

# **‘Changed by the Encounter’: The Learning and Change that Counsellors and Psychotherapists Experience as a Result of their Work with Clients**

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to the University of Exeter  
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.....(signature).

Consider Luke Skywalker's task  
in the Star Wars trilogy  
as he struggles with the conflicting urges  
to kill or yield to his father...  
in the climatic scene,  
at the very heart of the Death Star,  
in the belly of the beast,  
he is finally able to cut the Gordian knot,  
not by killing or yielding  
but by fighting his father  
and at the point of victory,  
laying down his weapon  
and refusing to kill him.  
At once he is able to give his own love voice,  
to fulfil his destiny in a quite unexpected way,  
and to become a Jedi knight.  
The transformation is complete.

(Daloz, 1987, p. 147).

This thesis is dedicated to my family, past, present and future.

## **Abstract**

This thesis focuses on the learning and change that counsellors and psychotherapists experience as a consequence of their work with clients. It details two qualitative studies: a constructivist grounded theory study, and a co-operative self-search inquiry (CSSI) that is based on both the heuristic and co-operative inquiry methodologies.

As part of the grounded theory study, I compared the learning and change in two cohorts of participants: a group of therapists who had had one or more significant experiences of working with clients with HIV, and a group that had had no such experiences. Following the theoretical sampling study and literature search, it became clear that no major differences seemed to be evident between the learning and change in both groups of therapists. I therefore constructed a model of general therapist learning and change from the findings of the grounded theory study. This model details the ways in which counsellors and psychotherapists learn and change both personally and professionally as a result of their work with clients. It also refers to the change process, difficult aspects of working as a therapist and other catalysts of learning and change for therapists.

For the CSSI, I studied my own and a co-researcher's learning and change experiences, which were recorded in journals over a period of 9 months. The findings of this study complement those of the grounded theory study by providing further insight into the ways in which learning experiences occur for therapists.

I have linked my findings to some of the literature on education and learning, as well as the literature on transformative learning, and have discussed their implications for practice, training and supervision in counselling and psychotherapy. As part of my reflexive process, and congruent with the theme of learning and change, I have also provided details about the ways in which I have learnt and changed as a result of engaging in my doctoral studies.

## Acknowledgements

As I began to finish writing this thesis, several of my friends either gave birth or started to think about having children. This thesis is my baby, born as a result of a long and sometimes difficult labour. Without the help of the people I acknowledge below, it might never have come into existence.

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Whilst working on this thesis, I have undertaken counselling training, which has been necessary for the co-operative self-search inquiry. I therefore also wish to acknowledge my diploma course trainers, who have been fantastic, and my fellow trainees, who have been great company, because I have learnt so much from all of you. Thank you to my therapists John and Susan, and to all my clients, whom I am privileged to have spent time with.

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## **Publications and presentations based on the thesis**

### **2004**

*Counsellors' transformational learning experiences in HIV and AIDS counselling: The first four interviews.* Paper presented at the Annual School of Education Research Conference, Exeter University, 13<sup>th</sup> May.

### **2005**

*Counsellors' transformational learning experiences in HIV and AIDS counselling.* Paper presented at the Annual School of Education Research Conference, Exeter University, 15<sup>th</sup> May.

*Counsellors' experiences of personal and professional change in HIV and AIDS counselling.* Poster presented at the British Association of Counselling and Psychotherapy Annual Research Conference, Nottingham, 21<sup>st</sup> May.

Comment on David Murphy 'A qualitative study into the experience of mandatory personal therapy during training' CPR, 5, 1, March 2005. *Counselling and Psychotherapy Research*, September 2005. Vol. 5, no. 3, p. 262.

### **2006**

*'Changed by the encounter': The learning and Change that Counsellors and Psychotherapists experience as a result of their client work .* Paper presented at the annual School of Education Research Conference, Exeter University, 13<sup>th</sup> May.

### **2007**

*What two trainees have learnt from their client work: a co-operative self-search inquiry.* Poster accepted for presentation at the British Association of Counselling and Psychotherapy Annual Research Conference, York, 11<sup>th</sup> May.

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## Abbreviation

CSSI: Co-operative self-search inquiry

# Chapter 1: Setting the Scene

‘The bounds of psychotherapy  
make it possible for the analyst  
to travel with the patient  
on a voyage of discovery’

(Schaverien, 2002, p. 34).



# **Introduction**

## **Three lenses**

Brookfield (1995b) refers to four lenses through which teachers can view their teaching: Their student's eyes, their colleagues' experiences, the theoretical literature, and their own autobiographies as teachers and learners. Within this thesis, I examine the learning that counsellors and psychotherapists experience as a result of their client work using three different lenses: The literature, the reflections of 42 qualified counsellors and psychotherapists, and my own and a co-researcher's experiences as trainees. In looking through these three lenses and writing about what I have seen, I have acknowledged that my vision is likely to be coloured by my own past experiences, thoughts, ideas and values. I have therefore also attempted to turn my sight in on itself and write about my relevant past experiences, thoughts, values and ideas, so that they are explicit. I begin by writing about my personal reasons for choosing my topic of study.

## **Rationale**

### **The personal component**

Carl Rogers, who coined the term 'counselling' in the 1930's, when developing his Person-Centred approach (Dryden and Mytton, 1999), wrote:

...the reason I devote myself to research...is to satisfy a need for perceiving order and meaning, a subjective need which exists in me. I have, at times, carried out research for other reasons – to satisfy others, to convince opponents and sceptics, to get ahead professionally, to gain prestige and for other unsavoury reasons. These errors in judgement and activity have only served to convince me more deeply that there is only one sound reason for pursuing scientific activities, and that is to satisfy a need for meaning which is in me (Rogers, 1961, p. 25).

Like Rogers, my previous experiences of research (within the fields of Biology, Counselling and Education) have taught me that in order to maintain enthusiasm I must have a personal interest in the outcomes of any study I set out to complete. Although it can be justified academically (see below) my main reason for choosing the topic of therapist learning and change for this thesis was that I am enormously interested in it.

Whilst studying counselling for the first time several years ago (on a one year full-time MA in Counselling Studies course) I became fascinated by the process of self-development that the course seemed to have catalysed for me. This led to a decision to focus my MA research dissertation on the learning and change that I was experiencing as a result of the course (Turner, 2001). My doctoral thesis reflects my wider interest in counsellors' and psychotherapists' learning and change and sets out to answer some of the questions that remained unanswered after my dissertation had been completed: *How are therapists affected by their clients? What do they learn from them? How are they changed by them?* The answers to these questions are likely to be of interest to counsellors, psychotherapists and researchers other than myself.

### **The academic component**

Part of the title of this thesis, 'changed by the encounter', is taken from the writings of three therapists, who explain that, like their clients, they are often affected by the therapeutic work in which they engage. Etherington (2004d, p. 109, emphasis added) states that, 'As counsellors and psychotherapists we usually accept that we are *changed by the encounters* that we have with our clients: we are impacted upon in their process of change'. Schaverien (2002, p. x, emphasis added) writes:

We are privileged to meet people at transitional times in their lives; they seek help because something is amiss for them. We come to share a little of their life's journey; it is as if our paths run parallel for a while, and so we travel together. Then, inevitably, we part, each of us a little *changed by the encounter*.

And Yalom (1991, p. 13, emphasis added) says:

Therapists have a dual role: they must both observe and participate in the lives of their patients. As observer, one must be sufficiently objective to provide necessary rudimentary guidance to the patient. As participant, one enters into the life of the patient and is affected and sometimes *changed by the encounter*'.

As Rogers (1951, p. 132) puts it, 'In a general way, therapy is a learning process. The client learns new aspects of himself, new ways of relating to others, new ways of behaving'. Clients often enter therapy in order to learn or change in some way, and this may be their main motivation for seeing a counsellor or psychotherapist. Much research work in counselling and psychotherapy has therefore focused on client experiences of therapy, aiming to discover how client change may be best facilitated (McLeod, 1990). Less research has been carried out on therapists' experiences (Daniel and McLeod, 2006). This thesis specifically focuses on the learning and change that therapists experience as a result of their client work: a topic that has been largely neglected in the literature.

Many studies on therapists' experiences have made use of questionnaires with rating scales to gather data on the difficulties that were experienced by counsellors and psychotherapists in sessions with clients, on their perceptions of their performance and on their feelings and confidence levels in sessions (McLeod, 1990). A limited amount of empirical studies on this topic include the use of interviews. These include Miller's (2001) study of the positive and negative effects on counsellors' personal and professional lives of treating torture survivors, and Kottler and Blau's (1989) research on the way in which failure to help a client can act as a learning opportunity for counsellors. In addition, Seibold and Avants (1999) interviewed 10 marriage and family therapist trainees in order to describe how learning from personal therapy was transferred to their work with clients.

