits can lead to unethical outcomes. The author reasoned that there is a constant need for increase in sales for profit. This can lead to skewing data to lower the bar on what is considered beneficial and increasing the number of behaviours to fit the diagnostic criteria.

Structure of the Brain

Since there was no clear evidence of a biological bases of behaviour for depression, the researchers focused their attention on the structure of the brain. During 1970s with advancement in technology, people were able to scan a live brain showing brain activity (Frost, 2012). Amico et al. (2011) demonstrated that there was about a five percent reduction of hippocampal volume in people with major depressive disorder. The study also demonstrated that grey matter was reduced in the hippocampus, anterior cingulate, and prefrontal cortices while the amygdala was found to be overactive in people with depression. The hallmark of this study showed that the cause is rooted in the brain's nerve pathways and neural connections involved in emotional regulation and cognitive appraisal known as the Neural Network Theory. Frost (2012) argues that if this Neural Network Theory is correct, the plasticity of brain neural connections would suggest that antidepressants as treatment would be ineffective in promoting full recovery in people with depression because the treatment only deals with neurochemistry not neural connections. This conclusion begs the question: how can neural connections be strengthened? The answer to this question is to view a human as a whole entity – a humanistic view. A psychotherapy service provider with such a view would consider all the factors that surround the individual with depression. A sole focus on biology will not suffice as a treatment for a full recovery in a person with depression (Bohart & Tallman, 1999).

Brief History of Psychotherapy

Cautin (2011) provides a brief overview of the history of psychotherapy. According to the author, the profession of psychotherapy in the western world is rooted

in the 19th century. It started with Jean Charcot's (1825-1893) clinical research into hysteria in 1870. Ten years later, Sigmund Freud (1856-1939) began his therapeutic practice in 1880 in Vienna. The American Psychological Association was founded in 1892. Psychotherapy is often associated with Freud's work on psychoanalysis starting with his visit to the United States in 1909. Freudian psychoanalysis effortlessly assimilated into western psychotherapy and eventually became a dominant form in the early 1900s (Cautin, 2011). Alfred Adler (1970-1937) left Freudian work to form Individual Psychology in 1910, while Carl Jung (1875-1961) left Freudian work to form Analytic Psychology in the same year. World War II (from 1939-1945) had a colossal impact on the field of psychotherapy. The need for therapeutic services during this time further increased awareness of what eventually became known as Post-Traumatic Stress Disorder (PTSD) and the field of psychotherapy flourished. The first Diagnostic and Statistical Manual of Mental Disorders (DSM) was published in 1950. Shortly after, gestalt therapy and behavioural therapy were developed. Rational Emotive Behaviour Therapy was created by Albert Ellis (1913-2007) in 1950 and Cognitive Behavioural Therapy (CBT) was developed by Aaron Beck (1921-2021) in 1960. Trauma-based Therapy began in 1970s and Interpersonal Psychotherapy began in 1969 by Gerald Klerman and Myrna Weissman. Narrative Therapy was developed in 1990 by Michael White and David Epston (Cautin, 2011). The *Diagnostic Statistical Manual of Mental Disorder*, fifth edition, text revision (DSM-V-TR) is the most recent diagnostic manual currently in use which was published in 2022 (American Psychiatric Association, 2023). Today, CBT combined with meditation and mindfulness is the most widely used

modality and is among many of therapeutic modalities practiced today (Soares et al., 2020).

Modern Trends in Psychotherapy

Prominent authors in the field of psychotherapy started to notice subtle shifts in psychotherapy and predicted likely future outcomes. Norcross et al. (1992) conducted a Delphi poll on *The Future of Psychotherapy* trends for the upcoming decade including changes in clinical interventions, therapeutic modalities, psychotherapy service providers, and theoretical orientations. The authors also predicted possible future scenarios based on acquired knowledge regarding the field of psychotherapy. The Delphi poll was completed by a panel of 75 experts (70 people with PhD degrees, 4 MDs, and 1 participant who possessed both degrees). The study predicted that directive techniques would increase, specifically, problem-solving, self-change, communication skills, cognitive restructuring, the use of audios and video for feedback, homework assignments, and social skills training (Norcross et al., 1992). The predictions related to therapeutic modalities yielded that short-term therapy was on a sharp increase while long-term therapy was expected to decrease (Norcross et al., 1992). Psychotherapy service providers, self-help groups, social workers, psychiatric nurses, doctoral-level clinical psychologists, and master-level counsellors were expected to increase while the number of psychiatrists decrease slightly (Norcross et al., 1992). They predicted that theoretical orientations in psychotherapy including systemic, eclectic, cognitive, and integrative persuasions would moderately increase alongside a slight growth in psychobiological, behavioral, and feminist perspectives. Further, transactional analysis and classic psychoanalysis were expected to decrease, but a person-centered orientation

would be encouraged. Overall, the future of psychotherapy was predicted to be headed towards short-term psychotherapy to accommodate increased psychotherapeutic demands (Barber, 1994; Norcross et al., 1992).

Twenty years later, Norcross et al. (2022) conducted another Delphi poll on *The Predicted Future of Psychotherapy* for the upcoming decade. Interventions including the use of computer technology (such as online and virtual reality) were predicted to increase. Moreover, relational skills, strength-oriented methods, skill-building techniques, and client self-change were also predicted to increase while free association and dream work were forecast to decrease (Norcross et al., 2022). As was found in the earlier study by Norcross et al. therapeutic modalities focused on short-term therapies were predicted to continue to rise while long-term therapies were thought to continue to decline. Master-level counsellors and social workers were predicted to be the most sought-after service providers. Like previous predictions, psychiatrists appeared to be the only discipline predicted to provide psychotherapy at a decreased rate (Norcross et al., 2022). Theoretical orientations, such as multicultural, mindfulness, cognitive-behaviour, motivational interviewing, acceptance and commitment, gay-affirming, and dialectical behaviour therapies were predicted to be most influential theoretical orientations in the coming decade while classical psychoanalysis, transactional analysis, and gestalt therapy were predicted to further decrease (Norcross et al., 2022).

Trends in psychotherapy research were also shifting. Soares et al. (2020) identified publication trends from peer-reviewed articles related to psychotherapy brands from the past 50 years. They used three popular search engines including PsycINFO, PubMed, and EbscoHost. The authors found that CBT, psychoanalysis, family systems,

and behavioural therapy accounted for 78% of all publications over the past 50 years. However, in the last decade, psychoanalysis declined sharply while CBT and meditation and mindfulness experienced an increase in mentions in published research. Their study also demonstrated the increased preference for mainstream popular brands of psychotherapy in social media and on the internet while there was a decreased preference for traditional psychotherapy. Soares et al. (2020) allude to the phenomenon of rich getting richer where the more a certain brand of psychotherapy stays in the public's eye, the more it is likely to receive funding for research. Many authors have predicted, and established, the modern shift towards the use of technology and short-term therapies utilizing popular psychotherapeutic modalities (Norcross et al., 2022; Kazdin & Ribbitt, 2013; Soares et al., 2020). These studies demonstrate evolution, preferences, and shifts in modern psychotherapy.

My Connection

As I grew older and gained an awareness of my mother's mental health, I realized something was different with her. I observed her battle depression as far as my memory serves me. As a child, it was heart-wrenching witnessing many lows and highs of her life. She sought the help of physicians who then prescribed her anti-depressants without mentioning various avenues where she could seek help, such as psychotherapy service providers. She battled depression with various anti-depressants prescribed to her throughout the years. However, this resulted in an addiction to some of the psychotropic drugs. In addition to battling depression, she now struggled with addiction. This was not the solution she had hoped for. Depression and addiction became a normal part of her

routine; She woke up, took the pills, faded and with every pill, she faded a little more. She was being consumed by something that she felt was out of her control. Over the years, doctors did not check on the progression of her depression or investigate the possibility of addiction to psychotropic drugs. In her case, being treated for depression by doctors who only viewed depression through a medical model lens was a temporary solution. As soon at the effect of the pills wore off, the depressive feelings were back. After being on anti-depressants for decades, she felt no improvement in depression. Perhaps, a humanistic approach would have made a difference in her life. At some point, I asked her how long she has felt depressed. She responded, “this is how I have always felt for as long as I can remember and it will likely remain this way” (personal communication, 2006). On one hand, I felt the pain and loss of hope in her words. On the other hand, it ignited my passion for counselling psychology. In hindsight, she is one of many examples of people who have been failed by the system. I wanted to know why people, like my mother, are unable to receive appropriate mental health services.

According to World Health Organization (WHO) 450 million people are struggling with mental illness and depression is a leading a cause of disability worldwide (WHO, 2024). According to Centre for Addiction and Mental Health (CAMH), one in two Canadians will experience mental illness by the time they reach age 40 years making it a leading cause of disability in the country. Furthermore, the cost to society is immense as it prevents about 500, 000 employees from attending work each week. CAMH (2024) estimated the economic burden costing about $51 billion annually including the health care costs, loss in productivity, and low quality of life. As a counselling student, I want to understand the relationship between the education system and the practical world of

psychotherapy. I want to understand the tension between the medical model that dominates the psychotherapy field, the humanistic approach to psychotherapy, and its impact on counselling students. It is timely and imperative that I explore many ways I can provide appropriate mental health care to clients. My observation of my mother's life ignited a passion in counselling psychology which led me to this area of research.

The Focus of My Study

Statement of Problem

As a student in Master of Counselling program, I noticed a difference between what we are taught and the various ways the field of psychotherapy is practiced. Upon reviewing current published peer-reviewed literature, I discovered an apparent tension between the medical model and the humanistic approach to counselling. Literature on addressing this tension is prolific, but few studies address the impact of this tension on counselling students. I am currently a counselling student in my last year of the program and will soon enter the practical field of psychotherapy as a registered psychotherapist. Because of my personal experience growing up with a mother who experienced depression and combined with my experiences as a master's student in a counselling program, I am interested in investigating the tension between the medical model and the humanistic approach to counselling through the lens of counselling students.

Purpose

The rationale and the purpose of this study is not to attack the medical model as it plays an important role in psychotherapy. Rather the purpose is to examine the tension

between the medical model and the humanistic approach to counselling through the lens of counselling students.

I used a qualitative methodology to provide an in-depth analysis of the tension and its impact on counselling students with hope that the findings and emerging themes will contribute to rich discussions and thought-provoking examination for future studies.

Research Question

What impact does the tension between the medical model and the humanistic approach to counselling have on students in a Master of Counselling in a psychology program?

Definition of Terms and Distinction between Counselling and Psychotherapy

It is important to differentiate counselling and psychotherapy. The Canadian Counselling and Psychotherapy Association (CCPA, 2024) defines counselling/psychotherapy as:

> a relational process based upon the ethical use of specific professional competencies to facilitate human change. Counselling addresses wellness, relationships, personal growth, career development, mental health, and psychological illness or distress. It is a process that is characterized by the application of recognized cognitive, affective, expressive, somatic, spiritual, developmental, behavioural, learning, and systemic principles. It is not possible to make a generally accepted distinction between counselling and psychotherapy. There are well founded traditions which use the terms interchangeably and others which distinguish between them. If there are differences, then they relate more to the individual psychotherapist's or counsellor's training and interests and to the

> setting in which they work, rather than to any intrinsic difference in the two activities. (para. 1)

To minimize confusion, I use the word *psychotherapy* throughout this document to refer to counselling and psychotherapy.

