

“The pain behind what you see,” The
lived experience of chronic pain and
counselling engagement.

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Abstract

Background

Chronic pain is a complex condition that affects approximately 28 million people in the United Kingdom alone. These conditions have a profound effect on both the physical and mental health of the individual.

Aims

This study aimed to explore the lived experience of counselling and their engagement and dis-engagement with the counselling process. The study also aimed to understand, how might counselling services become more accessible to disabled clients with less judgement and worry of being excluded from sessions due to ongoing lack of engagement due to illness.

Method

This research was qualitative design with an underpinning constructivist epistemology with a phenomenological approach. Semi-structured interviews were conducted with six adult Caucasian women all aged between 45 years and 60 years old. All data was analysed using Braun and Clarke's Thematic Analysis approach.

Four themes were generated from the data: Internalised Negative Evaluation, Lack of Clinical Support, The Therapeutic Relationship, and Engagement. Participants described experiences of not being heard, not being believed, moreover by medical professionals rather than therapists.

Findings

The findings suggest that counselling does not directly impact pain but helps clients understand emotional challenges associated with chronic pain. The findings also suggested that chronic pain is not a precursor to non-engagement but the therapeutic relationship and financial aspects of private counselling and organisational waiting times is. Participants expressed the importance of the therapeutic relationship and the experience of positive outcomes from sessions.

Conclusion

Keywords: Chronic pain, Counselling, Therapeutic Relationship, Lived Experience, Qualitative Research.

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STATEMENT 1

This dissertation is being submitted in partial fulfilment of the requirements for the degree of MA Psychotherapeutic Practice: Humanistic

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STATEMENT 2

This dissertation is the result of my own independent work / investigation, except where otherwise stated.

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Chapter 1

Introduction

The author of this research set out to address how chronic pain and chronic illness might affect engagement with psychological interventions, such as therapeutic counselling. Using the research question of “ How might counselling services be made more accessible to disabled clients with less judgement and the worry of being excluded from sessions due to ongoing lack of engagement due to illness?

The researcher poses this question due to their own lived experience of chronic pain, and an interest to understand what clients need to be supported within their psychological therapy, and what that looks like from them rather than the sole aspect of the therapists.

Accessibility to psychotherapy services extends beyond the physical aspects of engagement but rather encompasses organisational services, flexibility, and practitioner attitudes and biases.

Due to the unpredictable nature of chronic pain and disability, individuals find that this can cause interruptions in engagement, on occasions this can be interpreted as a lack of motivation, or commitment to counselling. This in turn can contribute to feelings of judgement, shame and misunderstanding, further leading to the prevention of ongoing psychotherapeutic support.

Psychotherapy has the potential to help individuals understand their thoughts and feelings toward their lived experience of chronic pain. To date there has been little qualitative research into how individuals experiences in counselling has assisted individuals to maintain engagement with psychotherapy.

Using Braun & Clarke, (2022), thematic analysis, the study consists of five interviews, two clients and three qualified therapists to obtain an overall picture. It became apparent from the interviews and the literature that disengagement is not always due to the

chronic pain or chronic illness but from unrelated issues. This research highlights the magnitude of chronic pain and chronic illness.

Aims.

To assess the impact of a client's mental and physical well-being when counselling services are more easily accessible.

To understand if and how the therapeutic relationship is affected, during both counselling takes place on a face-to-face basis or a virtual basis.

To explore the effectiveness of counselling to the client when they feel heard and understood on a physical level.

To explore ways on how to reduce the client feeling judged or excluded from sessions due to ongoing illness leading to a lack of engagement with counselling services.

Objectives

To provide a clear direction for the research, define its scope, and guide the methodology. Key characteristics of research objectives include age-appropriate interventions and understanding of developmental, educational, and social implications. All to be carried out with clarity, specificity, measurability, relevance and a realistic period within the guidance and scope of the time allowed for this research.

To achieve this, aim the researcher will carefully examine the existing literature alongside the participant's interview transcripts to obtain an understanding of what disabled clients wish to gain from counselling services.

The researcher intends to identify themes from the data collected that can add to existing literature for future areas of consideration to be explored.

In the chapters that follow the reader will gain an understanding of the lived experience of chronic pain and what the individual deals with daily, and how this affects their mental health, relationships, and work life balance, and the therapeutic experiences.

The following chapters will consist of a literature review; this will offer an overview of the existing literature around chronic illness and how this growing issue affects a great portion of individuals specifically within the United Kingdom.

There will be a methodology and method chapter, this chapter will explain why this researcher opted to utilise a Thematic Analysis approach to the research, and how the research was carried out, including the steps that were taken to obtain participants, and how their knowledge and understanding of chronic illness aligns with the existing literature.

The next chapter will be the findings of the research, this will contain the codes and themes generated from the participant's interviews, these were presented within a table for ease of reading, alongside extracts from the interviews that were carried out.

There will then be a discussion chapter which will endeavour to bring the research together as a whole, discussing what has generated within both the research and the existing literature.

The final chapter will be the conclusion which will include how the findings of this research and the existing literature suggested a different outcome to what the researcher was expecting, and what the implications for future research might be and how further research into this study is imperative to future understanding, for both client and therapist.

This research topic is important in the development of psychological therapies and in the understanding of chronic pain and chronic Illness to enhance the therapeutic

relationship and enhance continued engagement for the client. This research sits alongside existing literature and brings together an in-depth view of the issues that the client might be facing, highlighting these issues to the therapist.

This dissertation is worthy of reading as it highlights specific information that should be considered when looking at clients engagement, therefore it is able to offer a flexible way of delivering sessions in the future, benefitting the client and the therapist.

Chapter 2

Literature review

This chapter will be exploring the existing literature from the academic world, which is related to the research that this author is undertaking.

The author of this research began with a simple question, Are there gaps within academic literature around the lived experience of chronic pain and engagement with psychological therapies? This led to the research question becoming, how might counselling services become more accessible to disabled clients with less judgement and the worry of being excluded from sessions due to ongoing lack of engagement due to chronic pain and illness?

The answer to this question was sourced after by using a google search, the answer was yes there are gaps. databases were used, including Google scholar and the university library to access databases such as Pro Quest Central, and Wiley Online Library, using key words such as, chronic pain, engagement, and psychological therapies. A custom range of 2020 – 2026 was used to ensure the literature was up to date. This research focused on adults living with chronic pain and engagement with psychological therapies.

The results from these searches came back with 17,300 journal articles. The researcher then used the library database to access journals around “chronic pain in adults and counselling” as the previous search contained journal articles that had carried out research among young adults and this researcher is specifically looking at adults over the age of 25 years old.

This search then gave 768 results. The researcher continued to apply further filters to the search, such as, peer reviewed journals, open access journals, pain, chronic pain, and in adults, this brought the results down to 37 results, so for the literature review using

both the university library and google scholar the research worked with 39 journal articles.

The reader will note that there are some journal articles that predate 2020 due to them remaining relevant to today's writing and reports from organisations that have yet to be updated.

Chronic pain refers to pain that an individual has been experiencing for over three consecutive months, (Themelis, & Tang, 2023). With an estimated 1.5 billion people living with the condition worldwide. Approximately 28 million of them are living in the United Kingdom, which equates to roughly 43 percent of the adult population, and an estimated annual cost of £50 billion to the UK economy, therefore how to assist people must be addressed, (Office for national statistics, data and analysis from census, 2021). The psychological consequences of living with chronic pain have been described as an assault on, or a threat to, the person's sense of self, this observation applies across the lifespan, including children and adolescents, who express how pain has affected their aspirations and identity, (Heffernan, et al, 2021). Living with persistent and debilitating pain is seen as a repeated trigger of mental defeat, leading to negative self-appraisals, autonomy, and personal integrity, also including suicide risk or intent (Themelis et al, 2023).

Efforts are underway to establish a consensus among patients, researchers, and clinicians regarding outcome measures for the psychosocial treatment of chronic pain, (Hutting, et al, 2022). Further to this, ongoing clinical trials recognise that the perspectives and lived experience of the individual should go beyond clinical pain intervention, and that the day-to-day lives need to be considered when devising person-centred care plans. These include measures of fatigue, sleep, home and family care,

engagement in social and leisure activities, interpersonal relationships, and sexual activities, (Pilkington, Johnson, & Thompson, 2025).

In 2018, The Department of Health in England asked, (National Institute for Health and Care Excellence) (NICE), to develop a clinical guideline on chronic pain. NICE' research found that there is a significant impact on individuals and their families and carers. Pain affects mood, sleep, mobility, role within the family, ability to work as well as other aspects of life, further to this NICE (2018), also said that systematic review suggests that chronic pain in the UK affects between one-third to one-half of the population, and that two-thirds of the population have a diagnosis of depression, and are unable to engage with work practice outside of the home. In 2016, £537 million was spent on prescribing medication, Further healthcare costs include visits to primary care, referrals to secondary care for opinions from pain and other specialists, and costs of investigations and interventions, including surgery.