In carrying out the studies presented in this thesis, I have made use of interviews and personal experiences recorded in journal extracts. The first study I present compares learning and change in two groups of therapists: a group who have had a significant experience of working with at least one client infected with HIV and a group who have had no such experience. My own interest in HIV and AIDS counselling stems from laboratory research work that I have undertaken on a sexually transmitted virus which is thought to cause cancerous growths in AIDS patients, as well as voluntary work I have been involved in for two HIV and AIDS charities.

In the early 1990's Bor, Miller and Salt (1991, p. 136-137) pointed out that:

AIDS/HIV is currently a major public health concern throughout the world. Its psychological effects are felt by individuals, families, and health care staff. This, together with the nature of the illness – a potentially fatal, incurable, transmissible disease...makes the tasks of the counsellor complex and challenging.

As a result of advances in drug treatments, today, HIV infection is more of a ‘manageable problem’ (Slotten, 2005, p. 1). However, at the outset of my first study, I was interested to know whether working with clients infected with HIV affects the therapist in any unique way.

Some books on HIV and AIDS counselling contain brief mentions of what the authors have learnt from their client work. For example, Green (1989) describes how he learnt not to gloss over areas of difficulty in order to reassure clients. However, no known books or research articles focus specifically on counsellors’ learning experiences in HIV and AIDS counselling. In contrast, several studies on the learning and change that HIV positive people experience as a result of their diagnosis have been carried out (see for example Baumgartner, 2002; and Simoni, Martone and Kerwin, 2002). The first study presented in this thesis was carried out in order to complement and add to these studies by offering parallel insights on the learning and change that counsellors and psychotherapists experience as a result of working with HIV positive clients. A second study was later completed in order to add to the findings of the first.

### **My own ‘stories’**

McLeod (2001, p. 195, original emphasis) points out that in qualitative research, ‘the experience and identity of the researcher *always* influence the ‘findings’ that are produced’. According to Eisner, (1991), the researcher’s relevant preconceptions, prejudices and experiences should therefore be made clear at the outset. Rather than attempting this impossible task within the introduction, I have included details of my experiences, opinions and ideas throughout the thesis, wherever they seem to be of most relevance.

In including my own experiences and related opinions and ideas within my thesis, I have made use of some of the principles of autoethnography. As Baker (2001, p. 395) puts it, 'Through the use of...autobiographical narrative, the researcher...reveals the connections between herself and the topic under study'. As part of the sections on education and learning, and transformative learning within this chapter, I have included short 'stories' about my own experiences. My learning experiences also form part of the findings of my second study (chapter 4), and I have included an account of the ways in which I have learnt and changed as a result of my research in chapter 5.

Since some parts of it are written as personal 'stories', and other parts are written in a more formal, academic style, or a combination of the two styles, my thesis might seem fragmented. However, autoethnographic texts sometimes appear in the form of 'fragmented and layered writing' (Ellis and Bochner, 2000, p. 739), and this idea can be applied to my thesis as a whole. I have deliberately avoided attempting to reduce the jarring between my writing styles, so that this thesis reflects the struggle between my academic (scholarly and distant) and personal (open and vulnerable) selves that has taken place throughout my doctoral studies. My participants' voices are presented in a different font in comparison to the rest of the text, so that they stand out. My personal voice is presented in a different font again, so that it stands out from both the participant's voices, and my academic or academic/personal voice that is presented in the rest of the text.

### **A reflexive odyssey**

Reflexivity, and my use of it within this thesis, is discussed in more detail in chapter two (pages 95-103). Attard describes his research as a 'reflective odyssey':

Similarly to Homer's Odyssey, I never know where my next step will be...I rarely have proof that I am going in the right direction...and it seems to be a never-ending feat in search of my final goal (Attard and Armar, 2005, p. 197).

Similarly, this thesis may be seen as the story of my reflexive odyssey. I did not know what my journey would be like at the beginning of my doctoral studies, or even that it would be a reflexive one, involving so much of my own past and present experience.

Like Attard, as documented in my research journal (see appendix J), I did not always feel assured that I was moving in the ‘right’ direction.

My journey has not ended with the writing of this thesis. I will no doubt continue to learn (experientially and intellectually) about the learning and change that therapists experience as a result of their client work, as long as I remain working within the counselling and psychotherapy arena. It is likely that the other people who have contributed to this thesis will also continue to learn and change. As Lynne, one of the therapists whom I have interviewed, has put it, ‘Every session is different with every client and I never stop learning.’ My research findings, and the pieces of reflexive writing that are included in this thesis are therefore a collection of ‘stories and speculations without endings’ (West, 1996, p. xi).

### **Reflections on my experiences of therapy and relationships**

My doctoral studies have had a profound effect on my way of thinking about counselling and psychotherapy, and about myself and relationships. Undoubtedly, my way of thinking about counselling and psychotherapy, myself and relationships has also had an effect on the study. For these reasons, I have included a brief account of my entry into the therapy arena and a very brief mention of my experience of the relationships that have affected me.

Gilbert, Hughes and Dryden (1989, p. 4) suggest that ‘many are drawn to therapy as a career because of their own personal difficulties’. I am no exception. My first experience of therapy, as a teenager, addressed the eating disorder from which I was then suffering. I later linked this to my relationships with my parents, but at the time I did not know why I was starving myself. The counselling I was given, however, inspired me to study the subject later, for an MA degree.

Gilbert, Hughes and Dryden (*op. cit*, p. 5) point out that

If one studies at an institution where the only philosophy to mental life is, for example, behaviourist or psychoanalytic, then it is not surprising if this becomes the dominant orientation for the therapist to adopt.

There are several different schools of thought within the counselling and therapy arena (as discussed in more detail later in this chapter). My MA was a humanistic and largely person-centred course, and as Gilbert, Hughes and Dryden (1989) suggest, I have come to adopt this theoretical orientation as part of my own personal philosophy. This has undoubtedly had an effect on the research presented here.

This thesis focuses on the learning and change that may occur through relationships. Other than my sometimes difficult relationship with my parents, and the relationships I have formed as a client with therapists, I have experienced a variety of romantic relationships, work relationships and friendships in my lifetime. Throughout my doctoral studies I have had a small but strong network of friendships, a solid romantic relationship and good relationships with family members. I have formed relationships with two different therapists and several different clients. In addition, in working part-time with adults with learning difficulties and disabilities I have learnt a great deal about forming relationships, including the importance of non-verbal communication, mutual respect, flexibility and creativity in my interactions.

### **My initial expectations**

Phillips and Pugh (2000, p. 17) point out that ‘All...work of an experimental or exploratory nature starts with some expectation about the outcome.’ Although the research presented in this thesis was carried out primarily because I was personally interested in knowing the findings, as Phillips and Pugh (2000) suggest, at the outset, I had an idea about what those findings might be.

I wrote in my research journal:

What do I expect the outcomes of the research to be? That there will be some similarities and some differences in learning and change between the two groups [of therapists]. Since HIV is strongly associated with both death and sexuality, I imagine that the counsellors [and psychotherapists] working with HIV positive clients will have had to face those issues and become, perhaps, more accepting of both... I imagine all therapists, especially the very experienced ones, to have become more confident, approachable and comfortable in their own skin. These ideas are at least partially based on my own experiences of personal therapy and interactions with experienced counsellor/trainers on my MA course. (Turner, research journal, 2004-2007, entry 1).

My expectations about the outcomes of my studies may have influenced those outcomes, and this is discussed in more detail in chapter 5.

### The thesis

As shown in figure 1 (below) the two research studies presented here have been divided into three ‘phases’: The first part of a grounded theory study, in which I interviewed 39 counsellors and psychotherapists, is the first phase. I have made use of the data gathered to produce a model of therapist leaning and change. I then carried out a theoretical sampling study (with four participants) and an in-depth literature review, as part of phase two, which completed the grounded theory study and allowed me to refine the model. I believe that the model will be of use to potential counselling and psychotherapy trainees, as well as trainers and supervisors.

Phases one and two address a gap in the literature on the learning and change that therapists experience as a result of their client work, and in particular, therapists’ learning experiences in HIV and AIDS counselling. The third phase of my research, a ‘co-operative self-search inquiry’ (CSSI) has given rise to an experiential, and a more in-depth and longitudinal understanding of the topic of therapists’ learning and change.