Chapter 2. Review of the Literature

The Arms Race phenomenon within species is defined as "an adaptation in one lineage (i.e., predators) may change the selection pressure on another lineage (i.e., prey), giving rise to a counter-adaptation" (Dawkins & Krebs, 1979). The Arms Race phenomenon can also be applied to the human world in which various systems interact with one another adapting to the world's demands for survival. An example is the education system preparing students for the practical world by providing them with skills to keep up with the therapeutic demands as they enter the workforce. Likewise, counselling educational curricula must keep up with the ever-evolving mental health services and the demands in the practical world. If the counter-adaptation is not occurring in one system, the system will collapse and disadvantage a group of humans who are directly affected by it, in this case, the service providers and the service users. I argue that the counselling education system is not evolving and adapting to meet the therapeutic demands that therapists encounter in practice today. The education system is failing to prepare and equip students with the appropriate skills to provide quality therapeutic services, thus, creating tension for the students of counselling just as they enter the workforce.

There is abundant evidence in the literature in existence discussing tension between the medical model and the humanistic approach to psychotherapy. It is a debate that has existed for decades since psychotherapy became a profession. Numerous studies have argued on both sides, outlining advantages and disadvantages of both approaches in the field of psychotherapy. However, research demonstrating where or how the tension is created, is minimal.

The field of psychotherapy has come a long way since it became a profession. The evolution of psychotherapy, including an increase in demand for service, changes in format, and mode of delivery has significantly changed. There are many key factors and role players that impact this change including psychotherapists, psychiatrists, financial pressures from insurance companies, pharmaceutical companies, demand and supply of psychotherapeutic services, various modalities, shifts in economy, spread of pandemic – especially the recent COVID-19, and the increased awareness of psychotherapy generally. The growing pressures from the key factors and role players further increase constant push-and-pull between the medical model and the humanistic approach.

It appears that psychotherapy practiced thorough the medical model lens can be faster and cost-efficient, however, it begs the question, *is it effective?* One outcome response to keep up with supply and demand of psychotherapeutic service is providing short-term therapy (Barber, 1994). In this literature review, I provide a comprehensive overview of the tension by exploring the crucial elements, such as efficacy of short-term and long-term psychotherapy, cost-effectiveness of psychotherapy, and training in psychotherapy.

The Tension

According to Elkins (2009), psychotherapy has its roots in medicine. Despite the efforts to free psychotherapy from medicine and the medical model, it remains dominant in the field of psychotherapy. The medical model ideology is deeply ingrained into psychotherapy and many therapists are unaware of its impact on their clients and continue to embrace this approach. Thus, it created a tension of opposing views such as psychotherapy through a medical model lens or a humanistic lens. This tension has

always existed in psychotherapy. Many humanistic therapists and psychologists pushed back against the labeling and diagnosing of clients arguing that clients should be viewed as an entire entity and foster human growth instead of limiting growth (Elkins, 2009). For example, Carl Rogers (1951) started using the term *clients* instead of *patients* referring to people who sought therapy to characterize empathy and unconditional positive regard (as cited in Elkins, 2009, p. 70). According to Elkins (2009), there is no clear distinction between medical model and humanistic approach in the field of psychotherapy even if some therapists attempted to make one. The author argued that majority of the professionals took part in the medical model when providing therapy especially in the 1980s "to receive reimbursements from health insurance companies" (Elkins, 2009, p. 69). For example, in 1979, when the United States Court of Appeals in Virginia, USA ruled that psychologists would be reimbursed for their psychological services just as psychiatrists are from Blue Shield Insurance Company, many psychologists started to build their practices on third-party payments. Consequently, the medical model continued dominating the field of psychotherapy (Elkins, 2009).

Despite the major influences such as insurance companies, humanistic therapists continued to voice their efforts to oppose the medical model and its language use in the field of psychotherapy. The use of language such as patient, symptoms, diagnosis, pathology, treatment, mental disorders are regularly used in psychotherapy when defining a client's presenting concern. The American Psychological Association's (APA) monthly magazines and articles reflect the underlying assumption of medical model (Strong, 2014). The DSM is praised and used by most of therapists to diagnose a client or to gain an understanding of a client's diagnosis. In the same DSM that is being used for

knowledge purposes, there are many mental disorders that outline behaviours and subjective experiences that do not conform to cultural norms or that are simply deemed problematic when they are not (Elkins, 2009). For example, disorder diagnosing and labelling "normal bereavement, childhood temper tantrums, increased numbers of addictions (i.e., internet) and 'psychosis risk syndrome' exemplify new ways to pathologize and medicate normal human existence" (Strong, 2014, p. 107). According to Venkatesan and Suresh (2013), unnecessary diagnosing pathologizes normal human conditions, de-emphasizes suffering, and eliminates the individuality of clients. The tension is essentially a conflict between the use of biological versus psychological explanations as the bases of mental illness. As a result, two groups of professionals speaking completely different languages, alluding to the use of medical language in psychotherapy (Venkatesan & Suresh, 2023).

Efficacy of Short-term Psychotherapy

Short-term psychotherapy was first mentioned by Alexander and French (1946). Their approach was the correction of emotional experiences with psychoanalytic therapy. They suggested that optimally clients undergoing short-term therapy would have weekly rather than daily sessions. The rationale behind weekly sessions was that it would give sufficient time for clients to apply that they learned from therapy while also decreasing the dependency on the therapist (Alexander & French, 1946; Barber, 1994). The idea of short-term therapy was a response to the rise of clientele demand, growing demands of financial pressures, and awareness of the efficacy of short-term therapy (Barber, 1994). Barber (1994) reasoned that short-term therapy helps to meet growing demand for psychotherapeutic care which is why it is unlikely to slow down in the future.

Numerous authors highlight the demand for an increase of short-term therapies and decrease of long-term therapies (Norcross et al, 1992 & 2022; Barber, 1994). If the future of psychotherapy is short-term therapy, then investigating its efficacy and benefits would be worthwhile. Malan (1963) was among the first to show the efficacy of short-term dynamic therapy. Through research Malan (1967a & 1967b), demonstrated that short-term therapy is not be a good fit for every client. It is imperative for a therapist to make appropriate client selection, maintain focus on fostering changes in the client's personality, and appropriately interpret a client's presenting concerns when assessing if short-term therapy is appropriate for that person. Barber's (1994) summary of Malan's (1967a & 1967b) research highlights that the most important consideration related to short-term dynamic therapy is client selection and maintenance of treatment focus.

Knekt et al. (2016) conducted a study comparing short-term therapy to long-term therapy. In a randomized trial, clients received 20 sessions of short-term psychodynamic therapy (SPP), 240 sessions spaced out over three years of long-term psychodynamic therapy (LPP), and 12 sessions of solution-focused therapy (SFT). Semi-structured interviews were set up after a 10-year to study outcome measures, such as symptoms, work ability, personality, social functioning, need for psychiatric treatment (auxiliary treatment), and remission. Altogether 74% of clients were free from symptoms indicating the efficacy of psychotherapy. Overall, LPP showed greater efficacy compared to both SPP and SFT for all outcome measures. They also asked whether the clients used only psychotherapy, or only medication, or auxiliary treatment – a combination of both therapy and medication. The results showed that prevalence of auxiliary treatment was 58% in SPP, 47% SFT, and 33% in LPP. About 44% of all clients used some auxiliary

treatment. Of these clients, 59% used medication only, 24% used medication and psychotherapy, and 13% only used psychotherapy. About 85% preferred medication and less than 15% preferred only psychotherapy. The authors speculated that either the reason is being that the medication is faster, more cost efficient, and is readily available or that the tolerance for pain and suffering is set low. Perhaps society's aim is now to get rid of the pain and suffering altogether with medication while psychotherapy's goal would be to decrease suffering and foster holistic wellbeing.

Lorentzen et al. (2013) found similar results in their study. They conducted a study with clients receiving randomized group therapy. Groups received 20 weekly sessions of short-term therapy (ST) and 80 weekly sessions of long-term therapy (LT). They found significant treatment effect in favour of LT. The authors suggest that offering LT to certain clients may be unnecessary. More specifically, clients should be offered ST or LT based on their needs and presenting concern echoing Malan's (1967a & 1967b) suggestion of client selection criteria. Svartberg and Stiles (1991) did a meta-analysis of 19 studies comparing ST and LT conducted between 1978-1988. They found that although ST was better for clients with no therapy at all (or being waitlisted for therapy), the efficacy of ST decreased as time increased. Conversely, the efficacy of LT increased as time increased. Findings suggest that LT is more effective in the long run while the efficacy of ST starts to diminish with time. Perhaps, the rush of a quick fix may not be for every client establishing the importance of ensuring clients are suitable for ST before offering this option. Like Knekt et al. (2016), Svartberg and Stiles (1991) also found that ST was most effective with the addition of psychotropic medication. Interestingly, Crits-Christoph (1992) found that ST was effective, but their study included therapists who

were experienced in providing ST highlighting a link between therapists' training to the efficacy of therapy.

Training in Psychotherapy

Quality education and training are the most important initial steps in any profession. According to Gordon et al. (2021), the foundation of psychotherapy is built through the lenses of psychoanalysis, behaviourism, and humanistic psychology. Traditionally, most psychotherapists have been unquestionably practicing their preferred single modality. Recently, a shift from tradition to integrative approaches to psychotherapy has been observed. Norcross and Goldfried (2005) argued that an integration psychotherapy approach developed as a response from psychotherapists' dissatisfaction with a single psychotherapeutic approach leading to the exploration of how an integrative approach could be beneficial to clients.

The term *integrative* has evolved throughout the decade. According to Gordon et al. (2021), currently the term *integrative* can be characterized in six movements: assimilative integration, theoretical integration, common factors, pluralism, technical eclecticism, and unification. The shift from utilizing single modality to an integration approach to psychotherapy is clear and well established in literature. However, literature on training psychotherapists on how to adopt an integrative approach into their work is scarce. Gordon et al. (2021) found the theme of uncertainty to be the main feature in their study. The top reason for the challenges experienced by new psychotherapists was the "absence of a road map and given the complexity inherent in drawing simultaneously on different theoretical paradigms" (Gorden et al., 2021, p. 427). The ability to tolerate uncertainty or ambiguity is a key factor that educators and trainers should consider when

training their students and new psychotherapists. The study by Gordon et al. (2021) demonstrates a process of moving from uncertainty to certainty which correlates with Mason's (1993) description of training development. Mason (1993) describes this process as one moving from a position of unsafe certainty to safe certainty. It is a developmental process of feeling unsure and unconfident to embracing (while also recognizing) one's limitations (Mason, 1993; Gordon et al., 2021).