The impact of chronic pain also suggests that it forces individuals out of the work force, causing poor productivity is estimated to be between £5 billion and £10.7 billion, bringing about further impact to the countries welfare system. NICE (2018), reports that there is currently no pharmacological or non-pharmacological practice that works for all patients, and that the benefits are modest in terms of effect size and duration. Further reports from NICE (2021), failed to expand on further literature and recommendations, from their 2018 report, the report from 2021, however, did note in its future recommendations in research that there is currently not enough evidence as to if Psychotherapies including talking therapy and the use of mindful techniques have much if any effect on chronic pain experience.

There appears to be little in the way of literature published from NICE since 2021, therefore implying that the report that was written in 2018 is still the most relevant piece of work from NICE to date.

The burden of chronic pain with no effective treatments also increases the morbidity rates as indicated in later research by (Themelis et al, 2023). More recently, A report by The British Pain Society, (2024) stated that since 2017, there have been changes in recommended practice to how pain is managed within the UK, this includes a more conservative approach in the prescribing of opioids for chronic pain, including the reclassification of Gabapentinoid controlled drugs, to improve pain management, there is a steady move towards personalised, holistic care for a more pragmatic health care structure. Norton & Dibb, (2023), added that people living with chronic pain are also at a greater risk of developing addiction to painkillers and other pharmaceuticals being prescribed by medical professionals.

Therefore, adding a further impact on society and healthcare institutions and professionals. Norton & Dibb, (2023), also suggested that much of the current research into drug dependent behaviours is limited to the United States of America, continuing to suggest that there is a dearth of literature coming directly from the United Kingdom. Further to this Friebel, & Maynou, (2022), suggested in their findings that there has been a 48.9% increase in opioid-related hospitalisations in the ten years between 2008 – 2018 in England alone.

According to (ICD-11 International Classification of Diseases, 2023) Primary chronic pain is deemed to be a specific condition. The (ICD-11, 2023) also added that approximately 8 million adults report chronic pain in the UK as being moderate to severely disabling. In 2023 a report by Watt et al, written for The Health Foundation

projected that people living with chronic pain and chronic illness is likely to increase by 2.5 million by 2040. Watt et al, (2023), state that their findings are significant as they will help to improve and understand what choices and approaches are needed in the future of chronic pain and chronic illness care. Further to this Watt et al, (2023), predict that the population will grow Between 2019 and 2040 by 3.5 million, meaning that people are spending 1.3 more years on average living with major illness over the age of 70 years. This is suggesting that an increase of 2.5 million people aged 20 years and older, living with major illness by 2040. Which again is suggesting a greater impact on health and social care, it is worth noting that this chronic illness and chronic pain is apart from chronic heart conditions, high blood pressure and high cholesterol conditions.

Vase, Wager, & Eccleston, (2025), also published research containing the findings from the ICD-11 and their classification of chronic pain, further to this Nicholas, et al, (2019), added that the ICD-11 makes the clear distinction between primary and secondary pain syndromes (secondary syndromes originating from cancer and other forms of disease). Chronic pain is identified as nociceptive (Related to tissue damage), neuropathic (related to the nervous system), and or nociplastic (without evidence of tissue or nerve damage),

Additionally, further examination of the literature provides the reader with insights as to why some individuals live with chronic or persistent pain. An article written by Glare, Overton & Aubrey, (2020), found an alliance with both previous and current literature that chronic or persistent pain is experienced for several reasons, including social factors, gender, and varying degrees of biological factors. It is widely accepted that there are significant differences between acute pain and chronic or persistent pain, and that there are widely different causes.

According to chronic pain statistics UK 2025, 34% of patients live with lower back pain, 22% live with osteoarthritis, 15% live with neuropathic pain, and 11% live with fibromyalgia.

According to Israel, et al, (2025), Fibromyalgia affects Females. Fibromyalgia has a wide range of symptoms, not all symptoms are experienced by all individuals and vary in severity, Liu, et al, (2025) also stated that a greater number of females are affected by fibromyalgia and chronic pain than by their male counterparts. Marchesini, et al, (2025), add that the differences between male and female experience of chronic pain is due to biological, and psychological differences, including hormonal influences, immune response, and how pain is processed by differing gender. Patients express that they live with, distressing sensory allodynia, paraesthesia and dysaesthesia. alongside Pain and the perception of mechanical and thermal stimuli in Fibromyalgia, there is a process involving the peripheral and central nervous system. Sensory neurons in the periphery (e.g. skin) are activated by mechanical, thermal and chemical stimulation of their peripheral terminals. Studies of human afferents in FM have focused on C fibres, because of their obvious involvement in pain and nociception. Electrophysiological investigations in people with FM revealed sensitization of previously insensitive C-fibre afferents (silent nociceptors) to mechanical stimulation, and importantly, 25% of these fibres also exhibited spontaneous, ongoing activity in Fibromyalgia, (Pérez-Neri, et al, 2023).

In 1965, Melzack and Wall first proposed the Gate Control Theory. The theory posed that the pain perception is not solely determined by the physical stimulus but is also determined by psychological factors and the interaction of the different nerve fibres in the spinal cord.

The theory describes a "gate" mechanism located in the dorsal horn of the spinal cord,

specifically in the substantia gelatinosa. This gate can either allow or block pain signals from reaching the brain. Understanding gate control has led to various pain management strategies, including physical therapy, cognitive behavioural therapy, and the use of TENS (transcutaneous Electrical Nerve Stimulation) devices, which stimulate non-painful nerve fibres to help, (Campbell, Johnson, & Zernicke, 2020). Further to this, Shi, & Wu, (2023) argued that whilst Gate Control Theory explains acute pain, it in fact struggles to provide adequate explanation for chronic pain, these researchers studied Central Sensitisation and suggested that chronic pain often makes long-term changes to the central nervous system. It is suggested by Casey, (2023) that Melzack himself continued his research and found that stronger explanations for chronic pain can be offered by exploring Neuro-matrix model.

There is currently little in the way of specific understanding to what might cause Fibromyalgia. However, there is significant research that suggests that childhood trauma both emotional and physical trauma, may be linked to fibromyalgia. Combas, Ozturk, Derin, (2022), research suggested that childhood traumas have a long-term effect on cortisol secretion patterns, further studies also suggest that the frequency of childhood trauma in fibromyalgia patients varies between 34-82%.

Bacon & White, (2022), added further to the research by suggesting that even though there is a wealth of research surrounding chronic pain and that it is widely accepted that Adverse Childhood Experiences are a significant contributor to poor adult health including that of fibromyalgia patients, the complexity of biological and psychosocial factors makes it difficult for medical professionals to attribute any one cause to these chronic pain conditions.

Bacon & White, (2022), further explains that, due to people experiencing Adverse childhood experiences may show compromised immunity and raised biomarkers, when exposed to everyday stressors. Smith & Pollak, (2020), also contributed that emotionally invalidating childhood experiences are associated with emotional inhibition in adulthood, having difficulties in self-expression, displaying avoidant stress responses, depression, and anxiety. Furthermore, it is suggested that the consequences of these behaviours encourage the development in women particularly, self-censoring, becoming overall accommodating and to devalue their own experiences.

In 2021 The International Association for the study of Pain (IASP) published a study that suggested that self- management is important in the care of chronic pain. (IASP) suggested that it is important to build the professional alliance with healthcare professionals, applying modifications to daily lifestyles, engaging in pain management resources, and complementary therapies. IASP, (2021), further suggested that self-learning and the understanding of an individual's chronic pain can help a person come to terms with their illness. This would include the learning of healthy eating guidance, health exercise and the need for self-efficacy and self-mastery.

According to Raman & Sharma, (2022), there has been evidence from researchers that depression frequently contributes to the individual's chronic pain being experienced. Depression typically has significant effects on self-efficacy, which is likely to affect the severity of pain, negative psychological variables. It is further claimed that self-efficacy reconciles the association between pain intensity and disability. Raeder et al, (2019), suggests that lower levels of self-efficacy leads to fear avoidance behaviours, according to Devlin, et al (2020), the fear avoidance model postulates that individuals with chronic pain tend to avoid certain activities due to the belief that further pain and or injury might be caused and therefore exacerbating existing pain.

Themelis & Tang, (2023), added to existing literature that whilst psychological therapies are vitally important to those living with chronic pain, there is not a one model fits all scenario. Therapies such as Cognitive behavioural Therapy (CBT), mindfulness, and Acceptance and Commitment therapy (ACT) tend to be utilised within pain management settings. There is a growing assumption that person centred therapy needs to be brought into the process to aid further recovery, therefore bringing these therapies together to form a hybrid therapy.

Themelis & Tang, (2023) further note in their research that Cognitive Behavioural Therapy, Acceptance and commitment therapy, and mindfulness are often carried out in groups and therefore the person-centred approach becomes negated. It is important that during therapy sessions that the individual's sense of self is engaged with, however, due to the nature of most chronic pain experiences, the sense of self can invariably be lost over time. It is further noted that an individual may become so enmeshed in their experience of pain and illness, that the individual becomes defined by their pain, and illness, therefore impacting their self-worth and potential future. Initiatives are underway for patients, clinicians and researchers to unify a multifaceted approach to care plans and plan management.