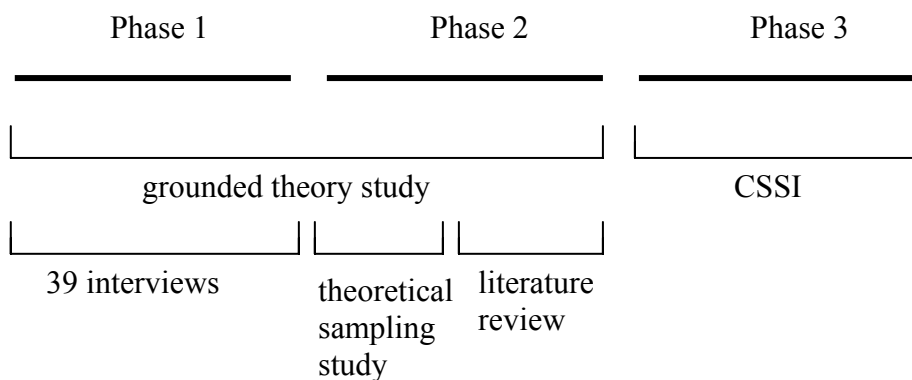


Figure 1: The three phases of my research



My thesis is divided into five chapters. In order to provide a context for the three phases of research, chapter one provides background information about adult education and learning, transformative learning, counselling and psychotherapy, HIV, HIV counselling, and the importance of self-development and personal growth for therapists. The aims of the research and associated research questions are detailed at the end of the chapter.

As noted above, for the first study, I made use of a grounded theory methodology. In a grounded theory report, a literature review on the subject studied follows the presentation of the emergent theory, and is only carried out after the theory has been formulated (McLeod, 2001). Therapist learning and change is therefore not discussed in chapter one, and a literature review of this topic is instead included later in the thesis (in chapter 3).

Furthermore, no single methodology chapter is present in my thesis. Instead, for convenience, I have discussed methodological issues relevant to each of the two studies before presenting the findings of each study. The first part of chapter two therefore provides a scene-setting description of relevant aspects of qualitative research and the interpretive paradigm. This is followed by an account of constructivist grounded theory, including details of the way in which I used and adapted this methodology. Interviewing and the interview procedure that was used in the first study are then discussed; and relevant ethical issues and my use of reflexivity are also detailed. In the second part of chapter two, the findings of the first phase of my grounded theory study are described, and an initial theory of therapist learning and change is presented in the form of a 'flower model'.

Like chapter two, chapter three is split into two parts. In first part, the findings of the phase two theoretical sampling study are presented, while the second part provides a literature review on the subject of therapist learning and change. Chapter four describes the co-operative self-study methodology that was used in carrying out my second study, as well as specific ethical issues related to that study. The findings are then presented.

Finally, the thesis is concluded in chapter five and connections between my research and relevant literature on education and learning, and transformative learning are made. My contributions to research methodology and to the literature are detailed, and implications for practice, supervision and training are discussed.

The limitations of my studies and recommendations for future research are also outlined. I finish chapter 5 by considering the impact that the research has had on me.

I have found that using 'he or she' or 'her or his' is cumbersome and gives rise to unappealing sentences. 'He' or 'she' and 'her' or 'his' have therefore often been used singularly in reference to people in general. I have avoided consistently referring to only one sex and have instead often used these words interchangeably.

## **A Context for Transformative Learning Theory**

This thesis is concerned with a particular area of learning and change in a specific group of adults: the learning and change that counsellors and psychotherapists experience as a result of their work with clients. I have made use of transformative learning theory as a theoretical framework for my research. In order to provide a wider context in which my research can also be viewed, I have included a short discussion of some other relevant aspects of education and learning, below. What follows is not intended to be a comprehensive literature review of the field of education and learning; instead, the following discussion focuses on the variety of meanings associated with terms like 'learning', 'education' and 'knowledge', and introduces the topics of adult education and learning, experiential learning, reflecting-in-practice and tacit knowledge, all of which are of importance to this thesis. Some of the ideas presented here are later referred to within the literature review I have included as part of my grounded theory study (chapter 3), and also within my connections and conclusions chapter (chapter 5).

### **Adult education and learning**

Miller (1964) and Knapper and Cropley (1991) discuss the differences between the education of adults and children. Miller (1964) notes, for example, that in contrast to children, adults enter education with a great deal of personal previous experiences which may both enrich and distort their learning. Knapper and Cropley (1991) add that adults have more clearly developed personal learning goals than children.

However, these generalisations ignore differences of culture, class, personality, ethnicity, learning styles and gender between different adults (Brookfield, 1995a). Some adults may not have much life experience, whilst some children may have had a great many diverse life experiences which could impact on their learning. Moreover, some adults may have more poorly developed personal learning goals than some children. As Hughes and Graham (1990, p. 8) write: ‘When adults engage in education, it is often assumed that they have a high level of maturity in directing their own learning. This may not always be the case...’

Differences between the education of adults and children may more accurately be linked to provision than learner maturity, life experience and self-direction. In contrast to the education of children in schools, which is based on a national curriculum, adult education can be adapted to the needs of a particular community, and may not require a long-term commitment. And tutors and learners may form a relationship ‘based on equality and mutual respect’ (Gidley, 1996, p. 17) that is, perhaps, less likely to be formed between child learners and their teachers.

### **Definitions**

Cranton (1994, p. 3) notes that ‘the phenomenon of adult learning is complex and difficult to capture in any one definition’. Many writers claim that adult learning is practical in nature, yet not all adult learners are interested in learning practically. Humanist thinkers suggest that it is participatory or collaborative, yet not all adult learners may want to participate or collaborate (*ibid.*). What is more, educators often suggest that adult learning involves sharing experiences, and Rogers (1961) suggests that teachers may use their own experience as a resource in the classroom. However, there is little evidence that adults learn through shared experience (Cranton, 1994).

Cranton (1994) has put forward a three-part typology of adult learning consisting of ‘subject-oriented adult learning’, ‘consumer-oriented adult learning’ and ‘emancipatory learning’. The first, subject-orientated adult learning, refers to ‘the acquisition of content, whether that is facts, concepts, problem-solving strategies, or technical or practical skills’ (*op. cit.*, p. 10). Within this mode of learning, an educator covers a certain amount of material so that learners may gain particular knowledge or skills.

Consumer-oriented learning is, in contrast, self-directed. Here, the learner decides when she needs to learn and actively seeks to fulfil that need, continually making decisions about what she wants. In contrast to subject-orientated adult learning, the pace of the learning here is more or less determined by the learner. This type of learning may be emotionally and cognitively demanding, and it may also have a profound impact on the learner: Rogers (1961, p. 276, original emphasis) writes, '*I have come to feel that the only learning which significantly influences behaviour is self-discovered, self-appropriated learning.*'

Emancipatory learning, according to Cranton (1994, p. 16), involves 'freeing ourselves from forces that limit our options and our control over our lives'. This may occur independently of the educator, or it may be deliberately facilitated. It can be a difficult and painful process: 'Emancipatory learning...is probably the most complex and difficult experience from the learner's point of view and the most challenging for the educator' (*op. cit.*, p. 21).

Cranton (1996) writes in some detail about subject-oriented, consumer-oriented and emancipatory learning, focusing on each one of these types of adult learning separately. She notes that at times, the distinction between consumer- and subject-orientated learning can seem to blur, but fails to detail any other potential blurring of boundaries between her three types of adult learning. Yet it is conceivable that subject- and consumer-orientated learning might both also, in some circumstances, be emancipatory. Furthermore, in some circumstances, all three types of learning may occur as part of a single learning experience.

Cranton (1996, p. 18) also notes that unlike the other types, 'emancipatory learning is a difficult and often painful process'. Elsewhere, though, she suggests that consumer-oriented learning 'is an emotionally...taxing process' (*op. cit.*, p. 14). I suggest that in some circumstances, subject-oriented learning may also be both highly demanding and distressing.

In contrast to Cranton (1996), Illeris (2004) provides a single definition of adult learning, which is perhaps more useful for the purposes of my research. He suggests that adult learning is the way in which adults make permanent changes in their emotional, social, rational and bodily capacities. These changes can take place with or without formal adult education.