Ladmanova et al. (2022) conducted a study on 26 trainees and identified 24 categories of helpful and 14 categories of hindering events during training for psychotherapists. Results showed that in the first year, trainees found that focusing on personal self-awareness such as awareness on the present moment and identifying one's own patterns, to be the most helpful event. Conversely, they found that feelings of personal uncertainty, such as self-doubt; unpleasant emotional responses characterized as trainees confronted by their own cognitive, behavioural, and emotional responses; and distraction to be the top three hindering events during the first year. The authors in this study acknowledged that facing oneself, such as reviewing session videos with a supervisor, to be the most helpful yet disturbing events in the process of becoming a psychotherapist. Facing oneself corresponds to Rogers' (1961) notion "training enhances trainees' personal and relational qualities, such as emotional maturity, empathy, positive regards, genuineness, and management of their own difficulties during an interpersonal encounter" (Rogers, 1961, as cited in Ladmanova et al., 2022, p. 160). Conversely, from a client's perspective, Timul'ak (2010) reported therapeutic relationships and session treatment outcomes to be the most helpful events in individual therapy. The author

further noted that clients' feelings of being understood, gaining reassurance, and gaining insight into their case conceptualization led to them experiencing relief.

Based on the gathered literature thus far, the future of psychotherapy is headed towards short-term therapy. If the future of psychotherapy is short-term therapy, then selection and maintenance of treatment focus is an important criterion (Barber, 1994). Selection of clients for appropriate psychotherapy and correct modality is dependent on therapist's ability to evaluate. A good evaluation comes from the client and therapist's working alliance and from the client's motivation to foster change (Barber, 1994). The therapist's ability to understand the client's personality characteristics, goals, and a comprehensive understanding of case conceptualization comes from education and training. Moncher and Prinz (1991) found that treatment fidelity was promoted when therapists were attentive and continued their supervision. Barber (1994) emphasized the important use of guidelines and manuals by the therapists to increase the treatment fidelity. Piper et al. (1984) found that long-term therapy was not far off in its efficacy as compared short-term therapy. However, the authors acknowledged that the absence of guidelines or manuals and specific training related to services such as short-term therapy, was a limitation. They recommended that efficacy of therapy should be measured in studies where therapists have received proper training in the discipline that they are practicing.

Comparatively, Henry et al. (1993a & 1993b) demonstrated the importance of supervision. The authors reported that trainees, specific to short-term dynamic therapy, improved their skills which was attributed to increased supervision. Similarly, Nieuwsma et al. (2012) showed that short-term therapy was more effective when therapists were

specifically trained in that discipline. The authors also found that short-term therapy is an effective option for the acute-phase treatment of depression.

Technology

In addition to short-term therapy, technology will also be dominating the future of psychotherapy (Norcross et al., 2022; Kazdin & Ribbitt, 2013; Soares et al, 2020). Significant increased use of technology in psychotherapy has already been observed in the recent years. The access to psychotherapy services through technological platforms such as Microsoft Teams, Zoom, telephones, or emails is also known as telepsychotherapy. An increased use of telepsychotherapy occurred during COVID-19 pandemic in early 2020 when physical distancing became mandatory to slow down the spread of the virus (MacMullin et al., 2020). MacMullin and colleagues (2020) conducted a study where they interviewed four psychotherapists on their use of technology in their practice. The authors found two key themes arising from the results (a) therapists' responsibility and (b) trust. Therapists' responsibility referred to a therapist's own responsibility for gaining competency with technology use and trust referred to as therapist's trust in technology that it will function as programmed. However, the participants did acknowledge the importance of reading the client's body language enhancing the competency of case conceptualization as a missing factor when providing telepsychotherapy. The authors acknowledged that their findings were inconsistent with the existing literature that expected therapists to have trouble using technology. A comprehensive understanding of evolving platforms and modes, such as inclusion of technology, is important in determining the most effective way of delivering treatment to clients (Paul, 1967; Soares et al., 2020). Although their study raises

important considerations of how to utilize technology in psychotherapy, the question of what and when to utilize technology with what type of clientele presenting concern remains unanswered in literature. Perhaps clients who display a personality characteristic of dependency or anaclitic depression would respond better with face-to-face interactive psychotherapy (Wallerstein, 1986; Blatt, 1992). The selection criterion where a therapist is expected to have high competency in the ability to select appropriate therapeutic modality, platform, and orientation to client's presenting concerns remains imperative for a future of psychotherapy to thrive.

Cost effectiveness of Psychotherapy, Financial Pressures, and Insurance plans

In the age of diminishing resources, future scenarios predicted by Norcross et al. (1992 & 2022) mentioned that economic factors would be the driving force behind the availability, modality, intervention, and orientation of psychotherapeutic services. This prediction is consistent with Karasu (1987) who hinted that it is imperative for the service providers to adhere to cost-effectiveness and the quality of service so that the clients will not have to pay a heavy price for their services. Norcross et al. (1992) predicted that the practitioner may start to lose control over the services to other business interests such as financial pressure by the pharmaceutical industries because of the unstable balance of supply and demand. The businesses of financial insurance companies, pharmaceutical companies, and mental health services have always been almost inseparable but now so more than ever.

Richman (1966) demonstrated that since the involvement of insurance companies, the frequency, modality, and form of psychotherapy has changed. For example, therapy of up to 15 sessions is covered by insurance companies increasing the demand for short-

term therapy. Financial pressures also dictated the type of diagnoses, treatment, and duration that would be covered under a particular insurance plan for a client. This is an indication of stepping away from an individual psychotherapy plan for a client's presenting concern and moving towards categorization and labelling – in other words, the medical model. Business interests such as insurance companies, pharmaceutical companies, and psychiatrists prescribing medication thrive on the medical model. Perhaps, the dominance of the medical model over the humanistic approach is maintained more for purposes of making profit from the client's mental health than the client's best interest. Therapists who embrace the humanistic pushback against the interests of big companies and defend the clients' best interests.

Psychotropic Medication

The field of psychotherapy started to shift during the 1950s with the introduction of Chemical Imbalance Therapy (CIT) and psychotropic medication. CIT for depressions states that depression is caused by deficiency of serotonin – a neurotransmitter responsible for transmitting electrical impulses in the nervous system (Young, 2007). As mentioned in chapter one, many scientists started researching three major neurotransmitters: (a) serotonin, (b) norepinephrine, and (c) dopamine. This led to the development of the SSRI class of drugs (Frost 2012; Leo & Lacasse, 2008). The long-standing CIT for depression that had a colossal impact on the field of mental health was recently debunked. Specifically, Moncrieff et al. (2022) published a systematic umbrella review aiming to synthesize and evaluate existing evidence on whether depression is associated with serotonin deficiency. They found that there is no convincing evidence that depression is associated with or caused by serotonin deficiency. Despite, the fact that

theory has been debunked, most of the public still endorses the chemical imbalance theory (Moncrieff et al., 2022). However, surveys reveal that most people struggling with depression prefer a psychological and social explanation over biological explanation and prefer therapy over psychotropic drugs as a treatment (van Schaik et al., 2004; Prins et al., 2008).

Advertisements promoting psychotropic drugs remain common fueled by the potential for financial gain for companies. Consequently, clients spent billions of dollars on purchasing psychotropic drugs (a fraction of that was spent in advertisements by the pharmaceutical companies from 2002-2007) due to psychiatrists and doctors prescribing these medications for depression (Leo & Lacasse, 2008). Mojtabai et al. (2010) examined the patterns and recent trends in prescription of psychotropic medications from 1996-2006 by office-based psychiatrists. The trend showed that if a client had two or more appointments with a psychiatrist, medication prescription rates increased from 42.6% in 1996-1997 to 59.8% in 2005-2006. With three or more visits, medication increased prescription rates went from 16.9% to 33.2% indicating a significant increase. It is important to note that while some of these psychotropic drugs are supported by clinical trials, many are of unproven in its efficacy. In the reanalysis of Cipriani et al. (2018) systematic review with meta-analysis review, Munkholm and Boesen (2019) concluded that "evidence does not support definitive conclusions regarding the benefits of antidepressants for depression in adults. It is unclear whether antidepressants are more efficacious than placebo" (p. 1).

These studies not only show the significant increase in the sales and prescriptions of psychotropic medication but also an increased risk of various drug interactions

impacting quality of care (Mojtabai et al., 2010). Forslund et al. (2020) demonstrated that the use of psychotropic drugs increased with client's age while psychotherapy decreased. Norris et al. (2011) also found an increased use of psychotropic drugs with age. Similarly, Husky et al. (2023) noted that of people struggling with suicidal ideation in 2023, 43.6% were receiving no mental health care, 36.6% were only taking psychotropic medication, 4.8% were receiving psychotherapy, and 15% were receiving both. When clients were asked what their treatment preference was, their response was that they generally preferred psychotherapy over psychotropic medication. One of the tenets of the humanistic approach is for the client to have autonomy and to make informed decisions related to medication use or a type of treatment.

The findings of Husky et al. (2023) suggests that most participants received therapy that was not of their preference. Like the participants in the Husky et al. (2023) study, many clients around the globe are on treatment they do not wish to be on, thus, an indication of decrease autonomy and absence informed decision. The advertisement and production of prescription psychotropic medication is continuing to rise offering the public the idea of diminishing pain and suffering which would be temporarily rather than focusing on helping them adapt and manage their illness. This, in essence, is the medical model view versus the humanistic approach to psychotherapy.

Dose-response Effect in Psychotherapy

Dose-response effect in psychotherapy refers to the phenomenon of optimal number of sessions needed to make a significant difference in therapy (Nordmo et al., 2021). Schlesinger et al. (1983) compared the claims of employees that were sent to the

federal government for U.S health plans between 1974 – 1978. They found that people who had chronic disease and received mental health care spent 39% less in medical costs than people who had chronic disease but who did not receive additional mental health care. In addition to the efficacy of psychotherapy, the dose-response effect was observed. The more sessions clients had, the better the outcome. They observed that number of sessions less than five proved to be ineffective. Nordmo et al. (2021) found that clients who displayed mild levels of psychopathology benefited from ST while clients who displayed severe levels of psychopathology benefited from LT. They established that clients who do not benefit from ST is because they never reach a Good Enough Level (GEL) (Barkham et al., 2006). According to Barkham et al. (2006), GEL contends that each client's response to therapy varies and exposure to just therapy is not an effective measure for successful therapy outcome. The authors assert that that instead of recommendations by therapists for attending a certain number of sessions (dose-effect), clients should discontinue therapy when they have obtained sufficient benefit or their GEL. The findings of Nordomo et al. (2021) study supports the argument that ST or LT is not for everyone arguing against one-size fits all and emphasizing the importance of Malan's (1967) selection criteria. Barber (1994) suggests that the optimal number for brief dynamic psychotherapy is 12-40 sessions while Schelesinger et al. (1983) found that psychological services to be ineffective when delivered in small number (i.e., $x < 5$). Howard et al. (1986) demonstrated that clients with acute chronic distressing symptoms had 60% chance of moving into normal range after one year of psychotherapy. Knekt et al. (2016) concluded that average of 100-120 session plus 85-95 auxiliary sessions and the use of psychotropic medication comparably more effective than 240-260 sessions in

LPP. Meanwhile, McGuinty et al. (2016) presented a model for short-term therapy of 4-6 sessions to be effective but emphasizing the importance of suitability criteria of clients and therapists' experience and/or training.