According to Fisher, et al, (2020), the efficacy of cognitive behavioural therapy for alleviating distress in chronic pain is low to moderate, whilst Ong, et al, (2020), alluded to the benefits that are being established within positive psychology approaches, focusing on positive adjustment. further research by Martinez-Calderon et al, (2020), explored psychological factors associated with risk of onset, and the persistence of chronic pain, the research suggested benefits of protective or positive associations that reduce risks, by re-enforcing self-efficacy beliefs, and positive beliefs, regarding recovery. Widdrington, et al, (2025), suggest that in order to encourage positive

engagement, elements of the individuals, require important consideration such as, personal strength, resources available to the individuals, and how help and support, can be provided for families, carers, and communities to help the individual for best therapeutic outcomes, and for the individual to be able to thrive in spite of difficulties. Thriving and flourishing are considered therapeutic outcomes, indicating subjective well-being and reflecting positive adjustment.

Thompson, et al, (2020), found that thriving involves resolving the disruption to the individuals self- coherence so that making sense of pain can be accomplished , encouraging the individual to see themselves as a person and not a patient, and therefore being able to engage with life flexibly. The miss understanding of chronic pain by medical professionals can negatively impact clinical interactions and is likely to damage therapeutic relationships between healthcare professionals, and patients, not just in the present but moving forward in the future.

Nicola, et al, (2025), suggest that some of the reasons are believed to be pain- invalidation, not being believed, lack of compassion, lack of pain awareness and understanding, feeling stigmatized and critical self- judgement. There has been significant research over the past few years relating to online therapy, due to it being convenient especially if the client has low mobility and or lives in rural areas with limited transport infrastructure. This has had a significant impact on waiting lists and the further decline in mental health of the client.

According to Trindade et al, (2021), Acceptance commitment therapy has become the therapy of choice for chronic pain, and this shows in its efficacy. However, according to Lin et al, (2019), suggest that further research is needed to ascertain if acceptance commitment therapy is effective online. That said due to its increasingly mounting

evidence the American Psychological association stated that acceptance commitment therapy is empirically supported for use in conjunction with chronic pain since 2012. Moens, et al, (2022), stated that Acceptance and commitment therapy aims to decrease suffering and increase well-being through specific processes of change, these include, awareness, non-judgemental acceptance of both negative and positive experiences, identification of values, and appropriate action toward goals.

According to Driscoll et al, (2021), the most widely accepted forms of psychological therapies are, supportive psychotherapy, meaning non- directive therapy and an emphasis on unconditional acceptance, and empathic understanding. Relaxation training, to include breath work, to add the relaxation of muscles, and introducing biofeedback therapy to regulate stress responses, and self- efficacy. This is by no means an exhaustive list but are suggested to aid in the recovery of headaches, lower back pain, and fibromyalgia. Despite the evidence that supports the benefits of psychological therapies, there is also evidence to suggest that the uptake of these therapies is complex and creates barriers for the client to engage, and lacking specialism within organisational systems. However, these barriers are not solely in regard to not fully understanding what psychological therapies are, but due to cost of private sessions, time to fully immerse in the sessions, especially if the sessions are being provided via organisations that rarely offer more than six sessions at a time. In relation to session cost Claes et al, (2025), suggested that whilst the cost for therapist working online has reduced due to not requiring office space and having little overheads, this has made minor difference to the paying client.

According to Paroli & Galdino, (2023), research has shown that people living with chronic pain disorders such as fibromyalgia are less likely to see significant improvement from cognitive behavioural therapy in comparison to acceptance and

commitment therapy, mindfulness-based therapies. The efficacy of psychological therapies is not in question, rather why is continued engagement lacking? the literature heavily suggests that the cost of private sessions is a contributing factor alongside the amount of sessions offered from organisations such as the NHS, (Hsu, et al, 2025).

Punton, Dodds, & McNeill, (2022), added that fifty percent of referrals can spend up to 162 days for initial consultations, which can exacerbate symptoms of anxiety and depression.

Casey, et al, (2020), suggests that there has been a significant shift in the way therapeutic approaches are being delivered, these subjects need future research in how to make psychological therapies more accessible. Prior to Covid-19 disengagement with therapy sessions was high. Verbist, Fabian, & Brooks, (2023), suggested that this could be due to inconvenient times and days and around work and other commitments.

Svendsen, et al, (2020), suggested that there is little evidence toward the uptake and positive outcomes in regard to online services, it is also suggested that difficulties to engage could be due to a lack of motivation, difficulties using technology, and a perceived lack of personal relevance.

Barker & Barker, (2022) adds that there are disadvantages with online therapy, suggesting that online therapy might be unsuitable for some clients with avoidant traits due to adverse childhood experiences, and emotional dysregulation. Barker & Barker, (2022) went on to say that online therapy might be more suitable for clients with elevated levels of shame, and self-consciousness.

Carrillo, et al, (2025) suggested that disengagement with counselling therapy is likely due to poor therapeutic alliance, particularly if the client may perceive that therapeutic interventions are more engaged with the cognitive processes over physical pain, leading

to a perceived lack of empathy and invalidation. However, Heffernan, et al, (2021) found that fluctuating and debilitating pain can limit an individual's capacity to consistently engage. Virk, et al, (2025), went further to suggest that this perspective requires balance alongside the evidence that many individuals engage fully when there is evidence of flexibility, validation, and empathy towards the lived experience of chronic pain. Bendelin, et al, (2020), suggested that goal setting may prove important for ongoing self-management and can serve to support self-efficacy to optimize consistent engagement.

Jerjes, Harding, & Hilton, (2025), when a client perceives that their gains from therapy are limited, this can also cause a lack of motivation to continue engaging, which may lead to further depression and frustration. These factors may also lead to negative effectiveness on therapy outcomes, leaving clients feeling that their therapy has been unsuccessful leading to further disengagement.

Further to this Jerjes, Harding, & Hilton, (2025), stated that there is evidence to suggest that if therapy can align with understanding the way in which the client views their own understanding self-efficacy and efficacy of therapy are enhanced.

This literature review has revealed that there is substantial research to support that psychological therapy is helpful to individuals that live with chronic pain, however this research is primarily centred around CBT, ACT and Mindfulness, there is little research in comparison into the effectiveness of implementing person- centred, humanistic, integrative, psychodynamic, or existential therapist within counselling, this therefore, makes this research important within the realm of academia and the counselling profession, Schwebel, McCool, & Witkiewitz, (2025).

Strain, Welch, & Sadler, (2024), suggested that whilst there is growing evidence to support the benefits of counselling and psychological interventions to individuals living with chronic pain, there is relatively little research into the lived experience of counselling and chronic pain, it is further suggested that this consequently leaves unexplained gaps within qualitative research that provides a voice for individuals to express their experiences.

This chapter has explored the literature in correlation with the lived experience of chronic pain and engagement with psychological therapies, including thoughts around how and why some people may experience chronic pain and Illness with little or no explanation, and the impacts that has.

The next chapter will explore the methodology and method of the research.

Chapter 3

Methodology

This chapter will explain how the research was conducted, including how the participants were recruited for this research, how the data was collected, and how the data was analysed.

This chapter will also show how the data and the participants were protected before, during and after the research had been conducted, and the ethical considerations that were taken from the start of the research project to the end, including how the data has been stored. The data will be kept until after the qualification has been awarded.

Method

This research is considered to have philosophical assumptions combined with a constructive epistemology and containing a phenomenological focus on the lived experience. This researcher also adds that this current research takes a position of relativist ontology, this is due to the understanding by the researcher that multiple realities exist and are formulated through the different lived experience of different individuals.

This understanding led to an exploratory review of existing literature around research that had previously focused on chronic pain, this researcher decided that to understand the lived experience of chronic pain it was important to carry out research using Thematic analysis.

By using a qualitative method, this would allow for a deeper consideration of “How” and “Why” chronic pain affects the daily life of an individual. As where a quantitative method would not allow for this exploration, (Lim, 2025).

This research was conducted using Braun & Clarkes 2022, updated Thematic analysis. Braun & Clarkes Thematic analysis is one of the most utilised methods within qualitative analysis (Ahmed, et al, 2025).

Thematic analysis is a versatile method which allows the researcher reflexivity and transparency throughout the research further ensuring rigor and credibility. Despite the strengths, Byrne, (2022) argued that there is some confusion surrounding Thematic Analysis, and further to this, Ahmed, et al, (2025) suggested that within some academic fields there is a question regarding inconsistencies when reporting findings and has suggested that clearer methodological guidance is needed.

Braun & Clarke, (2024) added that to ensure meaningful and accurate findings, reporting thematic analysis must be carried out systematically and there should be documentation of the interpretive decisions and engagement, which moves beyond the surface descriptions.

Campbell, et al, (2021), added that unlike some more rigid methods such as interpretative phenomenological analysis, (Smith, 1996). Thematic analysis emphasizes interpretive depth, researcher reflexivity, descriptive, rich, and conceptual analysis. (Braun & Clarke, 2024) argued that thematic analysis remains the cornerstone for conducting robust, meaningful analysis.

Due to the researcher wanting to understand further insights into the lived experience of the participant, the researcher considered thematic analysis to be an appropriate analytic approach.