## The nature of learning and knowledge

In a keynote speech on supervision at a counselling conference, Carroll (2005) noted that ‘People are incredible learners...[and] learning is essential’. Carroll (*ibid.*) made no attempt to define ‘learning’, though, perhaps assuming that his audience shared his understanding of the term. Yet ‘learning’ and the associated word ‘knowledge’ have been defined in various different ways. According to the *Oxford Dictionary and Thesaurus III*, for example, ‘learning’ is synonymous with ‘education’, and can be defined as ‘knowledge got by study’ (Elliott *et al.*, 2001, p. 428). ‘Knowledge’, in turn, is defined as: ‘1 awareness, familiarity. 2 person’s range of information, understanding (of subject). 3 information. 4 sum of what is known’ (*op. cit.*, p. 419).

These definitions seem to be biased towards taught or self-taught, explicit learning, which leads to intellectual knowledge; and other types of learning and knowledge are not overtly referred to. Knowledge is viewed in terms of an amount of information known and learning is seen as the process by which knowledge is acquired. In contrast, Polyani (1969, p. 132, emphasis added) views *knowledge* as a process: ‘Knowledge is an activity which would be better described as a *process* of knowing...[it is] ever on the move...towards a deeper understanding of what is already known’. Moreover, he stresses the importance of the body in this process:

Our body is the ultimate instrument of all our eternal knowledge, whether intellectual or practical. In all our waking moments we are *relying* on our awareness of contacts of our body with things outside for *attending* to these things (Polyani, 1966, p. 15, original emphasis).

Unlike the *Oxford Dictionary and Thesaurus II*, Polyani (1966) goes on to conceptualise learning in terms of making use of knowledge. He argues that, for example, ‘mathematical theory can be learned *only* by practicing its application: its true knowledge lies in our ability to use it’ (*op. cit.*, p. 15, emphasis added).

Heron (1992, p. 223) provides a more comprehensive definition of learning than the *Oxford Dictionary and Thesaurus III*, and this acknowledges the existence of experiential learning and non-intellectual knowledge:

In ordinary usage, 'learning' refers to the acquisition of knowledge or skills from experience, study or teaching...[and] it supposes understanding and retention: we have learnt something if we understand it or understand how to do it (in the case of a skill) and can retain that understanding for some significant period of time.

Here, Heron (1992) acknowledges that learning may involve being taught. He points out, however, that in his view, 'learning is necessarily self-directed: no one else can do it for you' (*op. cit*, p. 223).

### **Types of learning and knowledge**

Learning may be either formal or informal. Heron (1992, p. 227) notes that:

Formal learning...as I define it, is what occurs when an individual goes to classes to acquire knowledge and skills for work or leisure in some quite specific subject area, such as astronomy, a language, accountancy, or whatever.

Jeffs and Smith (1996, p. 12) add that 'Informal education is based around conversation, formal education around curriculum'. Informal learning occurs in or outside of a classroom context and is not necessarily subject specific. It may occur as a result of an experience or the provision of information, and it can take place with or without the conscious awareness of the learner (Jeffs and Smilt, 1996; Knapper and Copley, 1991). Both Jeffs and Smith (1996) and Knapper and Copley (1991), however, suggest that in reality, formal and informal learning are not two separate domains, and instead, they represent two areas of a continuum.

Daloz (1987, p.2) points out that even when not engaged in formal adult education 'we continually grow and change', and this may be because 'adult education, adult teaching, [and] adult learning happens everywhere' (McConnell-Imbriotis, (2004, p. 1). As part of this process, after leaving formal education settings, people continue to learn in daily life situations.

We are all adult learners. Most of us have learnt a good deal more out of school than in it. We have learned from our families, our work, our friends. We have learned from problems resolved and tasks achieved but also from mistakes confronted and illusions unmasked. Intentionally or not, we have learnt from the dilemmas our lives hand us daily. Some of what we have learnt is trivial; some has changed our lives forever (Daloz, 1987, p.1).

Both informal and formal learning may include the learning of skills as well as facts. In line with this, Scheffler (1965) distinguishes between two types of knowledge: propositional knowledge (or '*knowing that*', *op. cit.*, p. 91, original emphasis) and procedural knowledge (or '*knowing how to*', *op. cit.*, p. 92, original emphasis). Heron (1992) goes further, describing four types of learning and knowledge: Practical (procedural), presentational, propositional, and experiential. Practical leaning is gaining knowledge of how to do something by practicing a particular skill and presentational learning involves intuition, imagination and/or perception. Propositional learning involves gaining knowledge intellectually, whereas learning experientially involves participation.

These four types of learning may all involve emotion, and Heron (1992, p. 229) adds that 'The importance of emotionality in learning is fundamental'. In line with this Boud, Cohen and Walker (1993) note that although distinctions are made between cognitive (cerebral), affective (emotional) and conative (action-based) learning, learning is actually a holistic process, and 'all learning involves feelings and emotions' (Boud, Cohen and Walker, 1993, p. 13). Heron (1992, p. 229) also claims that 'People learn more effectively when they are enjoying themselves and what they are doing'. This may be true in a classroom situation, but I suggest that powerful learning may also occur in counselling or psychotherapy when a difficult experience is encountered and feelings such as anger, frustration, shame, embarrassment and sadness arise.

The focus of this thesis is on the learning that counsellors and psychotherapists experience as a result of their client work, and this learning may or may not involve the difficult emotions listed above. This learning could be practical (therapists might improve their counselling skills through working with clients and reflecting on their work), presentational (therapists may learn from intuitive insights in sessions), or propositional (therapists could gain intellectual knowledge as a result of communicating with a client).

It may be argued, however, that since the catalyst for this learning is engagement with clients, it is most likely to be experiential. Here, ‘experience is never *of* something or someone else but always an experience *with* the other’ (Hunt, 2007, original emphasis).

### ***Learning from experience***

Titus (1946, p. 126, emphasis added) argues that:

Education is the continuous *reconstruction of experience*; it is not the transmission of a body of beliefs. The growth of the person is the important thing. Education is the process of *sharing experiences* in associated living.

This definition of education is comparable with Kolb’s (1984) notion of experiential learning, which he describes as a continuous process in which knowledge is created through the transformation of experience. It involves holistic transactions between the learner and his environment, so that he can adapt better to that environment. As Jeffs and Smith (1996, p. 39) put it, ‘The process begins with a person carrying out an action and then seeing the effect of the action on and in the situation’. In fact, ‘we spend most of our time learning from experience’ (Boud, Cohen and Walker, 1993, p. 1), and it is ‘meaningless to talk about learning in isolation from experience’ (*op. cit.*, p. 8).

While we commonly assume that teaching leads to learning, it is the experiences which teaching helps create that prompt learning, not primarily the acts of the teacher’ (Boud, Cohen and Walker, 1993, p. 9).

Furthermore, Boud, Cohen and Walker (1993) propose that an experience does not have to be recent for learning to take place: Meanings may take years to become apparent, and learning from an experience can grow over time.

Learning that arises as a result of experience may occur as part of a taught course, for example, through role-play sessions in a counselling course or work experience as part of a vocational course (Sutherland, 1998). And it may also occur outside of a formal learning environment.



In addition, Usher (1993, p. 169) usefully distinguishes between ‘learning from experience’ which is an activity that occurs in a formal or informal learning environment, and ‘experiential learning’ which is a discourse or a body of knowledge about learning from experience.

‘Experience’, as a concept, is, however, problematic (Boud, Cohen and Walker, 1993). The *Oxford Dictionary and Thesaurus III* notes that it is both a noun and a verb. As a noun it may be a ‘personal observation or contact...knowledge or skill based on this,...[or an] event that affects one’ (Elliott *et al.*, 2001, p. 262). As a verb, it involves undergoing or feeling something (*ibid.*).

The *Oxford Dictionary and Thesaurus III* recognises that learning (the outcome of which may be knowledge or a skill) may occur as a result of experience. However, its author seems to have conceptualised ‘experience’ as an event that simply happens to a person: A person observes, comes into contact with, is affected by, undergoes or feels something. In contrast, Boud, Cohen and Walker (1993) argue that judgement is contained within experience, and it is not simply isolated sensing (or ‘direct experience’). It is not a passive undergoing of something, as the *Oxford Dictionary and Thesaurus III* suggests, it is, instead, an active engagement with the environment. Each experience and each learning experience is therefore unique to an individual: ‘When different learners are involved in the same event, their experience of it will vary’ (Boud, Cohen and Walker, 1993, p. 11).

Boud, Cohen and Walker (*op. cit.*, p. 7) suggest that each experience is ‘multifaceted...and...inextricably connected with other experiences’. The variation in experiences between learners is connected, at least in part, with the way the learner views herself, and with her levels of confidence and self-esteem (Boud, Cohen and Walker, 1993). Yet confidence and self-esteem may also arise as a *result* of a learning experience: ‘Developing confidence and building self-esteem both flow from, and are necessary for, learning from experience’ (*op. cit.*, pp. 15-16).