Maljanen et al. (2016) studied cost-effectiveness of short and long-term psychotherapy. They conducted a randomized study of 326 clients randomly assigned to SPP, and LPP. They interviewed the clients after a 5-year follow-up. The SPP was much more cost-effective due to their short-term nature and sessions being covered by most insurance companies. However, when adding the cost of auxiliary sessions over time, the cost amount was more than LPP. Knekt et al. (2016) found 85-95 auxiliary sessions for those receiving SPP as an optimal number of sessions as most effective response / successful remission rate of psychotherapy. The added cost of auxiliary sessions is perhaps the reason why SPP would cost more than LPP over time. Perhaps, the clients who utilized auxiliary sessions in SPP felt that they never reached their GEL or satisfaction from psychotherapy. SPP with auxiliary sessions mimic LPP with regards to the total number of sessions. Blatt (1992) found that personality characteristics in a client is a crucial indication in determining the suitability of the type of therapeutic intervention to be effective. In the reanalysis of Wallerstein's (1986) Menninger Psychotherapy Study, Blatt (1992) mentioned that self-critical (introjective) clients responded better to psychoanalysis, whereas dependent (anaclitic) patients responded better to face-to-face interactive psychotherapy. Furthermore, dependent clients improved the most regarding their interpersonal functioning while self-critical clients improved the most with their cognitive functioning (Blatt, 2004; Wallerstein, 1986; Blatt, 1992; Blatt et al., 1994).

Summary

Overall, the tension between the medical model and the humanistic approach to psychotherapy is well observed. However, literature on the underlying factors behind the tension is scattered and scarce. In this literature review, I have attempted to put various factors together to provide a comprehensive understanding and exploration of the tension and its impact on students of counselling. According to the literature, the trend in psychotherapy is headed towards ST models. Therefore, exploring the efficacy of ST models compared to LT models is fruitful. The evidence suggests that ST models are efficient, but the efficiency of these models decrease with time whereas, the efficiency of LT model increases with time (Knekt et al., 2016). Barber (1994) and Malan, (1967a & 1967b) maintained that ST can be effective and beneficial to the client if the therapist is able to differentiate what type of clients would benefit most from this approach. Thus, client assessment is an important part of training for students and new therapists. Studies such as Moncher and Prinz (1991) and Henry et al. (1993a & 1993b) tells us that students who improved the most in their skills were those who continued their supervision. Gap in literature is observed linking educational learning of ST and the use of modern technology in determining the suitability criteria among counselling students in their counselling programs curriculum.

In the age of diminishing mental health resources, finding the time from busy schedules, and financial stressors, the temptation of quick fix with psychotropic medication or ST is understandable. These factors give rise to the medical model continuing to dominate the field of psychotherapy. Since the involvement of insurance companies in psychotherapy, the modality and the delivery of therapy has changed

immensely (Richman, 1966). Some insurance companies will only cover clients with certain presenting concerns which increases the concerns of labelling and categorizing clients; and some will only cover the bill of eight to ten sessions annually, which further fosters the interest in ST. However, as mentioned above, ST is not efficient for every client. To make up for the lack of efficiency, clients may opt for psychotropic medication because its availability and affordability. Although, CIT has been debunked, the use of psychotropic medication as a common treatment for various mental health concerns remains dominant. On the contrary, people generally prefer psychotherapy over psychotropic medication (Husky et al., 2023). This contradiction raises serious concerns about taking away clients' autonomy and ability to make informed decisions about what therapeutic treatment is appropriate for them and the psychotherapists' ability to evaluate and guide clients in choosing appropriate treatment. This, in essence, is the tension between the medical model and its impact on students, psychotherapists, and on their clients.

Chapter 3. Methodology

The aim of this chapter is to provide a comprehensive overview of the research metholodogy utilized in this study. I start by introducing Interpretive Phenomenological Analysis (IPA) methodology and its theoretical underpinnings. I provide a rationale for selecting the IPA followed by an overview on the research design including the process of recruitment, data collection, and data analysis. I then discuss the limitations associated with IPA, ethical considerations, and strategies for quality in qualitative research.

Interpretive Phenomenological Analysis

Interpretive Phenomenological Analysis (IPA) is a research methodology developed by Jonathan Smith, Michael Larkin, and Paul Flowers in the 1990s and it has two primary aims: (a) in-depth investigation regarding how someone makes sense of their lived experiences, and (b) an in-depth interpretation of an understanding of their lived experiences (Smith et al., 2009; Tuffour, 2017). IPA attempts to study phenomenon in natural settings usually involving a small number of participants because the goal is to answer questions such as what, why, and how the experience is shaped by participants social, cultural, economic, and historical worlds. I adopted IPA as a research methodological approach to understand master-level counselling students' lived experiences of the tension between the medical model view and the humanistic approach to psychotherapy and the impact of this tension on them.

Theoretical Underpinnings

Hermeneutics

The theoretical underpinning of IPA stems from hermeneutic tradition where the researcher is attempting to understand how participants in the study are making sense of

their lived experiences (Smith et al., 2009). In essence, hermeneutics is the art and science of interpreting and meaning making. Meaning and experience are inseparable in language because they not only describe the experience, but also expresses the meaning of the experience (Tuffour, 2017).

Phenomenology

Phenomenology is an approach initially began by Edmund Husserl (1859-1938) which was later developed by his academic assistant Martin Heidegger (1889-1976) (Broward & Patton, 2023). Although Husserl brought forward the work of phenomenology, his work follows from the work of philosophers from ancient Greecesuch as Plato's (428-347 BCE) allegory of the cave illustrating that the observer's thinking may be illusory but shifting the attention can lead to greater clarity; Aristotle's (384-322 BCE) commitment to study concrete experiences aligns with phenomenology's approach; Descartes' (1596-1650) notion of never accepting anything as true unless clearly known and his priority of avoiding prejudice; and Kant's (1724-1804) focus on a subjective examination of phenomenon in question (as cited in Broward & Patton, 2023, p. 80). Phenomenology is a theoretical framework that supports researchers seeking an in-depth understanding of a phenomena in question at the level of subjective reality (Broward & Patton, 2023). Phenomenology seeks to study the lived experiences of humans and how these experiences are perceived in their consciousness (Tuffour, 2017).

Research Design

In this section, I will discuss participant recruitment processes, inclusion and exclusion criteria, describe the participants, present the method of data collection, and describe my approach to data analysis.

Data Collection: Semi-structured Interviews

Interviewing is central to IPA as it helps participants to recall their experiences from their memory and draws on the meaning of those experiences. According to Lauterbach (2018), holding interviews has two purposes: (a) drawing upon the meaning of the experience and developing a rich understanding of the phenomenon; and (b) developing a conversation-like interview around the meaning. Semi-structured interview is a common method for data collection in qualitative research. The quality of interview influences the outcome of the study (Kallio et al., 2016). Kallio et al. (2016) provided comprehensive guidelines for conducting an effective semi-structured interview. These guidelines are comprised of five phases were followed during the interviews I conducted with participants:

1. Identifying the prerequisites.
2. Retrieving and using previous knowledge.
3. Formulating preliminary interview guide.
4. Pilot testing the interview guide.
5. Presenting the complete interview guide.

In the first phase, the researcher identifies areas of the phenomenon based on their knowledge of the phenomenon under study. The phenomenon I am investigating is the impact of the tension between the medical model and humanistic approach to psychotherapy on master students of counselling. I was investigating participants' perceptions, opinions, and experiences. In the second phase the researcher retrieves and utilizes previous knowledge. To have a good grasp of the subject of research, I conducted an extensive literature review on the tension between the medical model and humanistic

approach to psychotherapy. Literature review on the tension, including various factors and key players that are both impact and impacted by the tension, were also explored. During the third phase a researcher creates a list of questions which would direct a conversation related to the research topic. I thoughtfully created 5 main questions directly discussing the research topic and six sub questions for clarifications if the conversation wandered off research topic or elaboration was needed. The fourth phase involves testing the guide. The list of questions was reviewed by Dr. Paul Jerry, thesis supervisor, to improve the pre-assessment of research ethics. The aim of this phase is to identify and assess information regarding research integrity. The final phase is to produce a complete interview guide that is clear and logical so that future researchers can also use it. After the feedback from Dr. Paul Jerry, the list of questions was finalized for semi-structured interview. Appendix D contains a list of examples of questions that were used in the interviews.

According to Bevan (2014) a semi-structure interview in phenomenological studies focuses on three stages: (a) asking questions that evoke the phenomenon in the interviewee's history and context; (b) a focus on the interviewee reconstructing their experience; (c) a shift to a focus on the interviewee reflecting on the meaning of their experience. Thus, the purpose of having a semi-structured interview is to have a conversation with the participant while staying on the topic. The process of participant recruitment is described in detail in the next section.

Data Collection

Semi-structured interviews were held for the participants (n = 4). All interviews were video recorded and auto transcribed. All participants signed their consent form a

week prior to the scheduled interviews. The interviews were conducted using an online software Microsoft Teams with a password-protected Athabasca University account. The recordings were all electronic and stored on a password-protected laptop in the researcher's home. The transcriptions of all interviews were saved in a Microsoft Word document in the same password-protected laptop. The identifying information was removed and deleted from the transcriptions and saved under the participants' pseudonym. To reduce the risk of privacy and confidentiality breach, identifying information was only contained on participants' consent forms.

Procedures

The inclusion criteria for participants included students who were currently enrolled in, or have completed, their practicum courses or who have recently graduated from the Master of Counselling program regardless of their attributes such as culture, language, religion, race, disability, sexual orientation, ethnicity, linguistic proficiency, gender, or age. All participants were given sufficient time to read through and sign the Letter of Information Consent form. All participants also chose their own pseudonym names to ensure confidentiality. They were assured that their real name would not be used for this research project.

Participants and Recruitment

Students at Athabasca University were contacted via a student announcement board on the university website. More specifically, only students enrolled in the Master of Counselling program and who were currently completing or had recently completed their practicum, were targeted for recruitment. The aim of this research project was to understand the meaning of students' practical and academic experiences. After the

announcement was posted on the announcement board, those who wish to participate in an interview, contacted me via email. I provided the participants with a Letter of Information and Consent Form (see Appendix C) outlining the intent of the project, procedures, and the importance of their contribution to the project. They consented to participate by providing consent with their printed name and their signatures. Participants were given a week to read and review the consent form before scheduling interviews on Microsoft Teams. Participants were also given an option of selecting their pseudonym name. It was made clear that their personal name would not be used in this project, instead their pseudonym names (if they selected one) was used. A maximum of one hour was allocated for each interview (see Appendix D for interview questions).

Data Analysis

Inductive-deductive Logic Process

Qualitative researchers typically use inductive logic to organize their data. This process involves researchers using an iterative process working back and forth between identifying themes and collecting data until a complete and comprehensive set of themes are identified (Creswell & Poth, 2016). Deductive logic means that a researcher is constantly checking their themes against the data. Therefore, an inductive-deductive logic process involves a researcher using complex reasoning skills throughout the process of research that involves constantly interpreting data and themes (Creswell & Poth, 2016).

Idiographic Approach

An idiographic approach in IPA requires that each participant's experience was carefully analyzed within the narrative they provided during the interview (Mannion et al., 2023). This process is done before the researcher starts noticing common themes and categories comprised of all participants' narratives. The idiographic approach comprises of detailed analysis of the phenomenon being studied (Tuffour, 2017). The primary goal of an idiographic approach in IPA is to offer detailed analysis and value in each case before moving to the next phase of developing themes (Tuffour, 2017).