Participants

Six participants were required for this current research. The researcher required three client participants and three qualified counselling practitioners. Three client participants were recruited via social media private support groups; it was stipulated that only three participants were needed for this research and that participants would be chosen on a

first come first served basis. The further three participants were qualified counselling practitioners were recruited via counselling organisation.

Participants may be classed as vulnerable if they are taking prescribed taking, and this medication could impact their thoughts and feelings at the point of interview, participants were asked about what if any medication they were currently taking, and how their medication might affect their understanding of the process and their ability to engage with the interview process prior to completing the interviews.

The criteria required for participants was specified, Participants were required to be over the age of twenty-one, to have been living with chronic pain for longer than three months, this is in accordance with the (WHO, ICD-11 2024) guidelines of chronic pain.

The researcher sent an email to a counselling service to enquire to if any qualified practitioners that have collaborated with clients that live with chronic pain, either within the organisation from GP referrals or in their own private practice. Again, the email specified that the research only required three qualified practitioners.

All participants were given pseudonyms client participants were identified as CP1, CP 2, and the qualified practitioners were identified as QP1, QP2, QP3.

The researcher successfully gained all the participants required for the study, however one of the client participants withdrew from the study and therefore all their data was removed and sensitivity deleted from the university cloud storage alongside their recorded interview that took place via teams platform.

This, therefore left, a total of five participants in the study meaning that the sample size was smaller than intended. At the time of the participants withdrawing, the researcher felt there would not be enough time to interview a new participant and add their data to the analysis.

Following conversations with the participants prior to the interviews, suitable times and dates were agreed by both parties, the researcher sent emails to all participants containing relevant information letter, consent forms, interview schedules, demographic information, and debrief forms, (these can also be seen with the appendices).

The participants were asked to return the consent forms prior to the start of the interviews, upon receipt of the consent forms, a Microsoft teams' invitation was sent to each participant. At the start of each interview, all participants were asked once again if they were still happy to continue with the study, they were also reminded that they have the right to withdraw from the study no later than 30th April 2026, without bias or questions asked, the researcher also reminded the participants that the interviews were going to be recorded and transcribed, and once again asked if they were still willing to continue.

This is in line with BACP Ethical Guidelines for Research in Counselling Professions (BACP, 2018-2019), UWTSD Research Ethics & Integrity Code of Practice, and Data Protection Regulation/GDPR (2016) and the Data Protection Act (2018). All documents such as consent forms, interview schedules, information sheets, and debrief forms were provided to all participants via their email addresses and sent from the researcher's email address to protect all parties.

Participants demographics

All of the participants were female, all participants reside with semi-rural towns, they are all drivers, the researcher found that it was important to ask the participants if they drove as this could affect the way they consider their engagement, (Longhurst & Full, 2023). Four of the participants were aged between 51-60 and one was aged between 41-50. The qualified participants have all been practicing for around five years.

The client participants stated that they preferred face to face counselling but would not turn down online counselling if they needed to engage in that form, as where all the qualified practitioners stated no preference and were all happy to engage with their clients in a way that suits the clients. The qualified participants have all been in private practice and organisational practice for around five to seven years, respectively.

Data collection.

This research was conducted via semi-structured interviews using the Microsoft Teams. Each interview lasted approximately one hour. There were five structured questions for the client participants and five different structured questions for the qualified counselling practitioners, however these structured questions were used in conjunction with some prompts, which may led to obtaining a deeper insight around the subject of chronic pain and engagement with counselling services (Such as “could you tell me more about that”?) and (How would you feel if that could be different?). (Both sets of questions can be seen in the appendices section). The researcher needed to ask differing questions to the different sets of participants due to obtaining information regarding engagement from the client participants and how engagement was viewed from the qualified counselling practitioners.

Once all the interviews had been completed, there researcher downloaded the transcripts to a password protected laptop and were then printed off for ease of reading, coding and theme generating. All printouts were kept in a locked draw meaning that no other individuals had access to the transcripts. The researcher read the transcripts five times each to immerse into the collected data, the researcher then began to go through the data and using a highlighter started to highlight words and sentences that initially became prominent.

Data Analysis

Once all interviews had been conducted, the interviews were transcribed by the researcher ready for data analysis. The researcher conducted qualitative research using Braun & Clarke's Thematic Analysis (2022). According to (Duncan, Hayes, & Cooper, 2025) thematic analysis is a flexible, adaptable, and effective way to obtain an in-depth understanding of a chosen research topic, in this case the lived experience of chronic pain and engagement with counselling services. There are six steps to follow when using thematic analysis,

Familiarise	Reading the data collected
Code	Label sections of the data that may be important
Search for themes	Looking for patterns within the data and start to group together
Review themes	Matching the themes to the data, combining, splitting the themes as needed
Define and name	Assign each theme a concise name, to accurately capture its essence
Write up	Present the data findings, using example from the data

The themes and sub- themes were presented in table format. Which can be seen in the findings chapter that follows.

At this stage, the highlighted words and sentences that were prominent for the research were used to form a separate list. This allowed the researcher to remove parts of the transcripts that were not relevant giving the researcher less to concentrate on.

The printed-out transcripts were then sensitively destroyed, once the researcher had finished working with them, however the original transcripts remained on the secure laptop saved in their own file in case they were required later.

The analytic process can be seen in the appendices.

Throughout the interviews and careful reading of the transcripts, a few of the early codes that were emerging as, uncertainty, overwhelm, cost, fatigue, guilt, judgement, despair. These early codes will be further explored within the findings section of this research paper.

The main four themes.

Theme 1:	Internalised Negative Evaluations
Theme 2:	Lack of Clinical Support
Theme 3:	Therapeutic Relationship
Theme 4:	Engagement

Ethical Considerations.

The ethics form was completed under the guidance of the research supervisor and in accordance with UWTSD Research Ethics & Integrity Code of Practice. Ethical approval for this research was obtained from University of Wales Trinity Saint David's ethics committee.

All participants were provided with an explanation in regards to the university's confidentiality policy, and all participants were given an explanation on how all the data collected will be stored on the university secure cloud that requires double authentication to be accessed, all participants were advised that all personal data and all

data collected will be carefully destroyed at the end of the examination period. All participants were informed that they could withdraw from the interview process and the research at any time up to one calendar month from the date of their interview.

This date is set so that once the research had been completed, the paper would then be submitted to the exam board for making and would render it impossible to remove their interview data after this time. All parties agreed that this date would be set for April 30th 2026.

All participants were given a debrief letter and the end of the interviews containing further information on where they can access support should they require it.

All participants were informed that should they wish to receive a copy of their interview transcript this could be sent to them via the email address they had supplied the researcher with.

The researcher took time to carefully consider the questions that would be asked to limit any possible risk to the participants and the researcher. All participants were given the researcher's and the dissertation supervisor's university email address should the participants need to make contact. The participants were also informed that their email addresses would be deleted from the email database and not be stored anywhere.

In this chapter the researcher explained how this research was conducted, including how the interviews were carried out, who the participants were including some demographic information from the participants. This chapter also looked at why thematic analysis was suitable for this research.

Chapter 4

Findings

The next chapter of this research is the findings following the analysis of the interviews that were conducted. The chapter will also contain a table containing the themes that have emerged throughout the analysis, how many themes were created from the data collection. This chapter will also contain extracts from the interviews that relate to the research question.

How might counselling services become more accessible to disabled clients with less judgement and the worry of being excluded from sessions due to ongoing lack of engagement due to illness?

Following the data analysis, the researcher had an exhaustive list of codes, there were around thirty in total, these codes were subsequently reviewed, checking for duplicate codes. The researcher was then able to eliminate duplicate codes and discover themes in which the codes can be placed. These themes are interrelated.

The researcher discovered four main themes, a table has been provided below for ease of reference, more detail on these themes will be found below. The first two themes are from the perspective of the client participants, themes three, and four will contain the perspectives of both the client participants and the qualified therapist participants.

Please see table 1 below.

Theme	Sub Theme	Supporting Quotation	Citations
Theme 1: Internalised Negative Evaluation	Guilt Depression Grief Anxiety	CP 2 <i>"I feel Guilty because I have to have people help me sometimes"</i>	(Asanova, et al, 2024)
Theme 2: Lack of Clinical Support	Negative Responses Judgement	CP 2 <i>"they say things like; you are on all this medication why aren't you better"</i> . CP 1 <i>"well I will have to send you for another Xray"</i> .	(Jordan et al, 2025) (Rahman, et al, 2023)
Theme 3: Therapeutic Relationship	Safe Heard Validated Empathy	<i>"clients need a safe space to be heard, for their lived experience to be heard, especially when the their voices are not being heard around them, they a space to be heard and validated"</i> .	(Levitt, 2022)
Theme 4: Engagement.	Flexibility Commitment	<i>"I can't image that trained therapists would not have it in their capability to move to online if the client has expressed the need beforehand" it builds trust and the therapeutic relationship, being able to be flexible"</i>	(Di-Malta, 2025)

Here the researcher will clarify the above thematic table.

Theme one, Internalised Negative evaluation.