Boud, Cohen and Walker (1993) do not mention the ways in which experience and the learning that arises from it may reduce an individual's confidence and diminish her self-esteem, yet it seems likely that this may also occur. However, Brew (1993, p. 87) notes that experience can lead to unlearning: 'the process of learning from experience can destroy previous learning'. I suggest that this could involve a subsequent decrease in confidence.

The process of unlearning that Brew (1993) describes may occur for a counselling or psychotherapy client. It involves the whole self of a person and may even change their conception of past experiences. It is both destructive, in that old ways of knowing are lost, and constructive, in that new frameworks are formed to replace those that are no longer useful.

Variations in different learners' experience of the same event may be attributed to the different social and cultural environments in which they live, as well as differences in their confidence and self-esteem levels:

While learners construct their own experience, they do so in the context of a particular social setting and range of cultural values; learners do not exist independently of their environment (Boud, Cohen and Walker, 1993, p. 13).

Interestingly, Boud, Cohen and Walker (1993) go on to suggest that while teachers create environments in which learners may experience and learn from their experience, the teacher may also learn in this environment. In agreement, Andresen (1993, p. 63) writes: 'When I cease learning more each time I teach, I am in danger of tiring of teaching itself'. In creating environments in which their clients can experience a certain type of relationship, and learn from this experience, counsellors and psychotherapists might also learn and change.

### ***Reflecting-in-practice***

Schon's (1995) book, *The Reflective Practitioner* is concerned with the experiential and practical learning that occurs when professionals engage in their work. He notes that the model of 'Technical Rationality' assumes that professional knowledge (based on scientific theory) is applied in practice in order to solve problems. In this way, it is presumed that a doctor applies her knowledge of medicine, learnt in medical school, in treating sick patients; and, similarly, a counsellor or psychotherapist applies his theoretical knowledge, learnt during training, in his work with clients. 'Theory and practice come together when a person's intentional attitudes determine the way he acts upon the world', notes Chisholm (1988, p. 53). Yet, as Schon (1995) points out, this model of technical rationality is incomplete because it does not account for the practical competence of professionals in situations in which previously learnt knowledge cannot be applied usefully.

'[T]he workday life of the professional depends on tacit knowing-in-action', Schon (1995, p. 49) says, even when research-based theories and techniques are used. Here, the know-how is *in* the practitioner's actions, and these actions expose 'a "knowing more than we [practitioners] can say"' (*op. cit*, p. 51). This somewhat hidden knowledge, then, may not be expressible in words by practitioners, and it is instead expressed through action.

Furthermore, practitioners can think about what they do as they do it, and in this way, their tacit 'knowing-in-action' can be critiqued. This process, which Schon (1995) has called 'reflecting-in-action' or 'reflecting-in-practice', tends to occur in uncertain professional situations, in what Schon (*ibid.*) refers to as the swampy lowlands of practice. The process may not be rapid - 'reflection-in-action may proceed in a leisurely fashion over the course of several months' (*op. cit*, p. 62) – but eventually it may lead to a new understanding of the work and a new way of practicing.

'An experienced practitioner learns all the time, and is open to being wrong', writes Bolton (2005, p. 275). Yet this statement does not account for those practitioners who may be closed to change. Furthermore, a novice practitioner may learn all the time and be open to working differently. I suggest that Bolton (2005) might have more accurately written 'A practitioner who reflects-in-practice is open to being wrong, and as a result she learns all the time'.

Schon (1995) devotes a chapter of his book to reflection-in-action in psychotherapy. Although it is of limited value to this thesis, as it focuses on supervision rather than client work, within the first few pages of this chapter, it is noted that:

[T]herapists, who are in other respects very different from one another must still frame the problem of the particular patient [or client], construct and test interpretations of his behaviour, and design interventions aimed at helping him (*op. cit.*, p. 108).

To do these things, Schon (1995, p. 130) argues that therapists reflect-in-practice on their tacit knowing-in-action: ‘It is the art of these practitioners that...seems to me to be, in considerable measure, a kind of reflection-in-action’. And during this reflection-in-action, further tacit knowledge may be produced.

### ***Tacit knowledge and implicit learning***

Michael Polanyi has made a profound contribution to the philosophy of science and social science with his work on tacit knowledge (Smith, 2003). He defined tacit knowledge as the ‘capacity of ours to know more than we can tell’ (Polanyi, 1969, p. 133). Although he makes only a very brief mention of Polanyi’s work in his book *The Reflective Practitioner*, Schon (1995, p. 51) seems to make use of the concept of tacit knowledge in writing about the work of practitioners:

Although we sometimes think before acting, it is also true that in much of the spontaneous behaviour of skilful practice we reveal a kind of knowing which does not stem from a prior intellectual operation...skilful action often reveals a “knowing more than we can say”.

In the *Oxford Dictionary and Thesaurus III* (Elliott *et al.*, 2001, p.784) the word ‘tacit’ is defined as ‘implicit, implied, silent, undeclared, understood, unexpressed, unsaid, unvoiced’. Tacit knowledge may therefore be seen as unexpressed or hidden knowledge. It is knowledge that we have, but which we do not know about. As Polanyi (1969, p. 135) says, ‘we are aware of far more particulars, and relations between particulars, than we could specify’.

Sternberg and Horvath (1999) note that tacit knowledge cannot be taught, but it can be learned or acquired, if relevant opportunities are provided. Polanyi (1966) believes that it is best illustrated with the example of a skill: We may know how to ride a bicycle or to swim, but this does not mean that we are able to say how we do these things. However, Barbiero (2004) stresses that tacit knowledge is not just found in skills - it also exists in language competence, for example. Much of our knowledge of other people is tacit, yet this knowledge forms the basis of our daily interactions with others. It is, however, likely to be distorted (Eraut, 2000).

Our encounters with others' behaviour, in which our tacit knowledge of them is formed, is unlikely to represent their behaviour as a whole, and our presence will also affect this behaviour. Our preconceptions, created during our initial encounter with others will affect their and our behaviour in later encounters, so that tacit knowledge is not built from a series of genuinely independent encounters. What is more, our previous life experiences will affect our understandings of other people when we first meet them.

Whilst tacit knowledge can be viewed as the (somewhat distorted) outcome, then, implicit learning may be seen as the process. It has been suggested that learning may either be explicit or implicit: Explicit learning occurs as a result of conscious effort and explicit knowledge may be produced as a result. Implicit learning, however, may be defined as the gaining of knowledge that takes place without any conscious attempts to learn and usually without any explicit knowledge being produced (Reber, 1995).

Both humans and animals can learn implicitly, and according to Reber (*ibid.*), implicit learning is an important and evolutionarily necessary process, vital for the adaptive behaviour of all complex organisms. Eraut (2000) adds another category between implicit and explicit learning: reactive learning. Although the learner is aware that learning is occurring here, this learning is unplanned, and often requires further reflection before explicit knowledge is produced.

Eraut (2000, p. 118) notes that although implicit learning is usually associated with tacit knowledge, ‘implicit learning may eventually lead to explicit knowledge’. And the opposite may also occur: ‘explicit learning can lead to tacit knowledge’ (*ibid.*). An example of the latter is a person who may be able to describe how they learned to ride a bike, but who cannot explain important aspects of the knowledge gained, such as their ability to respond rapidly to changes in the bike’s balance (Eraut, 2000). My teaching and learning experiences have involved both implicit and explicit learning, as described below.

### **My teaching and learning experiences to date**

Etherington (2004b, p. 46) notes that ‘reflexivity requires researchers to...[be] aware of what influences our relationship to our topic...’ In an attempt to engage reflexively with the topic of learning in general, I have included a brief account of some my own learning and teaching experiences so far, below. This account was written in order to shed light on the ways in which my experiences have affected my views about learning, and how these views might have impacted on the way in which this thesis has been written.

I can’t seem to be able to recall much of what I have formally learnt over the years. What I do remember in terms of the knowledge I gained as a child at school seems to be linked to the way in which I connected it to myself and my own experiences. It also seems to be linked to emotion: In primary school, for example, during a period of ‘carpet time’ I remember the teacher talking about the weather associated with different months of the year. When the teacher told the class that February was a cold, windy and rainy month, I remember feeling quite upset: My birthday is in February after all!

In secondary school, I remember becoming fascinated with the material I learnt in my sociology lessons, and I compared what I learnt to my own situation and the situations of those around me. I can recall very little of what I learnt in terms of content in those lessons, but I have a very vivid memory of sitting at my desk, at the end of one class, wondering why the material we had just learnt had not seemed to have an impact on my classmates in the way that it had had an impact on me.