I utilized an idiographic approach to analyze the transcriptions. Each participant's transcript was carefully analyzed within the narrative they provided during the interview. Sorting through relevant and irrelevant narrative was done during this stage. Relevant narrative for my research is defined as any discussion relating to the research topic such as the medical model, humanistic approach, participants' experience, knowledge, or opinions of the tension and the research topic. Irrelevant narrative was defined as any communication outside of the topic research such as initial greeting.

Thematic Analysis.

Thematic analysis is a process that involves coding data from raw data such as transcriptions, observing and searching for themes, refining the developing themes, and finally reporting the findings (Flick, 2022; Naeem et al., 2023). Naeem et al. (2023) introduced a six-step process for creating a conceptual model from qualitative research findings. I adopted their six-step process as it provided me with a roadmap to process and enhanced the qualitative findings thorough an in-depth analysis. Thematic analysis

involves focusing on the phenomenon being investigated while the researcher is brainstorming codes and themes from certain keywords. The six steps involve:

1. Transcription, familiarization with data, and selection of quotations
2. Selection of keywords
3. Coding
4. Theme development
5. Conceptualization through interpretation of keywords, codes, and themes
6. Development of conceptual model

According to Naeem et al. (2023), "this organized method enhances the consistency and replicability of the findings, and it enables clear connections between the data, interpretation, and final conclusions. This systematic structured approach ensures thoroughness and limits potential bias" (p. 2). The six steps are described in detail in Chapter 4.

Maintaining Rigour and Trustworthiness

Part of maintaining rigour in qualitative research is keeping a reflective Journal (Peddle, 2022). Reflectivity in qualitative research is known as a process in which a researcher critically reflects on themselves. This is to increase personal awareness and enlightenment of oneself in relation to the research topic and emerging findings (Peddle, 2022). A researcher should be able to clearly define their role in their research, their social position, and critically reflect on their biases, preferences, and theoretical predispositions (Flick, 2013; Peddle, 2022; Engward & Davis, 2015). Reflectivity is imperative in IPA as it is used as a criterion, a tool, and a strategy. According Peddle (2022), reflectivity as a criterion increases the confidence, congruence, and credibility of

the findings. Reflectivity as a tool promotes quality where it is impacting the researcher's judgment of the findings. Reflectivity as a strategy allows the researcher to ensure credibility of the findings. I adopted this approach to ensure credibility in this project. I kept a reflective journal from December 2022 to today. I created a checklist for myself in which I reflected on my values, beliefs, perspectives, and perceptions and took note of how I these might be influencing data collection and analysis. This process increased my self-awareness, focus, and the credibility of the findings and my communication with the participants during the interview and the interpretation phase of the study.

IPA research is tasked with interpreting participants' subjective experiences and creating meaningful themes; thus, language plays a crucial part in analyzing data. Pre-existing investigator's knowledge, presumptions, and biases can impact the credibility of the results (Irani, 2019). Therefore, it is important for the researcher to engage in reflectivity as it allows the researcher to increase self-awareness, confidence, and credibility while defining their biases, preferences, and theoretical predispositions (Peddle, 2022). In addition to reflective journals, regular supervisions were scheduled with the project supervisor, Dr. Paul Jerry, to ensure credibility and enhance trustworthiness of the project.

Ethical Considerations

This study received ethical approval from the Athabasca University Research Ethics Board (REB) (see Appendix A). REB follows the current version of the Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans (TCPS2) and Athabasca University Policy and Procedures (see Appendix B).

Strengths and Limitations of IPA

I have utilized the IPA methodology and incorporated semi-structured interviews which resulted in rich data and in-depth analysis of the phenomena being investigated. The semi-structured interviews were conducted online via Microsoft Teams. It is possible that inability to completely observe the non-verbal cues in video interviews could hinder the authentic rapport building with the participants (Irani, 2019). However, compared to other methods of online interviewing (i.e., email or online forums), video interviews closely resemble in-person qualitative interviews (Tuttas, 2015; Irani, 2019).

Chapter Summary

I utilized IPA research methodology and incorporated semi-structured interviews to answer my research question in exploring the tension between a humanistic approach to counselling and the medical model in practice from students of counselling perspectives. I attended to the ethical considerations through an informed consent process adhering to the principle of justice and ensuring confidentiality of participants. I also took steps to increase trustworthiness and credibility of the research by maintaining regular scheduled conversations about my project with my supervision and by keeping a reflective journal throughout the research project. In the next chapter, I present my findings and analysis. I discuss the coding method used to determine the emerging themes in relation to the literature review data discussed in chapter 2.

Chapter 4. Results

In this chapter, I will discuss the results using the thematic analysis. I adopted Naeem et al. (2023) six-step process to thematic analysis. The demonstration of their six-step process in my research is as follows. Appendix E contains a thematic analysis visual following all six steps.

Step 1. Transcription, Familiarization with Data, and Selection of Quotations

During this initial phase, I read through transcripts and familiarized myself with the content. The phenomenon that I was investigating was to observe the tension and its impact experienced by the students of counselling. I selected and highlighted relevant quotes while noticing the patterns that were pertinent to the tension being observed.

Step 2. Selection of Keywords

During this second phase, I identified recurring and repetitive keywords from the quotes and statements. These keywords are directly related to participants' experiences and perceptions.

Step 3. Coding

During the third phase, I started to code the keywords and statements that were selected in the first phase. Coding involves further refining the quotes, statements, and keywords into few words that capture a core message. The goal of this phase is to simplify a complex large body of data into a direction of theoretical form.

Step 4. Theme Development

During the fourth phase, I further refined codes and categories into meaningful and abstract interpretations to create themes. Step 4 allowed me to dive deeper into the

context and make connections that link to the research question. As a result, five themes emerged:

Theme One: Psychotherapy Through a Medical Model Lens Hinders the Successful Outcome of Therapy.

In this theme the participants discussed their personal views and experiences about the impact of the medical model on psychotherapy from their viewpoint. The participants asserted that the medical model labels, oppresses, and marginalizes the clients. For example, participant Anne said, “We are realizing how the medical model can marginalize and further oppress or can be pathologizing with clients."

Furthermore, participants discussed the neglect their clients felt because of being treated with the medical model. Participant Anne commented, "People would feel discouraged of being labeled, not understood, not heard". Participant Mark commented their clients reported that they did not feel heard or seen which left them felling like a number. Participant Jim mentioned that their clients expressed these feelings when discussing their past experiences with therapists who adopted the medical model. For example, "clients who had been seen by psychiatrists often expressed that they didn't feel heard, didn't feel seen, and felt like they were being judged" (participant Jim). The impact of medical model and the use of language is inherent in the system. This is evident in the following quote:

> I do think there is a lot of influence from the medical model. Where we do our masters, it is inherent in our language too. It is built into our system. We are collaborating with the medical offices, psychiatrists, other systems. I do not think

> it can be separate, it is kind of intertwined with everything else. (participant Anne)

Furthermore, participants expressed that building a strong therapeutic alliance with clients is hindered when applying medical model lenses with its “cut and dry fixes” towards clients (Participant Mark).

> If you've got a burn on your skin then you say apply the ointment, you know three times. Okay fine, I'll do that but when it's something deeply personal, then I don't know if this sort of cut and dry fixes will help people. (participant Mark)

Theme Two: A Humanistic Approach to Psychotherapy is Stronger than a Medical Model Approach.

In this theme, participants discussed their views and preferences for the humanistic approach to psychotherapy over the medical model. They mentioned that a humanistic approach to psychotherapy is stronger than the medical model approach because it treats clients as empathetic humans instead of objectifying their needs. One participant Sheena commented, "in terms of adjusting personal issues, I feel like humanistic approach is a lot stronger." Further, participant Jim said, "I feel like humanistic approach would facilitate self reflection fostering connection with another human being that may be missing in their lives."

Participants also expressed the importance of finding meaning through rapport building and conversations with clients that are supported by a humanistic approach to psychotherapy More specifically participant Anne noted, "I think maintaining a humanistic basis for clients which doesn't allow us to put [clients] into categories, allows us to find what they need through conversations and follow their lead to support them."

Theme Three: The Therapeutic Alliance is an Important Part of Therapy.

A humanistic approach fosters a strong therapeutic alliance with clients, which participants hold in high regard. For example, participant Jim reported, "to me, client need is super important. Above all else, building that relationship with them first is more of a humanistic approach for me and that takes priority." Furthermore, participants mentioned that client need is the most important part of any therapy session alluding to client-centered approach. Participant Jim described it this way,

> As much as the medical model has really defined counselling and psychotherapy, but the humanistic model has influenced to such a great degree. How we show up to our sessions, how we build relationships, and the importance of cultivating empathy and compassion for our clients.

Theme Four: Pharmaceutical drugs and Third-party Involvement (such as by Insurance Companies) Have Taken Control of Psychotherapy.

Participants expressed that they often felt the pressure to label clients so that they could access the resources they need. Participant Mark provided this example:

> The tension has always been there for me; I remember reading about medicalizing trends in counselling where it's becoming shorter amount of session to be more insurance based. If someone has anxiety, but they need to be labeled so they can get insurance and it will help them pay for everything. I think that leads into diagnostic model. Kids that I am working with sometimes need a label for something so they can access the resources that becomes available to them with that label.

One participant mentioned that they are aware of medicalization trends in counselling and felt the pressure to label their clients or converse with them in a diagnostic language. They also mentioned that they are aware of the evolution of the medical model and of its influence on pharmaceutical companies advocating for psychotropic medications.

> The medical model has politics behind counselling too. Historically, the big organizations pushed for their pills, and you question how ethical is the pill that is being prescribed that doesn't really need to be? There is a lot of evidence-based studies backing it, but solutions don't always work like that. So, I think there's a bit of distraction from going underneath the surface and trying to resolve things. This is why there is a strong push for humanistic side of therapy and figuring things out for yourself. (Participant Mark)

Theme five: Modality Flexibility Increases Confidence.

All participants possessed the freedom to adopt and practice any modality they saw fit for the client. They all had the freedom to evaluate and decide that for themselves. Participant Sheena commented, “we can use any modality. I really like the idea that we can just explore what works best for us and then work on that approach." However, they expressed that gaining confidence and to increasing their ability to evaluate came with time. The freedom to be able to apply any modality aligned with the values they hold about a workplace.

> At my practicum, the focus is pretty heavily on a humanistic lens when it comes to interacting with clients and helping. In this way, providing counselling offers

> an open space where I get to explore the different types of approaches that I find most valuable. It aligns with my values. (Participant Jim)

Step 5. Conceptualization Through Interpretation of Keywords, Codes, and Themes

In this phase, keywords, codes, and themes are observed together simultaneously to understand and define concepts that align with the research. According to Naeem et al. (2023) clarity, accuracy, reliability, applicability, and the researcher's contribution to theory and practice is coming to life either in a diagram format or in writing. I developed a table showing the results of the six-step process of thematic analysis (see Appendix E).

Preference for a Humanistic Approach over the Medical Model Approach to Psychotherapy.