Sub- themes, Guilt, Depression, Grief, Anxiety.

According to Perugino, et al, (2022) Internalised negative evaluation and the lived experience of chronic pain can lead to social exclusion, social discrimination, and social inequalities. These can also lead to stigma within both social and clinical settings, causing a myriad of underassessment, underestimation, scepticism, and suspicion. Not only does the literature suggest this, but personal experience also concludes this to be the case, as expressed by the participants.

This participant expressed a feeling of being patronised, and left feeling that what was experienced in their daily life was not real.

CP3 , P 28 Line 946, stated in interview that *“I felt like I was overdramatizing everything”*. *“Medical professionals acting as though I should be better by now, they just don’t understand what it’s like.”* *“Almost like it’s all in my imagination”*.

The participant expressed how this made them feel as if they were being invalidated within their experience of pain, validating their own feelings of not being heard and being dismissed.

Further to this Scott, et al, (2025) go as far as suggesting that health stigma is closely linked with “deviant behaviour” by where a more “powerful group” of individuals may reject those with chronic pain or persistent illness from biosocial processes, leaving these individuals to feel, embarrassment, shame, and fear. Hickling, et al, (2024) suggests that there has been a significant positive correlation between stigma, pain intensity, disability, and depression. Asanova, et al, (2024) added that with the stigma and depression there is also mounting evidence that supports levels of grief that is felt

by individuals living with chronic pain. This grief is for the life they once lived, the things they were once able to do.

There appears to be a social construct in where it is widely believed that if you do not go out to work then you must be lazy, it is widely misunderstood that people do not want to work but this is not the case as evidenced by this participant below,

CP3 , p 19- line 655, Stated *“I hate working from home” I loved working in the school” I miss the life I had”*.

Guilt, can also manifest itself as inconvenience, the participant stated that the guilt and inconvenience stems to friends, family and the wider society, as more often than not individuals need help and support from others to carry out their daily activities, this can feel like an inconvenience, sometimes forcing the individual to struggle alone.

CP3 p12, line 420, Stated *“I feel Guilty because I have to have people help me sometimes, getting the children to school because I can’t do it”. “I feel guilty because sometimes I just can’t do day to day things, simple things, like make a coffee, do the washing, take a shower” its belittling, degrading, and lonely.”*

QP 3 page 12, line 395, *“It’s your identity, isn’t it, there’s grief and loss in that, it is tremendously difficult, if you think of your capacity, your emotion capacity, your physical capacity, the pain takes space within your capacity, stealing space for better things”*.

The quote above from a qualified practitioner, agreed with the feeling of loss, and guilt, and understood the need to meet the client where they are more over than what they are going through on any one given day.

Further to this Galvez-Sanchez, Castelli, & Montoro, (2023) added that people living with chronic pain disorders experience levels of, comorbid emotional alterations, and also levels of concerning cognitive deficits, this includes planning, organising, verbal memory processing, self- regulation, poor cognitive flexibility. Further studies proclaim that chronic pain can disrupt dopamine levels, and therefore, can be a predicting factor to the development of depression, Meda, et al, (2022).

CP3 P 13 line 437, *“sort of like depression, unless you have been through it, you just don’t understand, even family and friends stop listening”*.

CP1 *“Living with the pain gets you down, then you must fight the depression as well as the pain, it becomes exhausting”*.

CP3 p 24 line 802, *“the whole thing is just totally frustrating”*.

From the above quotes it can be assumed that these feelings can make an individual feel isolated and lonely, which can also exacerbate feelings of depression, and the need to mask what is really be felt.

Chronic pain is known to have adverse impacts on day-to-day living, this encompasses cognition and develops a highly charged impact on emotional regulation, this is also known to have negative reaction to emotionally charged decision making, Horta, et al, (2025).

Theme 2, Lack of Clinical support

Sub-themes, Negative responses, Judgement.

Anecdotally, there has long been an understanding that individuals do not always receive positive, and empathic support from some of the medical professional that individuals meet. However, in alignment with this study, Jordan, et al, (2025) appear to have suggested that this may well be the case. They stated that unhelpful comments and

leaving patients feeling invalidated can exacerbate not only the pain that is present, but also the feeling of not receiving positive, supportive care, which can also lead to the individual disengaging with medical professional and feeling like they have nowhere to turn. The research conducted by Jordan et al, (2025) also suggested that participants report receiving a poor reception.

CP3 p 28, line 947, *“they don’t hear us, they don’t know what it feels like”*. And *“they say things like, you are on all this medication why aren’t you better,”*

CP 3 p 28, line 947, *“well I will have to send you for another Xray”*, and CP 3 *“it should be better by now it’s been months”*.

It has been argued by van Rysewyk, Blomkvist, &Toye, (2023), that one rational for individuals receiving poor or unsatisfactory care from medical professionals is in part due to clinicians not fully appreciating the lived experience of chronic pain.

CP 1 *“but a little bit of empathy would be nice”*.

CP 3 p 28, line 937, *“I just felt like cattle”*.

It is estimated that around 40% of patients with chronic pain experience dismissal, disbelief and even diminishing attitudes towards their pain by medical professionals, (Fenelon et al, 2025).

The feelings that are felt in these moments can be that of great despair, the feeling of being pushed from one place to another, likely because of the inconsistency of pain felt, the disparity of symptoms within different individuals, a lack of medical knowledge of what chronic pain is and how it manifests itself.

Theme 3: Therapeutic Relationship.

Sub Themes, Safe, Heard, Validation, Empathy.

It has been documented that the therapeutic relationship as at the for front of any form of counselling. Agarwal, (2020), by cultivating the therapeutic relationship the client will tend to experience a fuller, safer space in which they can explore their inner thoughts and feelings, not only does this allow the client to start understanding and accepting their body has it is now, it helps the client to form an awareness and control over their environment, and relationships.

CP 3, p 30, line 1020 *“to have empathy and understanding from your therapist is really important”. The acknowledgment from your therapist that they do not live with your condition but asking to be told about it, how it feels, really shows that they have some interest in what you might be going through.”*

QP , p8, line 245-247, *“from the perspective of a therapist, when you live with chronic pain, the idea of being heard, someone to listen to you, rather than being told what to do, is important and individuals engage with that”.*

QP 2, p3, line 82-83, *“my clients with chronic pain are really engaged, we built up a really good therapeutic relationship”.*

QP 3, p7, line 220, *“the client is always the best expert on themselves, and if they are engaging then they are willing to turn the lens inward, and work through issues”. The pain is isolating, and when it is not visible other people do not see your pain, they might disbelieve your pain or not taken seriously.” To be heard, to have your feelings validated for someone else to try and get a real sense of what your life in pain might feel like, that is healing, that’s belief, which is important.”*

QP 2, p4, line 136, *“it’s about offering them that space where they can explore, a safe space to feel heard and to express themselves, not be judged”.*

The researcher noted that these statements expressed a sense of relief to the participant, the sense of being heard on a human level, and by therapists showing that they want to know what it's like to live with chronic pain.

Empathy within psychological therapies helps to build the working relationship, However, too much empathy that borders on collusion can provoke negative outcomes for the client, the acceptance of empathy determines the client's ability to understand their own self-realisation and their ability to communicate their needs, (Dudar, 2024). Levitt, (2022) suggested that client's relationships with their therapists are often transformative, with clients experiencing new and improved levels of self-acceptance and empathic capacity.

QP 2, p6, line 183-184, *"What's it like to be you, what's a day in your life like"*.

QP 1, p10, line 331, *"clients need a safe space to be heard, for their lived experience to be heard, especially when their voices are not being heard around them, they a space to be heard and validated"*.

CP 1, p1 line 26, *"you need to know that you can trust your therapist, to feel safe, to form a bond"*.

QP 3, p27, line 914, *"very often emotions can be suppressed deep inside, the therapist needs to work mindfully and take each session step by step"*.

As noted in the above participant quote, showing empathy, understanding and interest, this shows that future therapists can understand future clients in similar situations.

Theme 4: Engagement.

Sub- themes, Flexibility, Accessibility.

The covid-19 pandemic rapidly shifted the way in which psychotherapy is delivered moving more therapists to working online and via the telephone. This therefore has

made engagement and accessibility easier for individuals that have mobility issues or transport issues, (Goldsmith, et al, 2023).

It has been documented that individuals seeking counselling, not only consider the risk perception, and stigma, but also the financial elements.

Hsu, et al, (2023) suggested that people who have previously engaged in counselling and have benefited from sessions have a willingness to pay higher sessional rates, especially if the counsellor has been in practice for a significant length of time.

The decision on employment of a counsellor is multifaceted for the client. the client will carefully consider age, race, and gender of a counsellor before engagement, and will also go on word of mouth from trusted family and friends. It was mentioned that a client on a lower income does not always lead to the client wanting to pay a lower rate, once the client has found a counsellor, they build a therapeutic relationship with they continually chose in to engage with. If money is the object a client will tend to wait until they can pay the therapist, they have already engaged with.

CP 3, p27, line 14, *“I did have a really good therapist, I just cannot afford him at the moment”*.