In retrospect, I can also see that I learnt informally during my time at school. The first informal learning experience I can remember took place in primary school, probably during my first few school years. My class teacher was standing up with her back to the class, talking to another adult. In the time in which my classmates and I waited for the teacher to finish talking and begin teaching again, I found something on the floor. It seemed very important at the time to tell the teacher about it straight away.

I walked up to the teacher and called out her name. She didn’t turn around. It was noisy in the classroom, so I reasoned that she obviously hadn’t heard me. I tried again, but she still didn’t

respond. As I stood looking up to her, she seemed very tall. How could I make her notice me? I remember grabbing hold of her dress and tugging it, then, after gaining no response, giving up and sitting back down. After finishing her conversation, I remember that the teacher addressed the class, asking us who had tugged her dress so rudely during her important conversation. I was too scared to own up - the teacher looked angry. But that day, I may well have learnt not to disturb an adult in school when they are talking to another adult.

After leaving school, I spent five years studying Biology. What I remember in terms of the content of my undergraduate degree seems to be linked to my surroundings, including the people with whom I shared my time with: I remember the experiments and projects I worked on in terms of where I sat, who sat next to me and who worked with me. My memories of the two postgraduate years I spent working in a research laboratory are also firmly linked to the people around me, and these are also linked to strong emotion. [Some of my experiences of this time are discussed further at the end of the section on transformative learning within this chapter].

Next, I spent a year studying for an MA in Counselling Studies, then spent a year travelling and working abroad, before embarking on teacher training. I learnt a great deal doing all of these things, and much of which I remember is linked to the people around me, and strong emotion. Yet this learning seems to be very difficult to put into words. What I can put into words is that I learnt more about myself, more about what is important to me, and more about others. And I learnt to be more independent, but also to value relationships.

For the past few years, whilst studying for my doctoral studies, I have spent a few hours a week tutoring adults with learning difficulties. In the classroom, I am a facilitator rather than a teacher, and I am very much a learner as well as a facilitator. I believe that I learn *with* the adults I tutor, and *through* the relationships we form together. I have learnt to adopt a very flexible, responsive approach to teaching, and to adapt to the needs and interests of the learners.

Finally, I have no doubt learnt both formally and informally, explicitly and implicitly during the time I have devoted to this thesis and the preceding MSc in Educational Research that I have undertaken. I expect to continue to learn, in a variety of ways, throughout my life.

## **Transformative Learning**

The theoretical framework that I have used for the research presented in this thesis is transformative learning theory. One of the aims of my research is to determine whether

the theory of transformative learning can be usefully applied to the learning and change that counsellors and psychotherapists experience as a result of their client work. A literature review on transformative learning is therefore included here in order to provide a suitable background for the conclusions reached.

Many social science studies are catalysed by the researcher's personal observations or experiences (Etherington, 2004a). Jack Mezirow's (1975) study of women who returned to college after a long period of time away is no exception. In the early 1970's, Mezirow's wife Edee decided to go back to college:

Interested as I was in attempting to understand both her and adult learning, I found her dramatically transformative experience, which led to a new career and life-style, both fascinating and enlightening. Her experience influenced my decision to undertake an ambitious national study of women returning to college... (Mezirow, 1991a, p. xvii).

Mezirow's (1975) study gave rise to his theory of perspective transformation (Mezirow, 1978), a theory which has stimulated a great deal of discussion within the field of adult education (Taylor, 1997). This theory has been heavily criticised and, as a result, Mezirow's ideas about perspective transformation have gradually widened. This is reflected in his later use of the terms 'transformation theory' and 'transformative learning', as well as 'perspective transformation'. While other academics (including Bennetts, 2003b; Pohland and Bova, 2000; and Merriam, 2004) also use the term 'transformational learning', Mezirow himself appears to prefer not to do so.

As Tokiwa-Fuse (2000) observes, although 'perspective transformation' and 'transformational learning' are commonly used terms, and although many empirical studies have focused on them, they are still not fully understood. Further empirical work is needed (Taylor, 1997), and at present, transformative learning theory should be viewed as 'an evolving theory of adult learning' (Mezirow, 1996, p.162). It is a theory that is currently 'in the process of development' (Mezirow 2004, p.70).

### **Defining transformative learning**

Within the worlds of academia and adult education, there is little agreement about what transformative learning actually is. Mezirow (1994, p. 222) is aware of this, and admits that: 'Perhaps transformation theory seems to generate so many divergent interpretations



because I have been unclear in what I have published...’ This may well be true. Newman (1994, p. 236) confesses that he found Mezirow’s 1981 article ‘hard going’ at first. In my experience, most of Mezirow’s early writing (1975, 1978, 1991a, 1991b, 1992) is difficult to read, and his use of different terms in different papers to describe the same thing is particularly unhelpful. Cranton’s (1994) account of Mezirow’s early work is, in contrast, lucid, well-structured and highly understandable.

In agreement with Tennant (1994), I believe that Mezirow’s 1994 account of transformation theory (written in response to a critique from Tennant) is much more clear than his preceding work. In my opinion, Mezirow is generally clearer in his responses to critics than in his original writings. But despite this, even his later writing has been misread: For example, Taylor (1997, p. 34 and 2001, p. 220) twice quotes Mezirow’s definition of transformative learning as ‘the social process of construing and appropriating a new or revised interpretation of the meaning of one’s experience as a guide to action’. This is, in fact, Mezirow’s (1994) definition of learning. Although the title of his 1994 paper is ‘Understanding Transformation Theory’, Mezirow does not give an explicit definition of transformative learning here.

Kegan (2000) notes that ‘transformative learning’ has been used to refer to any kind of change. Genuine transformative learning, he argues, refers to a change in a person’s way of thinking – an epistemological change - rather than just a change in behaviour or an increase in confidence or knowledge. Mezirow’s (2000, p. 7-8) definition of transformative learning reflects this idea:

Transformative learning refers to the process by which we transform our taken-for-granted...mind sets...to make them more inclusive, discriminating, open, emotionally capable of change, and reflective so that they may generate beliefs and opinions that will prove more true or justified to guide action.

In contrast, Kasl and Elias (2000, p. 233, *italic added for emphasis*), who note that learning can be a group experience as well as an individual one, provide a more inclusive definition of transformative learning:

Transformative learning is the expansion of consciousness in any human system, thus the collective as well as individual. This expanded consciousness is

characterised by new frames of reference [‘meaning structures’ or perceptions we filter our experiences through], points of view [‘meaning schemes’ or specific perceptions], *or* habits of mind [‘meaning perspectives’ or more general perceptions]...

### **Mezirow’s early ideas on perspective transformation**

Mezirow’s 1981 paper summarises his early ideas on perspective transformation. In it, he outlines Jurgen Habermas’s three domains of learning and notes that the third, emancipatory domain, which ‘involves an interest in self-knowledge...[and] the way one sees oneself, one’s roles and social expectations’ (Mezirow, 1981, p. 5) is synonymous with his idea of perspective transformation. He explains that the idea of perspective transformation:

...was inductively derived from a national study of women participating in college re-entry programmes. Through extensive interviews, it became apparent that movement through the existential challenges of adulthood involves a process of negotiating an irregular succession of transformations in ‘meaning perspective’ (Mezirow, 1981, p. 6).

Making meaning is dependent on our ‘meaning structures’ (which Mezirow also calls ‘frames of reference’). These consist of ‘meaning perspectives’ and ‘meaning schemes’ (Mezirow, 1981). Taylor (1994a, p.158) defines meaning perspectives as ‘expectations framed within cultural assumptions and presuppositions [which] directly influence the meaning an individual derives from her experience’.

Meaning perspectives are broad sets of predispositions which fall into one of three categories: ‘Sociolinguistic codes’ (for example, “I should work hard and earn a lot of money”), ‘psychological codes’ (such as “I should not get angry”) and ‘epistemic codes’ (like “I focus on the whole rather than parts of something”).

In contrast, meaning schemes are particular expressions of meaning perspectives. They are views on particular topics, such as abortion, the Catholic religion or black people, which are formed by a combination of beliefs, judgements, feelings and ideas (Mezirow, 1994a).

In his writing, Mezirow gives few examples of meaning perspectives and schemes. In addition, I am not aware of any examples which illustrate the way in which the two are linked. For this reason, I have devised my own example: A meaning scheme associated with the meaning perspective “everyone should be treated equally” that an ethical therapist might have is “black clients should be treated in the same way as white clients”.