From the data collected, I observed that all participants expressed their preference for a humanistic approach over the medical model approach to psychotherapy. They collectively reasoned that the medical model objectifies clients whereas humanistic psychotherapy sees a client as an entire entity including their social location, culture, and unique experiences. The participants stressed the importance on building a strong therapeutic alliance as a foundation fora successful therapeutic outcome. They cautioned that the medical model approach hinders the process of building a strong therapeutic alliance, whereas a humanistic approach fosters it. The impact of insurance companies on clients was mentioned as a double-edged sword. On one hand, clients can access the resources through insurance companies which would be financially beneficial. On the other hand, clients and psychotherapists are required to use diagnostic labels and categories because insurance companies will only financially cover certain presenting concerns if the client has a label. Although, diagnostic labels and categories can provide

clarity to some clients and psychotherapists, labels can also raise concerns for creating stigma. All participants mentioned the tension their clients felt who received therapeutic services from practitioners using a medical model lens in the past. They mentioned that their clients did not feel seen or heard and felt like a number in these instances. Some participants discussed their concerns over the "medical model [having] politics behind counselling" (Participant Mark).

Step 6. Development of Conceptual Model

The final phase involves the researcher developing a conceptual model – a unique representation of the data collected and guided by the existing theories mentioned in the literature review. This phase intends to answer the research question and creates new knowledge. This will be discussed in the next chapter.

Chapter 5. Discussion

Medical Model Influence Ingrained into The System

Overall, the tension was observed within all participants, and it aligns with the research mentioned earlier in the literature review. Elkins (2009) asserted that humanistic therapists have always pushed back against the unnecessary use of labeling and diagnosing of clients that comes with the medical model approach. The use of DSM for diagnoses and categorization of clients can cause tension amongst therapists for the fear of pathologizing normal human behaviour (Strong, 2014). In addition to pathologizing, it de-emphasizes the client's suffering while eliminating their individuality (Venkatesan & Suresh, 2023). The DSM was built with the strong influence of the medical model (Elkins, 2009). The DSM identifies mental illness more on a biological bases than on a psychological bases of behaviours. Consequently, it creates a language that is commonly used by physicians and psychiatrists dominating the areas of both physical and mental health concerns (Venkatesan & Suresh, 2023).

Within my study, I noticed a complex and contradictory relationship between participants' preference for practicing using a humanistic approach and the pressure they felt to adopt medical model views in psychotherapy. Participants expressed their concern over the use of language that is ingrained into the system in both education and in practice. They also mentioned that although they had the freedom to practice any modality they preferred, and opportunity to master these skills under supervision, they felt the pressure to label and categorize clients so their sessions could be covered under insurance plans. They expressed this as a double-edged-sword where they feel that

labeling their clients would create stigma and limit their holistic wellbeing, but that labeling may also help them financially.

This tension, in essence, demonstrates the powerful impact of medical model in psychotherapy deeply ingrained into the system. It takes away the power from service providers and dictates the process. Echoing Norcross et al.'s (1992) prediction on the future of psychotherapy, the authors predicted that service providers may start to lose control over the services to other business interests to stabilize the balance of supply and demand and economic pressures. In essence, economic factors would be the driving force behind the availability, modality, intervention, and orientation of psychotherapeutic services.

Importance of Training and Education Addressing the World Demands

One participant mentioned that when in practicum "you realize what you are and what your role is" (Participant Anne). All participants stated that they are currently feeling more confident compared to when they started their practicum journey. This coincides with Mason's (1993) description of the process of one moving from a position of unsafe certainty to safe certainty. It is a developmental process of feeling unsure and unconfident to embracing and recognizing one's limitations (Mason, 1993; Gordon et al., 2021). It also alludes to the level of preparedness students feel when entering their practicum journey of their program. Gordon et al. (2021) discovered that the main reason for the challenges experienced by new psychotherapists in their work was the uncertainty and absence of direction on how to draw knowledge with different theoretical paradigms. The absence of direction was observed when one Participant Mark mentioned "figuring things out for yourself". Participants also felt unprepared on how to draw knowledge

with different theoretical paradigms. This was observed when participant Anne commented, “I think it's been a roller coaster from the very beginning where I thought I knew how to fix things. For a long time, I was like okay what am I doing? I don't know what or who I am in this role.” Gordon et al. (2021) recommended that educators should consider training new therapists on the ability to tolerate ambiguity while acquiring knowledge of direction. Furthermore, Barber (1994) establishes that the success of psychotherapy depends on the ability of a psychotherapist to evaluate and select a therapeutic plan that is beneficial for the client. As demonstrated by Henry et al. (1993a & 1993b), students who improved their skills the most attributed this to the increased supervision they received during their educational program, establishing the importance of supervision in student success.

Nieuwsma et al. (2012) demonstrated that short-term psychotherapy to be most effective when delivered by therapists trained in the model, they are providing services in. If the future of psychotherapy is short-term therapy, then it is imperative for students of counselling to be well educated and trained in the short-term therapy model. Numerous studies show the importance of training in a specific discipline correlating to successful outcome in that discipline. Unfortunately, the education and training of short-term therapy is minimal to non-existent in counselling curricula. This contributes to the tension in this research study, as students are inadequately prepared.

Confusion of Roles and Identities as Students of Counselling

Although not discussed fully with participants, a contradiction between a client-centered approach and their views on medical model as hindering successful outcome in psychotherapy emerged. All participants highlighted the importance of a client-centered

approach. According to McCance et al. (2011) the client-centered approach is focused on client needs above all. It values that client's right to self-determination with mutual respect and understanding. It fosters autonomy and informed decision by viewing the client as an expert on their own life. In response to my research question - what impact does the tension which arises between the views of medical model and the humanistic model have on the students of counselling, the tension was apparent with all participants; however, the impact of the tension has left the students of counselling in a state of confusion. For instance, if the client expresses the need of acquiring therapy through a medical model lens, then the therapist would adhere to this need request, echoing a client-centered approach. However, all participants expressed their views that the medical model hinders the successful outcome of therapy. Perhaps, this is alluding to the lack of preparedness or absence of knowledge in addressing the tension that is felt by the students of counselling?

Theoretically, this study adds two dimensions to knowledge related to the tension investigated. The first dimension is the lack of awareness counselling students have regarding the depth of this tension. The second dimension is the lack of preparedness counselling students have (based on what they learn in their programs) to have the ability to manage this tension. Both dimensions start in the counselling curriculum and practicum – the counselling education system. Ability to evaluate, ability to tolerate uncertainty, education and training related to short-term therapy, a comprehensive understanding of the tension, and how to address this tension should be considered by future educators and supervisors of counselling program.

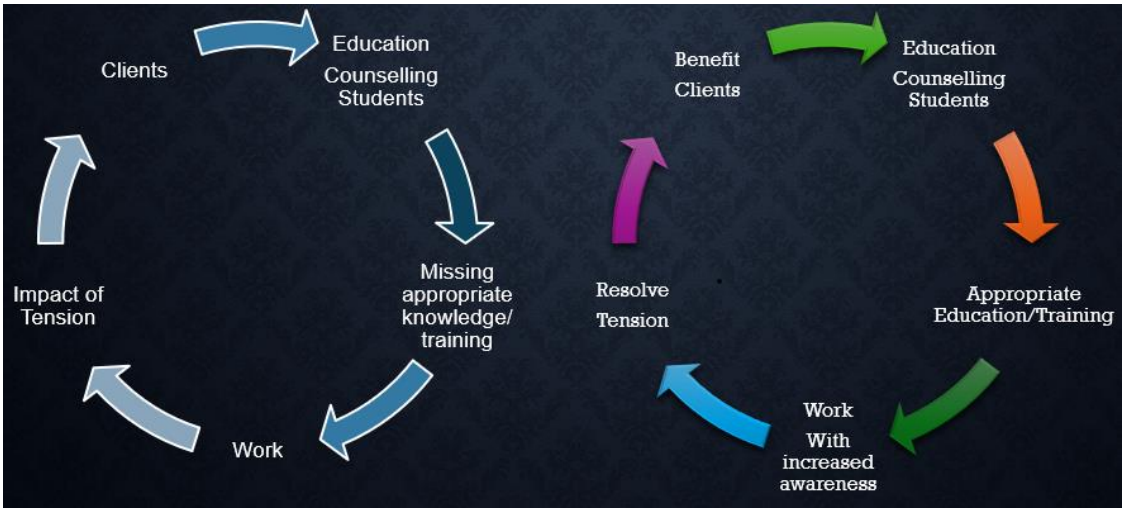
For the mental health system to be sustainable and efficient, the education system needs to evolve with the growing demands of public mental health services. As delineated in this research, the tension between medical model and a humanistic approach to psychotherapy exists and has a tremendous impact on mental health. However, this tension can be managed by re-evaluating the counselling education curriculum and how it is taught to students who are the future of psychotherapy. Master of counselling students are the most sought-after professionals for psychotherapy services (Norcross et al., 2022). Therefore, providing these students with appropriate education, skills, and training is imperative for sustainable future of psychotherapy.

Implications

The research and the findings of this study has implications for the educators and the students of counselling. The educators should invest in providing counselling students with appropriate education so that students are well prepared and equipped with the right set of skills to resolve the tension as it is experienced as therapists.

Figure 1

Impact of the Tension



Note. Diagram showing an impact of the tension arising from the humanistic and the medical model approach to psychotherapy on counselling students/new therapists and their clients. Own work.

Current counselling curriculum is outdated which does not provide students with relevant education or training. Consequently, students or newly graduated psychotherapists do not possess increased awareness or have skills to be able to resolve tension they experience. Tension may result in confusion, low self-esteem, or self-doubt. This will impact the psychotherapist and their clients. If students are well educated and prepared with the relevant skills of the current demands of counselling, they will have increased awareness of the tension and be equipped to resolve the tension at work. As a result, this will benefit the psychotherapist and their clients.

Suggestions For Future Studies

The goal of IPA is not to generalize findings, but they may be transferable to counsellors with multiple views. The underlying point here is that education programs are fundamentally shaped by externally imposed requirements (Kaori et al., 2020). Health services are provincially regulated in Canada, which means that every provincial jurisdiction differs in relation to requirements for counselling such as education and training. The confusion and the differences are inherent in the system. For example, the title of "counsellor" varies across Canada and can include conseiller/conseillère d'orientation and guidance counsellor in Quebec; counselling therapist in Alberta, New Brunswick, and Nova Scotia; and registered psychotherapist in Ontario (Kaori et al., 2020 p. 575). Inevitably, the counselling-related training offered to students can vary.

This concern was expressed by counselling students in the report titled, *Future of Counselling Psychology Education and Training in Canada* in 2018 (Kaori et al., 2020).

My study is complementary to the literature in addressing the gaps and ways to make the field of counselling more efficient, sustainable, and adhering to the growing demands of psychotherapy. The current counselling curriculum does not include a course addressing and discussing the impact of the tension studied on students and ways to manage this tension. My research generated five themes emerging from results mentioned in chapter four. The five themes are psychotherapy through medical model lens hinders the successful outcome of therapy (theme one); a humanistic approach to psychotherapy is stronger than a medical model approach (theme two); therapeutic alliance is an essential part of therapy (theme three); pharmaceutical drugs and third-party involvement such as insurance companies have taken much control of psychotherapy (theme four); and modality flexibility increases confidence (theme five). Future studies could explore the link between these themes and successful outcomes in psychotherapy.