CP3, p40, line 1360-1363, *“flexibility is a thing.*

you know, because there are a lot of people out there that have got the money and they can afford to spend 30, 40 pound on therapy every week, but they might not be physically well to do it”.

One topic of conversation that was clear throughout the interviews with all participants was flexibility of the therapist. It became clear that a client living with chronic pain does not know how they are going to be from one day to the next.

Smith & Gillon, (2021) acknowledges that since the covid- 19 pandemic the rise of engagement with both online and telephone psychological therapies has proven to be vast.

Donisi, et al, (2023) suggested that clients living with chronic pain are often limited in resources for accessing psychological therapies, these include geographical barriers, and cost, with the rapidly growing access to online psychological therapy, there has been a positive recognition to increased efficiency, accessibility and therefore has also seen positive outcomes for chronic pain, pain relief, and cognitive function.

One of the questions that the researcher asked during this study was regarding the flexibility of both client and therapist, for example, if the client was to contact their therapist would the therapist be able to move a face to face appointment to an online appointment if the client was struggling with mobility issues on the day. All the participants in this study commented that they have found that changing an appointment from face to face to online has not been an issue.

CP 3, p34, line 1175-1177, *“stated that the therapist that they were seeing was always flexible and accessible, he had even swapped they face- to-face meetings for online and even gone as far as offering a cancelation for later on in the day or week to help”*.

The researcher asked *“ if a client booked in for that day rang at 10am, explaining that they were un well to attend at 2pm, if you had capacity online, is that something you could do”?*

QP2, p7, line 225-227, *“ Yeah I do, I think that can work well, so the client doesn't forfeit the session”*.

QP 1, p6 line 191-195, ". *I'm a big believer if I can transfer it and fit them in a different time, I will, and it's within my private practice, nobody can help being ill, if someone is ill I don't charge, and if they have already paid I just roll it over to the next week*"

There was very little evidence throughout this research to suggest that therapists would not move from face- to- face to online sessions or even offer an alternative appointment if that was need to encourage continued engagement, there was also no evidence throughout this research to suggest that people living with chronic pain had poor engagement, they just had differing needs on how their counselling is delivered. There is also little evidence, if any at all to suggest poor engagement in the literature at this current time.

In this chapter the researcher has explored if individuals living with chronic pain have poor engagement with psychotherapeutic services, this research found that there is very little evidence to support the research question of "How might counselling services become more accessible to disabled clients with less judgement and the worry of being excluded from sessions due to ongoing lack of engagement due to Illness?.

The following chapter is the discussion, in this chapter the researcher will reflect on the research that has been carried out, discuss any and limitations within the study, and will finally make recommendations for future research.

Chapter 5

Discussion

In this chapter the researcher will discuss and reflect on the research that has been carried out, including any limitations that may have arisen throughout the research and will make recommendations for future research.

This research aimed to explore “How might counselling services become more accessible to disabled clients with less judgement and the worry of being excluded from sessions due to ongoing lack of engagement due to chronic pain.”

Four themes were identified from the participants interviews, Internalised Negative Evaluation, lack of clinical support, therapeutic relationship, and engagement. The themes showed positive outcomes, and the participants highlighted positive attitudes towards their engagement with psychotherapy sessions, However, the emphasis appeared to be placed on the qualified practitioner to offer alternative arrangements for continued client engagement.

Whilst Norder et al, (2022) stated that internalised negative evaluations such as shame and guilt, has been linked to premature therapy termination. However, Rabinowitz, et al, (2025) stated that clients wanting to prematurely terminate therapy are more likely to cite external factors, such as home life, or work commitments, rather than admitting they are feeling shame or guilt regarding the need to engage with therapy.

There appears to be little evidence that a lack of clinical support directly encourages individuals to engage with psychological therapies, it has been researched by Carrillo, et al, (2025), Virk, et al, (2025) and Baker et al, (2024) that individuals may engage with psychological therapies, as it is generally understood that therapy assists the individual to be heard and not dismissed or disbelieved.

This comes from the understanding of the therapeutic relationship and person centred approach, according to Pasini, et al, (2023) the therapeutic relationship is considered to

be a key moderator in understanding how pain affects the client, how the client can understand and explore traumatic experiences, and difficulties around emotional regulation, and encourage self-pain management.

It was noted that none of the qualified psychotherapist disclosed a direct personal experience of living with chronic pain, there was a general understanding from clients and professionals, and within the literature that there is a level of disbelief in chronic pain conditions.

It would be detrimental to the therapeutic relationship to question a client's self-efficacy and what could be a learnt helplessness on the client's behalf, rather than encouraging boundaries and improvement to self-efficacy, (Ramen, & Sharma, 2022).

The important findings within this research helped the researcher to understand that chronic pain is not a precursor to non-engagement with psychotherapeutic services, in general terms chronic pain does not inhibit the client from engaging it is suggested that the issues in fundamentally less complicated. This research and previous research all have similar correlations around therapy costs, lengthy organisational waiting lists, and ease of access.

It is widely accepted that individuals that require psychotherapeutic counselling, hold an invested interest in engagement, and that if the individual can move between, face-to-face sessions to online as and when needed, then whether or not the client lives with a disability of any kind the flexibility of both client and psychotherapist can form the therapeutic relationship.

The therapeutic relationship is the most important part of psychotherapeutic counselling, this sentiment has been echoed throughout previous literature and this research alike, as previously mentioned, individual's that live with chronic pain and any

other form of disability, regularly mention that being heard, and understood by medical professionals can lead to further frustration and therefore increasing poor mental health, (Nicola, et al, 2021).

Longhurst, & Full, (2023), indicated that disabled people are likely to face significant inequalities when accessing counselling and psychotherapy, it is also suggested that disabled people have the lowest rates for well-being and quality of life, which can lead to higher rates of anxiety and depression. Longhurst & Full, (2023) also stated that counsellors and psychotherapists are making strides in practice adaptations.

This can often lead to individuals withdrawing from society, work industries, and further education. As mentioned in the analysis of this research, a good psychotherapist can be the difference between clients engaging in life or not.

Whilst this research identified positive outcomes, it would be remiss to not acknowledge that there have been some studies that have identified negative outcomes within therapy, Vybiral, et al, (2023) stated that some individual's may have experienced therapist that appear to be dominating or avoidant, the client having a perceived experience of lack of warmth, connection and genuine interested from the therapist. Vybiral, et al, (2023) continued to add that these reported negative experiences may derive from a client's self-deception, own biases and unresolved experiences from previous therapeutic encounters and encounters from medical professionals.

The limitations within this research were that the sample size was modest and one of the original six participant's decided to withdraw from the research, that's not to suggest that this research did not provide an insight toward the lived experience of chronic pain and engagement with psychological therapies, the researcher acknowledges that a larger sample size would have given further insight and I wider perspective, and much like

other research time also plays a contributing factor, for the researcher, and participants. Time was also a considering factor for both the researcher and the participants; there was all a small window in which all participants could allow for the interview process.

Whilst the researcher gained insight into the subject, it is evident that the depth of questions posed to the participants could have been greater. The strengths of this research can be seen from the use of thematic analysis as this is a proven form of data collection for qualitative research, (Paapa, & Ouma, 2025). Along with gathering perspective from both qualified psychotherapists and clients respectively, (Cosmoiu, Papasteri, & Nedelcea, 2025).

A further limitation to this research was the lack of diversity. It is accepted that to formulate a fair overview, it is important to address diversity, (Solomonov, et al, 2025).

All participants within this research were Caucasian women, between 40- 60, all participants were drivers and have access to vehicles. This meant that there was no way of understanding some limitations that disabled clients may face.

All participants are employed, so this in itself narrowed the understanding of financial struggles when needing to access private counselling sessions, whilst it was mentioned during the research that money can be tight, if a client was in receipt of state benefits to engage in private counselling might be near impossible to do.

This would imply that for future research a larger sample size with a more diverse participant panel would give a deeper understanding into the subject matter.

The researcher offers why having a comprehensive overview of diversity is important with research. If this research had a mixed diversity of ethnicity, race, culture and gender, it would have provided a better understanding on how chronic pain effects different ethnic groups, and how they can be assisted to access therapeutic services.

Online working has also made it easier for therapist to work all over the world and therefore interacting with more diversity.

According to Lee, Greenblatt, & Hu, (2021) as of 2017 global diversity has significantly increased, in part to migration. This increase has meant that therapeutic practice has increased by both clients and therapists representing diverse backgrounds, not to mention the increase in cultural backgrounds, including age, gender, religion, disability, and sexual orientation.

Watkinson, Sutton, & Turner, (2021) suggested that there are higher rates of chronic pain conditions in older adults from most minority ethnic groups than that found in white British counterparts, they further add that there are often greater disparities for women than men.

Bull, Young, & Malpus, (2022) acknowledged that there are many health inequalities for individuals from minority backgrounds, they also acknowledge that their lived experience of pain is shaped by the cultural beliefs. A UK survey suggested that individuals that self-identify as Black or Asian are more likely to report chronic pain than that of their white counterparts, minority groups are more likely to experience more disability, depression, and post-traumatic stress disorder, language and health literacy barriers also play a role within pain management and support.