Mezirow (1981) suggests that meaning perspectives, which are dependent on our past experiences, shape the way we think, feel, act in and view the world. These are brought into being through language. But since language is an imperfect and socially constructed means of communication, experiences are often distorted so that meaning perspectives involve cultural stereotypes (which Mezirow refers to as ‘categories’), ideologies and norms:

As we mature, we attempt to improve our ability to anticipate reality by the development of categoric or stereotyped systems for sorting out our perceptions...Experience strengthens the personal category system...but what we actually experience is the category, which is evoked by a particular stimulus, rather than the occurrence in the real world. We construct a model of the world with our system of categories, come to expect certain relationships and behaviours to occur and then experience our categories (Mezirow, 1981, pp. 14-15).

Mezirow’s (1981) explains that the psychological, sociolinguistic and epistemic codes mentioned above include unresolved childhood dilemmas as well as uncritically internalised cultural assumptions. However, his (1981, p. 10) example of an internalised cultural assumption (“One can feel strongly about her conviction that “A woman’s place is in the home””) is perhaps somewhat outdated in the Western world today.

According to Mezirow (1981), perspective transformation involves becoming aware that our distorted meaning structures restrict our view of the world:

[Perspective transformation is] the emancipatory process of becoming critically aware of how and why the structure of psycho-cultural assumptions has come to constrain the way we see ourselves and our relationships, reconstituting this structure to permit a more inclusive and discriminating integration of experience and acting upon these new understandings (*op. cit*, p. 6).

From his 1975 research study on women who re-entered college after a long period of time away from academic work, Mezirow developed a 10 stage model of perspective transformation: (1) A catalysing crisis (which he refers to as a ‘disorienting dilemma’), (2) self-reflection, (3) a critical assessment of one’s role assumptions and a rejection of traditional social expectations, (4) the recognition that the problem is reflected in others, (5) an exploration of alternative ways of being, (6) building competence and confidence in a new role, (7) planning a course of action, (8) acquiring the knowledge and skills necessary for the course of action, (9) initial trials of the new role, and (10) re-entering society with a new role and perspective (Mezirow, 1981).

Mezirow (2000) has slightly altered the order of these changes, and has also added an extra one, without giving any explanation for doing this. He notes that the steps can arise as either a sudden insight into the psycho-cultural assumptions that have distorted a person’s self-understanding and their awareness of their relationships with others; or a series of smaller transitions. He suggests that the latter is perhaps more commonly experienced (Mezirow, 1981).

Mezirow’s theory of perspective transformation relies heavily on the role of critical reflection in the transformation process. His model of critical reflectivity, a simplified version of which is shown overleaf (figure 2), suggests that there are seven stages of reflectivity.

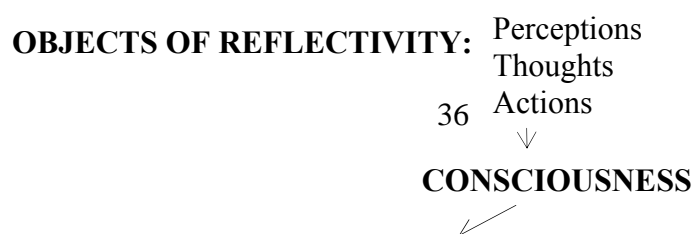


Figure 2: The seven stages of reflectivity in perspective transformation  
(adapted from Mezirow, 1981).

### **Critical reflection**

Mezirow devotes a whole paper, as well as a book chapter to the discussion of critical reflection (Mezirow 1998, 1991a). Reflection, he writes,

...can mean many things: simple awareness of an object,...letting one's thoughts wander over something, taking something into consideration, or imagining alternatives. One can reflect on one's self reflecting. Reflection does not necessarily imply making an assessment of what is being reflected upon, a distinction that differentiates it from critical reflection (Mezirow 1998, p. 186).

Critical reflection can lead to changes in meaning structures. Perspective transformation, Mezirow (1994a) notes, can occur as a result of critical reflection leading to a sudden change in a meaning perspective (a process catalysed by a disorienting dilemma). Alternatively, the accumulation of changes in a set of related meaning schemes may give rise to perspective transformation, a process which, according to Mezirow (1994a) is also dependent on critical reflection.

Mezirow (1991a, 1994a) identifies three types of critical reflection: content, process and premise reflection. Critically reflecting on the content and process of our problems can lead to changes in meaning schemes, whilst reflecting on the premise of our problems will lead to changes in meaning perspectives (Mezirow, 1991a, 1994a). Mezirow provides two somewhat confusing and unhelpful examples of this idea, in which the questions of whether someone called 'Joe' is telling the truth about his age (Mezirow 1991a) and of who is the best in a fictitious class (Mezirow 1994a) are addressed. In keeping with the example of a meaning scheme and related meaning perspective associated with black people provided earlier, I will therefore offer my own example.

Reflecting on the content of the problem of whether or not he should treat black and white people equally, a therapist might think about the ways in which black and white people he knows are similar. In reflecting on the process of the problem, he might ask himself if he has good enough evidence to make a fair judgement – are the people he knows a representative sample of all black and white people? In reflecting on the premise of the problem, however, the therapist might ask himself why similarity between black and white people is important in his decision of whether or not to treat them equally. Perhaps people should be treated equally even if they are different.

Premise reflection (which Mezirow (1998) also calls 'critical reflection of assumptions') can occur as a result of the way in which an individual responds to a disorienting dilemma (Mezirow 1998). It can also be promoted by adult educators through rational discourse, a dialogue in which the 'comprehensibility, truth, appropriateness (in relation to norms), or

authenticity (in relation to feelings)' of an assertion about something is critically analysed (Mezirow 1991a, p. 77). However, when rational discourse is not possible (as in the case of issues such as abortion) Mezirow (1991b) suggests that we must turn to established forms of authority, like religion and science, and agree to differ with others who hold dissimilar views.

When it is possible, rational discourse allows us to judge the validity of our own interpretations and beliefs, as well as those of others (Mezirow, 1996). Mezirow (1994a) argues that the most significant learning for adults involves reflecting on premises about one's self. Piper (2004) adds to the discussion by pointing out that there are two types of self-reflection – a detail which Mezirow ignores: A monological interpretation of self-reflection involves gaining a single, 'objective' view of the self. In contrast, a dialogical view of self-reflection recognises the existence of multiple selves, multiple roles and multiple narratives. Different selves can engage in dialogue with each other, leading to multiple perspectives of the self.

Mezirow's empirical study of women who returned to college after a long period away focused on the way women in college re-entry programmes in the 1970's reflected on themselves and their social roles (Mezirow, 1975). However, the (1978) theory that this study led to has been heavily criticised for its overemphasis on the role of critical reflection and poor representation of other factors involved in perspective transformation (Taylor, 1997). This oversight may be due to the fact that Mezirow's theory of perspective transformation was based on only one empirical study.

Merriam (2004) notes that if perspective transformation really is dependent on critical reflection and rational discourse, it could be argued that 'to be able to engage in the process in the first place requires a certain level of development, and in particular, cognitive development' (Merriam, 2004, p. 61). She points out that in several models of cognitive development, only those people at the highest stages are able to critically reflect on assumptions.

In addition, Merriam (2004) argues that to be able to take part in rational discourse, a learner must have the capacity to think dialectically, analyse a range of perspectives and withhold judgement. But as Belenky and Stanton (2000, p. 73) point out:

Most adults simply have not developed their capacities for articulating and criticising the underlying assumptions of their own thinking, nor do they analyse the thinking of others in these ways. Furthermore, many have not had experience with the kinds of reflective discourse that Mezirow prescribes...[They may] come from cultural communities that do not stress the kinds of values and activities associated with rational discourse.

I suggest that some counsellors and psychotherapists might come from such backgrounds, yet they could experience transformative learning. Merriam (2004, p. 66) reasons that ‘we intuitively know that adults need not be at the pinnacle of some model of cognitive development to experience transformational learning’ and cites examples of empirical studies which show that some people can transform without being consciously aware of the process. She concludes that further studies should address the question of whether critical reflection and rational discourse are necessary for transformative learning.

One of the studies cited by Merriam (2004) is Taylor’s (1993) PhD study on ‘intercultural competency’ (a perspective which allows a person to cope with the demands of living in a different country). This study reveals that critical reflection is neither sufficient nor necessary for transformational learning. Taylor interviewed 12 people whom he believed to have become interculturally competent and found that only a few of these used critical reflection in their transformation process. Most participants used ‘thoughtful action’, a process in which taken for granted assumptions are not consciously questioned: ‘...by the very act of taking on and practicing new habits, meaning structures may become altered outside the participants’ focal awareness’ (Taylor 1994, p. 171).