Final Thoughts

This thesis has illuminated the literature gap addressing the impact of the tension between the humanistic approach and the medical model on counselling students and how it becomes apparent in various areas of their professional lives. It impacts their confidence, the ability to appropriately evaluate, and the ability to progress in their career. The participants also demonstrated confusion when explaining their preferred approach to psychotherapy. This confusion alluded to a phenomenon that perhaps students lack the awareness and how to properly manage the tension. This leads me to

highlight the importance of properly educating and training students who are the future of counselling. The tension not only impacts the students but also their clients. In chapter 2, I discussed how the tension arises and the key role players influencing this tension in the mental health sector, such as financial pressures from insurance companies, psychiatrists, and pharmaceutical companies. I also discussed the predictions and possible future of psychotherapy. Based on current trends such as short-term therapy models; and future concerns such as increased demands of therapy services, it is imperative to think about ways in which the future of psychotherapy can be more efficient and sustainable. The efficiency and sustainability of psychotherapy starts with the education system and a goal to evolve with the changes in the practice of psychotherapy. I argue that the Master of Counselling curriculum should include a mandatory course addressing the tension between the medical model and the humanistic approach to psychotherapy. It should appropriately discuss the impact of, and ways to manage, the tension. Additionally, the curriculum should include education on DSM-5-TR and a comprehensive discussion and training related to short-term therapy models, the ability to appropriately evaluate suitability for clients, and the number of sessions a client requires based on their presenting concern. Finally, the curriculum should include a comprehensive discussion and appropriate training for determining when and what type of technology is suitable depending on a client's presenting concern. As mentioned in chapter 2, the literature addressing how to utilize technology in counselling sessions is prolific as it emerged from the experience of the COVID-19 pandemic. However, the literature on determining when, why, and what type of technology is suitable for various types o client concern is limited.

My research illuminates the importance of teaching and training students of counselling as it impacts them and their clients' safety. Every client and their needs are unique. If they are treated through a medical model lens based on the theory that one glove fits all, then many clients will not benefit from psychotherapy intended to help them and their struggles will continue. This was the case for my mother and many people who do not receive appropriate treatment for their presenting concern. Exploring ways to appropriately equip students with skills vital to survival and success of psychotherapy may improve the mental health system by being more efficient, effective, and sustainable.

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Appendix A: Certification of Ethical Approval

Athabasca University
RESEARCH CENTRE

CERTIFICATION OF ETHICAL APPROVAL

The Athabasca University Research Ethics Board (REB) has reviewed and approved the research project noted below. The REB is constituted and operates in accordance with the current version of the Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans (TCPS2) and Athabasca University Policy and Procedures.

Ethics File No.: 25261

Principal Investigator:
Ms. Jasmine Sheikh, Graduate Student
Faculty of Health Disciplines\Master of Counselling

Supervisor/Project Team:
Dr. Paul Jerry (Supervisor)

Project Title:
Counselling Views and The Medical Model: An Exploration of the Tension

Effective Date: May 19, 2023 **Expiry Date:** May 18, 2024

Restrictions:

Any modification/amendment to the approved research must be submitted to the AUREB for approval prior to proceeding.

Any adverse event or incidental findings must be reported to the AUREB as soon as possible, for review.

Ethical approval is valid *for a period of one year*. An annual request for renewal must be submitted and approved by the above expiry date if a project is ongoing beyond one year.

An Ethics Final Report must be submitted when the research is complete *(i.e. all participant contact and data collection is concluded, no follow-up with participants is anticipated and findings have been made available/provided to participants (if applicable))* or the research is terminated.

Approved by: **Date: May 19, 2023**

Barbara Wilson-Keates, Chair
Faculty of Health Disciplines, Departmental Ethics Review Committee

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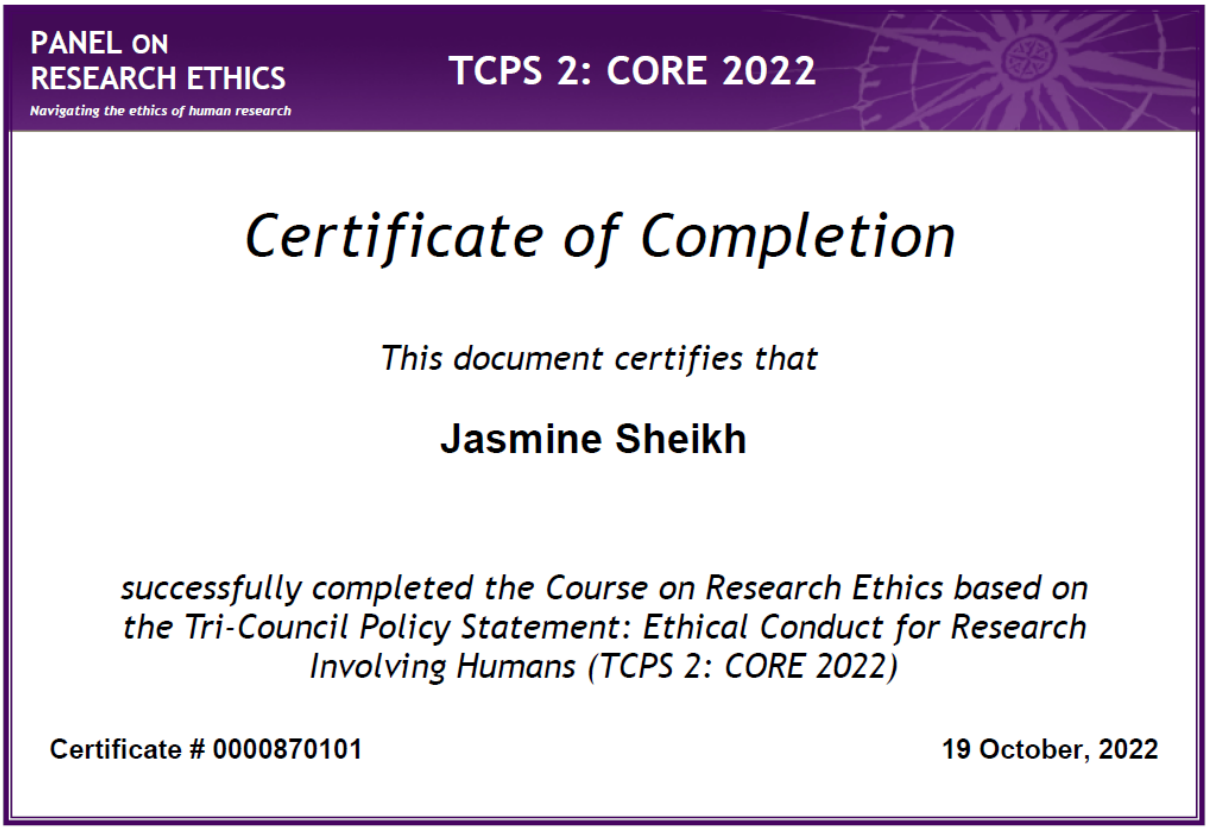
Athabasca University Research Ethics Board
University Research Services Office
1 University Drive, Athabasca AB Canada T9S 3A3
E-mail rebsec@athabascau.ca
Telephone: 780.213.2033

Appendix B: Ethical Conduct for Research Involving Humans Certificate



PANEL ON RESEARCH ETHICS
Navigating the ethics of human research

TCPS 2: CORE 2022

Certificate of Completion

This document certifies that

Jasmine Sheikh

successfully completed the Course on Research Ethics based on the Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans (TCPS 2: CORE 2022)

Certificate # 0000870101 **19 October, 2022**

Appendix C: Letter of Information and Consent Form

LETTER OF INFORMATION / INFORMED CONSENT FORM

Counselling Views and The Medical Model: An Exploration of the Tension

April 25, 2023

Principal Investigator (Researcher):
Jasmine Sheikh jahmad1@learn.athabascau.ca

Supervisor:
Dr. Paul Jerry Paulj@athabascau.ca

You are invited to take part in a research project entitled 'Counselling Views and The Medical Model: An Exploration of the Tension'.

This form is part of the process of informed consent. The information presented should give you the basic idea of what this research is about and what your participation will involve, should you choose to participate. It also describes your right to withdraw from the project. In order to decide whether you wish to participate in this research project, you should understand enough about its risks, benefits and what it requires of you to be able to make an informed decision. This is the informed consent process. Take time to read this carefully as it is important that you understand the information given to you. Please contact the principal investigator, Jasmine Sheikh if you have any questions about the project or would like more information before you consent to participate.

It is entirely up to you whether or not you take part in this research. If you choose not to take part, or if you decide to withdraw from the research once it has started, there will be no negative consequences for you now, or in the future.

Introduction
My name is Jasmine Sheikh, and I am a Master of Counselling Student at Athabasca University. As a requirement to complete my degree, I am conducting a research project to explore the tension between the two polar approaches to counselling: the medical model and the humanistic approach. I am conducting this project under the supervision *of* Dr. Paul Jerry.

Why are you being asked to take part in this research project?
You are being invited to participate in this project because you have felt the tension on which approach to adopt with counselling when entering the workforce. You are requested to discuss the tension arising from when your ideal approach did not align with your organization's approach.

What is the purpose of this research project?

CURRENT COUNSELLING VIEWS AND THE MEDICAL MODEL: AN EXPLORATION OF THE TENSION

When the values of our workforce do not align with our personal values, it creates distress and tension. The purpose of this research is to understand this tension and what this means to the students of counselling. I am hoping to increase awareness around this tension which would ideally initiate a change within the system.

What will you be asked to do? You will be asked to participate in a 1 hour in virtual interview, scheduled at your convenience. It will be held via Microsoft Teams. You will be invited to answer questions regarding the tension you felt when you started counselling clients. I will be transcribing the interview using Microsoft Teams with the transcription feature on; however, there will be no need to record a video session.

No follow up interviews will be required but can be requested.

What are the risks and benefits?
Risks: There may be psychological risks involved in participating in this study. It could be difficult to discuss some aspects of your life and lived experiences. You may be triggered physically and emotionally by what you are discussing.

If you are feeling uncomfortable or triggered, the interview will be paused (or discontinued if you choose to do so). We will take the time to do some deep breathing and you will have a chance to contact the support person you have indicated at the beginning of the interview. The author will also provide an opportunity for defragging and provide available organizational supports to the participant. You may also choose to reschedule the interview for another time or withdraw from the study.
If you speak about criminal activity or I have reason to believe a vulnerable person is at risk I have a duty to report and I may have to break confidentiality.

Benefits: The anticipated benefit of participation is the opportunity to discuss feelings, perceptions, and concerns related to the experience of the tension felt by the majority of the counselling students. Your participation may increase your own awareness of this phenomenon.

Do you have to take part in this project?
As stated earlier in this letter, involvement in this project is entirely voluntary. You may stop at any time during the interview without any negative consequences. **Up until the point of data analysis**, you may choose whether or not your data will be included in the study. After this point, data may not be withdrawn because data will be anonymized and cannot be withdrawn.

You will have to inform the principal investigator if you wish to withdraw.

How will your privacy and confidentiality be protected?
The ethical duty of confidentiality includes safeguarding participants' identities, personal information, and data from unauthorized access, use or disclosure.

Confidentiality and privacy will be protected by anonymity. Your name and anyone you name in the interview will be changed to protect privacy.

All information will be held confidential, except when legislation or a professional code of conduct requires that it be reported. For example, if you report to me that a child or vulnerable person is being abused, you report to me that you have a communicable disease or other threat to public safety, then I may need to report that to the appropriate authorities. Also, if you tell me that you are an immediate and grave risk to harming yourself or another person or an immediate and grave risk to public safety, then I will need to contact the appropriate authorities.