Leach et al, (2023) argue that there is limited evidence to support how many individuals from minority groups live with chronic pain caused by conflicting numbers within studies, they do agree that there is clear evidence of ethnic disparities in treatment and support, and how different cultures engage with not just health services but also counselling services.

It is therefore important that minority groups are given greater consideration in future research.

Lowther-Payne, et al, (2023) stated that despite efforts within UK policy to improve accessibility to counselling services, inequalities to underprivileged communities remain. Sedgwick, (2025) offers that therapy in the UK can be less effective within poorer communities and poorer clients.

Isaacs, (2021) linked “poorer clients” to a matter of unemployment, low social standing, chronic health conditions, inadequate housing, and Limited access to public services. This, therefore, links to the participant demographics within this research, demonstrating that the participant’s were all classed as being in positive financial and social situations, highlighting once again the importance of research obtain input from all levels of society.

In 2025, the BACP stated that much of the literature researching disability and counselling is somewhat out of date, and therefore demonstrating how research into disability and counselling has been left behind. While it is understood that there might be physical barriers to disabled people accessing counselling, assessors within counselling organisations and private practitioners need to acknowledge the less obvious barriers. Do clients use a service dog? Do those with speech impairments or limited communication skills need longer sessions? Do disabled people need to take breaks during sessions?

BACP, (2025) also add that whilst many private practitioners offer concessions for students, and people receiving benefits, does the same apply to disabled people if they require longer sessions? Or is there concern around financial costs of longer sessions?,

furthermore, what do counselling and psychotherapy sessions look like if the disabled client needs a third party to assist them?

This chapter has explored the findings of this research and linked the findings to existing research. The limitations in this research have also been explored along with recommendations for future research. This chapter has also raised as many questions as it answers in regards to future considerations in research. This chapter has also demonstrated the importance of having a strong mixed diversity within research.

The following chapter is the conclusion.

Chapter 6

Conclusion

This chapter will focus on the key elements of this research, including the main findings throughout the research, and where it might sit within academic research in the future.

This research set out to explore “how might counselling services become more accessible to disabled clients with less judgement and the worry of being excluded from sessions due to ongoing lack of engagement due to Illness and chronic pain”?

The researcher found that it was important to set out what chronic pain is, and how it affects an individual and their daily lives. Whilst there is no definitive explanation to why some people live with chronic pain that is not linked to life limiting Illnesses, or physical injury, there have been substantial suggestions from medical professionals and academic researchers around trauma and adverse childhood experiences, (Pasini, et al, 2023).

The literature review informed us that there is a substantial number of people that live with some form of chronic pain, and in varying degrees. One of the main points was that no matter the type of chronic pain or the level of pain, a large portion of individuals struggle with their mental health at some point, and nearly all have the same experience when it comes to being heard by medical professionals, (Fenelon, et al, 2025).

A further key point mentioned throughout the literature was the financial costs of privately funding counselling sessions, and how this can also add to poor mental health, stress and increase pain levels, (Hsu, et al, 2025).

The costs become an issue due to long waiting lists with NHS services or local counselling services that are charity funded, Punton, Dodd, & McNeill, (2022).

There has been much conversation around the cost of private therapeutic services, as Claes et al, (2025) suggested whilst some therapists are taking full advantage of internet-based services, and having little overheads to consider the hour rates for paying

clients has not seen a reduction. The cost of private therapy to underprivileged communities has been explored and that there remains inequality in this area.

There were five participants within this research, three were qualified therapists, and two were client participants. Braun & Clarke's, (2022) Thematic analysis was utilized for this research, and semi structured interviews were conducted, under the guidelines of the BACP and University of Wales Trinity Saint David ethical guidelines.

The data that was collected via these interviews showed no correlation between Chronic pain and chronic illness and poor engagement in psychological therapies, this is suggested to be due to the flexibility of the therapists being able to adapt their working style from face to face, to online as and when needed, which in turn causes the client to remain engaged.

There were four main themes identified from this research, Internalised Negative Evaluation, Lack of Clinical support, Therapeutic relationship, and Engagement. Participants described how feelings of not being heard, not being believed, and perceived judgement heavily impacted their sense of self, and added that the lack of clinical support impacted their mental health negatively.

Participants stated that their level of engagement mostly depended on the therapeutic relationship, however it was noted that the financial cost to therapy also gives substance to engagement or non-engagement. This has been discussed throughout this research and has been noted that all participants within this research were identified as white women within privileged means. As has the effects of being from minority communities and unprivileged backgrounds.

It is acknowledged, that a good therapeutic relationship is an integral part of engagement, and throughout not only this current research but also of previous research that has been conducted.

It is understood that engagement with psychotherapy does not resolve chronic pain and disability for the client, therapy does help with the thoughts, feelings and understanding around chronic pain and therefore can result in positive outcomes.

There is also little in the way of literature evidence to suggest that chronic pain and chronic illness have any bearing on engagement.

In conclusion, chronic pain, and chronic illness have little to do with disengagement of psychological therapies, but much more to do with, feelings of being judged, not being believed, financial costs, and locality.

Whilst costs have an impact client in need of psychological intervention are willing to engage with therapists if the therapists are flexible, empathic and can meet the needs of the client in moment.

The research question asked “how might counselling services become more accessible to disabled clients with less judgement and the worry of being excluded from sessions due to a lack of engagement due to illness”? the answer simply put, is that there needs to be flexibility within therapeutic practice, within both private practice and organisational supplied counselling, the financial aspect needs to be considered and the availability to online services, and a better understanding of how chronic illness effects clients on a daily basis.

As the previous chapter discussed there also needs to be more consideration into how physical barriers are addressed and explored in the future.

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Appendices.

1A- Participant Information Letter.



Participant Information Sheet.

Title of Study: “The pain behind what you see”, The Lived Experience of Chronic Pain and Counselling Engagement.

Researcher: Kirsty Briscoe. Supervisor DR Beverly Cole.

Institution: University of Wales Trinity Saint David. MA Psychotherapeutic practice.

Contacts: Kirsty Briscoe, 1805778@student.uwtsd.ac.uk

DR Beverly Cole, Beverly.cole@uwtsd.ac.uk

You are invited to take part in a research study about your experience of living with chronic pain and engaging with counselling, before you decide please take the time to read the following information carefully, please feel free to ask any questions before making your decision.

Purpose of the study

The aim of the study is to understand how individuals manage their chronic pain and engaging with counselling services, specifically Psychotherapeutic counselling (rather than cognitive behavioural therapy). To understand how engagement with counselling services can be made more easily accessible, and to help counsellors achieve best outcomes and understand the client's needs.

Participant involvement

- One to one interviews, which will last around one hour.
- Your interview will be audio recorded (With your consent) to ensure accuracy.
- You may skip any question you do not wish to answer.
- Taking part in this study is entirely voluntary, you can withdraw from the study at any time without explanation.
- Your name and any identifying details will be removed from all transcripts to ensure confidentiality.
- Findings of the study may be published, however no participants will be identifiable.

Risks and benefits

- **Risks-** some questions may feel personal you can pause or stop the interview at any time, you do not need to return to the interview if you do not wish too.
- **Benefits** – you may find it valuable to reflect on your experiences and be able to have an input to future best practices.

Data Protection.

All data will be stored in accordance with UK GDPR and University of Wales Trinity Saint David policy, which can be found at [www.uwtsd.ac.uk>dataprotection](http://www.uwtsd.ac.uk/dataprotection). And [www.gov.uk>dataprotection](http://www.gov.uk/dataprotection)

Please feel free to ask any questions you may have.

Thank you for your time.

1B- Covering Letter



Covering letter for participants

Date:

Title of Study: “ The pain behind what you see”, The Lived Experience of Chronic Pain and Counselling Engagement.

You are invited to take part in a research study to explore: “ The pain behind what you see”, The Lived Experience of Chronic Pain and Counselling Engagement.

Before you decide whether you wish to participate, it is important that you understand why the research is being undertaken and what it entails. You should therefore read the attached information carefully and discuss it with others if you wish.

This MA research is supervised by DR Beverly Cole [UWTSD] and has been approved by the university’s Research Ethics Committee. The research is also bound by the ethical guidelines of the British Psychological Society and the British Association for Psychology and Counselling and it is hoped that this research will enhance understanding of: How Individuals living with chronic pain engage with counselling services, and how counselling services can be adapted to these individuals.

Taking part in this study is voluntary and the attached information should clarify any questions you may have. If you still have concerns, please feel free to contact me using the contact details given in the information sheet.

Thank you for taking the time to read this information.

1C- Consent form



CONSENT FORM

Research Project: “ The pain behind what you see”, The Lived Experience of Chronic Pain and Counselling Engagement.

Please read this form carefully, initialling each box to indicate agreement as appropriate.

☐ I have read and I understand the information provided about this research, I have a copy of the information sheet for future reference [dated:] and I have no reservations regarding content.

☐ I have had the opportunity to consider the information and ask questions. I have had these answered satisfactorily and I understand that there will be a further opportunity to address any questions at the end of the interview.

☐ I have an email address for the researcher, and contact details of the main project supervisor should I have any concerns.

☐ I understand that if email is the mode of communication, data will be exchanged, stored and retrieved, electronically. MS Teams is a secure platform in which online interviews will take place and are recorded for the benefit of the research to transcribe for analysis and final write up of the research project. I have viewed and understand micro soft Teams policy of data storage and privacy, www.microsoft.com/en-us/privacy/data-collection-teams

☐ I also understand that actual quotations from my contributions may be used to support the research. My involvement in the study will be anonymous and -findings may be the subject of journal articles/conference presentations and/or any other related educational or work. Data collected will be destroyed once the research project is finalised and the degree is awarded.

☐ I understand that I can withdraw from this study at any time up to the designated cut-off point, without giving any reason, if I do so data collected relating to me will be sensitively destroyed and not used in the study.

☐ I consent to participate in a MS Teams/face-to-face interview and to this being recorded.

Signature: _____

Date: _____

Tel Number: _____

Print Name: _____

Email: _____

If you return this form via email, you may be able to sign it electronically. If this is not the case please note that receipt of the Completed form via your email address will be taken as informed consent.

I would like to have sight of the research findings when these are produced Yes/No

1D- Debrief letter



DEBRIEFING

TITLE OF RESEARCH: “ The pain behind what you see”, The Lived Experience of Chronic Pain and Counselling Engagement.

Date: _____

Thank you for participating in this study.

Your time and effort are appreciated.

This research explored the lived experience of chronic pain and engagement with psychotherapeutic counselling, which this research is important in that it will help therapists to understand the difficulties that some clients may be experiencing. To date chronic pain and engagement with counselling specifically talking therapies rather than CBT has been under-researched and under-represented within academic literature and by taking part in this study you have contributed to the growing body of knowledge concerning this important research. You are reminded, however, that you still have the right to withdraw at this point, and that this remains the case until the cut-off point of 30th April 2026.

Should you decide to withdraw you will not have to give any reason and collected data will not be used and will be sensitively destroyed.

You will be aware that this study has received ethics approval from the UWTSD Research Ethics Committee and if you have any questions or concerns about your participation in this study, you can contact the researcher, Kirsty Briscoe by email at 1805778@student.uwtsd.ac.uk, or the research supervisor, Dr Beverly Cole by email at beverly.cole@uwtsd.ac.uk

Although this study did not focus on any issues which would normally invoke emotionally sensitive reflection, sometimes the process of reflecting can prove to be disturbing.

Do you have any questions? Would you like to see a copy of your interview once it has been transcribed,? I refer you to the above cut off point to withdraw after this date submission of this research will take place and therefore cannot be changed after that point. should you feel concerned about any issue which has arisen during this research, you may contact myself the researcher Kirsty Briscoe on 1805778@student.uwtsd.ac.uk or the research supervisor Dr Beverly Cole on Beverly.cole@uwstd.ac.uk

If answering any of these questions led you to feel distressed and if you would like to speak to someone about your thoughts, please see information below on where you can find further help and support. If you would like to learn more about chronic pain you will find some excellent Information on Live well with pain website, and British pain society.

[Home - Live Well with Pain](#)

<https://www.britishpainsociety.org/>

1E- Demographic questions participants



Demographic questions for participants

For research purposes there are a few questions that I would like you to answer. Please return these questions via email to 1805778@student.uwtsd.ac.uk

Which age group are you?

- ☐ 21-30
- ☐ 31-40
- ☐ 41-50
- ☐ 51-60
- ☐ rather not say

Where do you live ?

- ☐ rural
- ☐ town
- ☐ city

What are your transport arrangements ?

- ☐ I am a driver
- ☐ I do not drive
- ☐ I use public transport
- ☐ I require friends or family members to escort me to places

Do you prefer face to face counselling sessions or online counselling ?

- ☐ face to face counselling
- ☐ online counselling

Your answers are confidential and will be sensitively destroyed on submission of the research.

1f- Demographic questions practitioners



Demographics for practitioners

For research purposes can I ask you to complete a few questions and return them to via email to 1805778@student.uwtsd.ac.uk

Age group

- ☐ 21- 30
- ☐ 31-40
- ☐ 41-50
- ☐ 51-60
- ☐ prefer not to say

Do you work?

- ☐ face to face
- ☐ online
- ☐ both

Do you have a preference ?

- ☐ yes
- ☐ no
- ☐ face to face
- ☐ online

Where do you work ?

- ☐ Rural
- ☐ town
- ☐ city

How long have you been in practice ?

1G- Interview questions Participants



INTERVIEW SCHEDULE

Project: Date: _____

Time of interview: Start: _____ Finish: _____

Venue//Mode of
interview: _____

Interview with participant [insert code] recorded on [insert recording ref. no.]

Welcome to the study, you will note that below are the five questions that will be ask to you. Can I please check that you have read the information sheet and read and signed the consent form.

The purpose of this interview is to obtain an understanding of the lived experience of living with chronic pain and engaging in counselling services.

Topic 1: what do you know about Psychological Therapies ? and what do you expect from Psychological Therapies

Topic 2: Engagement with therapy, how do you find engaging with therapy?

Topic 3: what are your experiences of Psychological therapy ?

Topic 4: how important is the therapeutic relationship to you ? what is your understanding of what you need from Psychological therapy ?

Topic 5: what would make your continued engagement with Psychological therapy easier?

Topic 6: We have ten minutes left Is there anything you would like to add? Please use this time to continue until you have discussed your thoughts/feelings as completely as possible

Subsidiary questions for all topics, if necessary: What meaning do you make of this?
Further prompts will be derived, e.g. participant's meaning – concreteness – asking for examples, etc. and more specific follow on questions used as necessary. Thank you for participating, please be reassured that all information you have given will remain confidential.

1H- Interview Questions Practitioners



INTERVIEW SCHEDULE

Project: Date: _____

Time of interview: Start: _____ Finish: _____

Venue//Mode of
interview: _____

Interview with participant [insert code] recorded on [insert recording ref. no.]

Welcome to the study, you will note that below are the five questions that will be ask to you. Can I please check that you have read the information sheet and read and signed the consent form.

The purpose of this interview is to obtain an understanding of the lived experience of living with chronic pain and engaging in counselling services.

Topic 1: what are your expectations of therapy with clients ?

Topic 2: what has been your experience of client engagement with therapy ?

Topic 3: what are your experiences of therapy with chronic pain clients ?

Topic 4: what do you think the therapeutic relationship and understanding of client needs bring in the therapy room ?

Topic 5: what is needed within the therapy world to make continued engagement of clients easier?

Topic 6: We have 10 minutes left Is there anything you would like to add? Please use this time to continue until you have discussed your thoughts/feelings as completely as possible

Subsidiary questions for all topics, if necessary: What meaning do you make of this? Further prompts will be derived, e.g. participant's meaning – concreteness – asking for examples, etc. and more specific follow on questions used as necessary. Thank you for participating, please be reassured that all information you have given will remain confidential.

Check picture in phone for start of conclusion

writing up findings

Simple Introduction to each section of findings
discussion
conclusion

How to write up thematic analysis findings

including research aim/question
explain how many themes you found
on how they are organised
mention if the themes are interrelated or hierarchical

Tell the reader what the themes are in the first paragraph.

emotional struggles Guilt fear depression Grief Anxiety Internalised negative evaluation	Identity Disrupted Identity loss of identity Masking the pain negative capacity on life and identity Therapeutic relationship Safe, heard, validated empathic, flexible
--	--

wellbeing and the therapeutic relationship

poor quality of life
difficulty with day-to-day activities (such as bathing, cooking, making drinks, & walking)
navigating stairs

Themes 1, 2, 3 show how a psychological client living with chronic pain may be presenting in a session
Theme 4 shows what a client is looking for and expecting from a therapist and sessions.

always link it to the literature) core conclusions.

Raw Data-2

Rough .

notes for codes and themes including
Sub themes .

confident in knowledge of therapy .
coping mechanisms - anxiety, panic attacks .

Patience .

cost

not feeling heard . - disappear .

Illnesses stated - Fibromyalgia, MS, knee pain
Shoulder pain leading to back pain)
degenerative spinal disease osteoporosis

medical professionals " They just don't know
what to do with me " disappear .

" not wanting to carry on "

"Sickness overwhelms" guilt as a human
guilt as a parent .

depression

lack of understanding

lack of empathy

} Family - Friends .

never knowing what the next day is going to
bring (uncertainty) .

quality of life

personal care - fatigue

Raw Data - 3

Inconvenience -

Feeling judged
grief for life before

Feeling the need to carry on regardless.
(pressure)

having an escape - pleasure
change in hobbies

to one size fits all.

therapeutic relationship. important.

NHS - poor attitude, no empathy

Safe

Interest

Flexibility - face-to-face to online.

Misbelief

trust

Safe

} therapeutic relationship

Convenience of online

Raw Data - 4

QP.

masking the pain.
differences in life - different people.

Identity - loss
or becoming.

negative capacity on life and identity.

emotions, stability, disregulation, destructive.
isolated

heard, validated.

Seeing the client - meeting the client where
they are that day.

trauma

✱