Note that the recorded data and transcripts may be court ordered by a judge.
The ethical duty of confidentiality includes safeguarding participants' identities, personal information, and data from unauthorized access, use or disclosure.

Your information will not be shared with anyone outside of the research team. Your identity will be protected by a chosen pseudonym. All identifiable information will be stored on a computer accessed by the primary researcher/supervisor with a password protected encryption.

How will my anonymity be protected?
Anonymity refers to protecting participants' identifying characteristics, such as name or description of physical appearance.

Each participant will have the opportunity to choose a pseudonym instead of their name. Your name and the name of anyone you mention will be changed. Only the researcher and supervisor will have the information regarding personal identifiers.

Every reasonable effort will be made to ensure your anonymity; you will not be identified in publications.

How will the data collected be stored?
Data will be recorded on a password-protected Microsoft Teams school account, which backs up data to AU's cloud. The transcription produced from the feature in Microsoft Teams will be transferred to password protected Microsoft Word File. The data will be stored on password-protected principal investigator's computer.

Data will be deleted after five years of storage, as per Athabasca University guidelines. There will be no hard copies.

Only myself, Jasmine Sheikh, and my supervisor, Dr. Paul Jerry, will have access to the data collected.

Who will receive the results of the research project?
The existence of the research will be listed in an abstract posted online at the Athabasca University Library's Digital Thesis and Project Room and the final research paper will be publicly available.

- Given the descriptive nature of the study, direct quotations will be reported.
- The findings of this research project may be submitted for publication to a research journal (to be determined).
- The author may present the findings in a conference and poster presentations.
- Final research paper will be made available to participants who are interested in receiving the final paper.
- Participants will also be able to retrieve the paper from the Athabasca digital thesis room: https://dt.athabascau.ca/jspui/

Who can you contact for more information or to indicate your interest in participating in the research project?
Thank you for considering this invitation. If you have any questions or would like more information, please contact me, (the principal investigator) by e-mail jahmad1@learn.athabascau.ca or phone: 780-695-6468 or my supervisor by email paulj@athabascau.ca. If you are ready to participate in this project, please complete and sign the attached Consent Form and return it by _____to Jasmine Sheikh by sending a signed electronic copy via email to jahmad1@learn.athabascau.ca

Thank you.

Jasmine Sheikh
Student at Athabasca University

Informed Consent:
Your signature on this form means that:

- You have read the information about the research project.
- You have been able to ask questions about this project.
- You are satisfied with the answers to any questions you may have had.
- You understand what the research project is about and what you will be asked to do.

- You understand that you are free to withdraw your participation in the research project without having to give a reason, and that doing so will not affect you now, or in the future.
- You understand that if you choose to end your participation **during** data collection, any data collected from you up to that point will be retained by the researcher.
- You understand that your data is being collected anonymously, and therefore cannot be removed once the data collection has ended.

	YES	**NO**
I agree to have my interview to transcribe	◯	◯
I agree to the use of direct quotations	◯	◯
I allow data collected from me to be archived in the Athabasca University Library's Digital Thesis and Project Room	◯	◯
I am willing to be contacted following the interview to verify that my comments are accurately reflected in the transcript.	◯	◯

Your signature confirms:

- You have read what this research project is about and understood the risks and benefits. You have had time to think about participating in the project and had the opportunity to ask questions and have those questions answered to your satisfaction.
- You understand that participating in the project is entirely voluntary and that you may end your participation at any time without any penalty or negative consequences.
- You have been given a copy of this Informed Consent form for your records; and
- You agree to participate in this research project.

_____ _____

Signature of Participant Date

Principal Investigator's Signature:

I have explained this project to the best of my ability. I invited questions and responded to any that were asked. I believe that the participant fully understands what is involved in participating in the research project, any potential risks and that he or she has freely chosen to participate.

_____ _____

Signature of Principal Investigator Date

Appendix D: Semi-Structured Interview Questions

Demographic data:

1. **Name:**
2. **School status:**
3. **Program of Education:**
4. **Employment status:**
5. **Type of organization where you have counselled clients:**

Questions:

1) When I mention the medical model and humanistic approach to counselling, what comes to your mind that you would like to share?
2) What is your ideal approach to counselling clients?
3) Have you ever felt that your values did not align with your work values?
    a. Sub question: Please describe the distress or tension you felt when your values did not align with your work values?
    b. What sort of values did not align with your values?
    c. At what point did you realize that you were feeling the tension?
    d. Please describe the outcome.
4) If you were to assume based on your observation, what can you tell me about how clients would feel receiving services from a medical model lens?
5) If you were to assume based on your observation, what can you tell me about how clients would feel receiving services from a humanistic approach?

My notes: potential guiding questions

1. To the best of your knowledge, what do you know about the medical model influence in the field of counselling?
2. To the best of your knowledge, what do you know about the humanistic approach in the field of counselling?
3. How was your overall experience of being a counsellor?
4. At what point, if any, did you feel like you had to compromise your personal values with work?
5. Tell me about your overall level of happiness with your work?
6. If you wish you could change anything about your work so that yours and your work values would align, what would you change?

Research Question:

What impact does the tension which arises from the views of medical model and humanistic approach in counselling have on counsellors?

Appendix E: Thematic Analysis

Statements and Quotes	Keywords	Codes	Themes	Concept
"People would feel discouraged of being labeled, not understood, not heard"	Labeled, not understood, not heard	Impact of medical model on clients	Psychotherapy Through Medical Model Lens Hinders the Successful Outcome of Therapy	Preference for Humanistic Approach over Medical Model Approach to Psychotherapy
"We are realizing how the medical model can marginalize and further oppress or can be pathologizing with clients"	Medical model, marginalize, oppress, pathologizing			
"Clients who had been seen by psychiatrists often expressed that they didn't feel heard, didn't feel seen, and felt like they were being judged"	Didn't feel heard, didn't feel seen, judged			
"If you've got a burn on your skin then you say apply the ointment, you know three times. Okay fine, I'll do that but when it's something deeply personal, then I don't know if this sort of cut and dry fixes will help people"	Cut and dry, fixes			
"Many clients or their families think they can be fixed or cured which I think comes from the medical model"	Fixed, cured, medical model			
"We set our clients for finding their most authentic selves, but we have a DSM beside us telling them oh sorry you only scored 6 out of 9 categories. I feel like there is a power imbalance with that"	DSM, power imbalance	Impact of medical model on the system		
"I do think there is a lot of influence from the medical model. Where we do our masters, it is inherent in our language too.	Influence, medical model,			

It is built into our system. We are collaborating with the medical offices, psychiatrists, other systems. I do not think it can be separate, it is kind of intertwined with everything else"	language, system			
"If I had to classify people into categories using the DSM, it would bring quite a bit of tension. I feel like I would push against the supervisors or managers who were pushing this lens of understanding clients from a particular disease model"	Categories, DSM, tension, lens, disease model			
"I've always been worried about the nature of medical model and the cut and dry nature of it. It's a temptation I think we as humans want to put things in a box and say okay this is what it is. To fit somebody into that and that's where I worry it can take the humanity out of it, which I'm very interested in preserving"	Worried, medical model, cut and dry, box, take the humanity out			
"Sometimes clients would tell me that I felt like I was just a number. They just wanted the money out of me. I think the problem can come when you lose that human aspect. I think the pitfall is relying too heavily on a cure or a fix, when you're neglecting the person in front of you, that's when people feel dismissed"	Number, lose that human aspect, cure, fix, dismissed	Impact of medical model on building a therapeutic alliance		
"This kind of tension and dichotomy between arts and science where they can weave together, overlap, or where they can kind of buttheads as well as make it challenging for practitioners, researchers, clients, and counsellors"	Tension, weave together or overlap, challenging			
"If I was to solely apply the medical model, I would kind of be limiting myself when it comes	Medical model,			

to building that alliance with clients"	limiting, alliance		
"In terms of adjusting personal issues, I feel like humanistic approach is a lot stronger"	Humanistic approach, stronger	Difference between humanistic approach and medical model	Humanistic Approach to Psychotherapy is Stronger than Medical Model Approach
"The medical model treats illness more like physical illness, humanistic is more of like from within [human]"	Medical model, illness, humanistic is more like within		
"I feel like humanistic approach would facilitate self reflection fostering connection with another human being that may be missing in their lives"	Humanistic approach, self reflection, fostering connection	Impact of humanistic approach on building therapeutic alliance	
"I think maintaining a humanistic basis for clients which doesn't allow us to put [clients] into categories, allows us to find what they need through conversations and follow their lead to support them"	Maintaining humanistic, categories, find what they need through conversations	Importance of conversation	
"As much as the medical model has really defined counselling and psychotherapy, but the humanistic model has influenced to such a great degree. How we show up to our sessions, how we build relationships, and the importance of cultivating empathy and compassion for our clients"	Humanistic, relationships, empathy, compassion	Humanistic influence on therapeutic alliance	Therapeutic Alliance is Utmost Important Part of Therapy
"To me, client need is super important. Above all else, building that relationship with them first is more of a humanistic approach for me and that takes priority"	Client need, relationship	Client-centred approach	

"Therapists that diverge from mainstream therapies, are not funded by insurance companies because they're not attached to evidence-based studies or proof that our culture needs to feel good about something so that medical model of study and test and repeat things that are seemingly successful and not repeat things that are unsuccessful. It fully been part of what defines our sort of counselling profession"	Funded, insurance	Impact of insurance companies on clients and counsellors	Pharmaceutical drugs and Third-party Involvement such as Insurance Companies Have Taken Control of Psychotherapy	
"The tension has always been there for me; I remember reading about medicalizing trends in counselling where it's becoming shorter amount of session to be more insurance based. If someone has anxiety, but they need to be labeled so they can get insurance and it will help them pay for everything. I think that leads into diagnostic model. Kids that I am working with sometimes need a label for something so they can access the resources that becomes available to them with that label"	Tension, medicalizing, insurance, label			
"The medical model has politics behind counselling too. Historically, the big organizations pushed for their pills, and you question how ethical is the pill that is being prescribed that doesn't really need to be? There is a lot of evidence-based studies backing it, but solutions don't always work like that. So, I think there's a bit of distraction from going underneath the surface and trying to resolve things. This is why there is a strong push for humanistic side of therapy and figuring things out for yourself"	Medical model has politics, big organizations, pills, strong push for humanistic, figuring things out for yourself	Influence of pharmaceutical companies		

"I think it's only when you get your feet into the practicum experience, you really realize who you are and what you are in that role. I had such a different perspective of counselling before I started, I was like I'm going to do CBT or I'm going to be this, but it was not like that at all, and I changed my tone"	Practicum experience, realize, role	Role of the therapist	Modality Flexibility Increases Confidence	
"We can use any modality. I really like the idea that we can just explore what works best for us and then work on that approach"	Any modality, explore			
"At my practicum, the focus is pretty heavily on a humanistic lens when it comes to interacting with clients and helping. In this way, providing counselling offers an open space where I get to explore the different types of approaches that I find most valuable. It aligns with my values"	Practicum, humanistic lens, open space, explore	Freedom to explore and practice any modality		

Impact of the tension between Humanistic Approach and Medical Model approach to Psychotherapy on the students of counselling