## **The development of Mezirow’s early ideas**

### **The factors involved in transformative learning**

Taylor (1997) admits that in contrast to his own study, some studies show that critical reflection is a significant component in the process of transformational learning. However,



in his review of 39 empirical studies on transformative learning (*ibid.*), he presents a large amount of evidence which supports the idea that other factors are also of great importance: ‘In essence, it became clear through a review of these studies that Mezirow’s model was not inclusive of all the essential aspects inherent in the process of a perspective transformation’ (*op. cit.*, p. 44).

In a paper which reviews research from the fields of neuroscience and psychology showing that we cannot reason properly without emotions, Taylor (2001, p. 231, emphasis added) argues that ‘...rationality promoted through critical reflection is *one* means of *several* to promote change in perspectives’. Coffman (1991) and Sveinunggaard (1993) have also both found that people must first work through their emotions before they can begin to critically reflect on their lives. Mezirow’s model of critical reflectivity (see figure 2) includes an affective reflectivity stage, where awareness of feelings associated with one’s perceptions, thoughts, behaviour and habits is necessary for critical reflectivity. However, Taylor (1997) argues that Mezirow downplays the role of emotion in transformational learning.

Several studies have shown that as well as emotion, the unconscious, intuition, spiritual (or extra-rational) influences, and relationships are significant in transformational learning (Taylor, 1997) – factors which Mezirow’s early writings largely ignore but which are important in the fields of counselling and psychotherapy. If one or more of these factors is present, even in the absence of critical reflection, transformational learning can occur (*ibid.*).

In agreement with Taylor (1997), Belenky and Stanton (2000) point out that Mezirow’s transformative learning theory focuses on ‘separate knowing’ (an approach which values objectivity, reasoning and looking for flaws in an argument). However, ‘connected’ and ‘constructivist’ ways of knowing (which value relating well and empathising with others, as well as learning from intuition and feelings) are equally as important.

I suggest that ‘connected’ and ‘constructivist’ ways of knowing are perhaps more important than ‘separate knowing’ for therapists.

Bennett’s (2003b) study of 197 individuals (‘Fellows’) who had been awarded small amounts of money in order to support them in changing their lives in some way, further

supports Taylor's view that emotions, relationships and 'other ways of knowing' are important factors in transformational learning. She writes:

...although it can be said that [my] study supports Mezirow's theory...it is not the whole story. Fellows portrayed a series of emotional...highs and lows aided by supportive relationships, hard work, determination and risk-taking, coupled with an instinctive knowledge that they were on the right path (Bennetts, 2003b, p. 474).

With regard to relationships, Taylor (1997, p. 49) observes that:

Relationships are referred to indirectly by Mezirow (1995)...However, he overlooks the more subjective elements of relationships (trust, friendship, support) and their impact on transformational learning.

In his 1997a paper, Mezirow also refers, briefly and indirectly, to the importance of relationships in transformational learning:

Transformative learning is rooted in the way human beings communicate and is a common [shared] learning experience not exclusively concerned with...personal transformations" (Mezirow, 1997a, pp. 9-10).

In the same article, Mezirow (1997a) also refers, indirectly, to the role of the unconscious in transformational learning. He notes that 'habits of mind' (meaning perspectives) are more durable and less accessible to awareness than 'points of view' (meaning schemes). This suggests that changing a meaning perspective might necessitate gaining access to unconscious material.

However, in his early writings, Mezirow makes no mention at all of spirituality. In contrast, spirituality in transformative learning is discussed in two chapters of the recently published book 'Expanding the Boundaries of Transformative Learning' (O'Sullivan, Morrell and O'Connor, 2002). Miller (2002, p. 97) notes that 'there may be links between learning and the brain, but learning and development also have a mysterious and

spontaneous element'. Sefa Dei (2002) adds that we gain answers to some questions through our intuition. Learning from a spiritual perspective involves our intellectual, physical, emotional and spiritual selves, as well as unlearning and letting go of some perceptions, habits and ideas. When we learn to see life from a spiritual perspective, we become aware of our interconnectedness, and this is transformative in that it leads to a different world-view (Miller 2002).

Sefa Dei (2002, p. 123) confirms the importance of positive relationships in this process:

Spirituality and spiritual discourses broach ideas and ontologies that emphasize connectedness, belongingness, identifications, well-being, love, compassion, peaceful co-existence with nature and among groups.

Other authors point to different factors which may be important in transformational learning, but which are not mentioned by Mezirow (1978) or Taylor (1997). Grabove (1997, p. 90), for example, mentions creativity: '...imagining alternative ways of thinking and living entails a deliberate break with rational modes of thought and leaps in creativity'.

However, as Wiessner (2004) points out, critics of Mezirow's theory often focus on his initial work, ignoring more recent developments. It is therefore important to stress that Mezirow seems to have taken the criticisms of others into consideration. He refers to the role of relationships, unconscious processes, imagination, intuition, emotion and dreams in meaning making in a more recently published book (Mezirow, 2000). And while Brookfield (2000) argues that critical reflection is necessary but not sufficient for transformative learning, Mezirow has gone one step further: 'Learning, including transformative learning...may or may not involve deliberate thought or critical reflection' (Mezirow and associates 2000, p. xiv).

### **Other aspects of transformative learning**

As well as his exaggeration of the role of critical reflection and minimization of other factors involved in perspective transformation, other aspects of Mezirow's original work have been criticised. Taylor (1997) notes that although Mezirow (1981) presented his 10 stage model of perspective transformation as linear, some studies have found the process to

be ‘more recursive, evolving and spiralling in nature’ (Taylor, 1997, p. 44). Mezirow himself admits in a later publication that the course of perspective transformation does not always follow his sequence exactly (Mezirow, 1995).

In addition, Mezirow’s (1981) definition of a disorientating dilemma (the first stage in his model) has been criticised for being too narrow. Clark (1993) has found that ‘integrating circumstances’, as well as disorientating dilemmas can trigger transformational learning. He defines these as:

...indefinite periods in which the person consciously or unconsciously searches for something which is missing in their life; when they find this missing piece, the transformation process is catalysed” (Clark, 1993, p. 79).

Additionally, Scott (1991) has identified *two* types of dilemma that are necessary for change in a person’s assumptions: an external event that leads to an internal difficulty and an internal awareness that previous ways of coping are no longer useful. And Lange (2004) has shown that ‘restorative learning’ is just as important as a disorienting dilemma: After experiencing a crisis, individuals find stability in reconnecting with personal ethics that had been previously masked by dominant cultural norms and values. They lean on these rediscovered parts of themselves, and this allows them to withstand the upheaval and disturbance of the transformation process.

Taylor (1997) goes on to argue that not all disorientating dilemmas lead to transformational learning:

Mezirow’s description of a disorientating dilemma has been criticised as being decontextualised, as though all life crises would lead to perspective transformation. As we know, this is not the case. Whether a disorientating dilemma results in a perspective transformation can possibly be explained to a large extent by the immediate and historical context surrounding the crisis (*op. cit*, p. 46).

With regard to context, Daloz (2000) suggests that a person’s historical, cultural and social contexts seem to determine whether transformation will occur. These include an individual’s personal and professional situation, their family background and social history, their past experiences (including previous stressful life events), and their personal goals (Taylor, 1997). Yet Mezirow’s (1975) research on women who re-entered college

after a long time away - the research which led to his theory of transformational learning - does not seem to take the contexts of each of these women into account (Taylor 1997).

Clark and Wilson (1991) also contend that Mezirow's original theory does not take cultural context into account. However, Mezirow (1991b) reminds them that meaning perspectives are culturally assimilated. In addition, altering meaning perspectives through rational discourse involves others (who embody our culture) and this is therefore a social process. Mezirow (1991b) acknowledges that his 1975 study included mainly white, middle class women, but suggests that this does not affect the validity of his theory.

Tennant (1993) argues that although Mezirow makes reference to the social dimension of adult learning, he overemphasises personal transformation. Therefore, although Clark and Wilson's (1991) particular critique is flawed, the general criticism that Mezirow's original theory largely overlooks the social dimension still stands. Social forces, Tennant (1993) points out, shape theory as well as individuals. Mezirow (1991a) makes reference to the developmental theories of Piaget and others, but ignores the fact that growth and progress are historically and socially defined. In reply to Tennant (1993) Mezirow (1994a, p. 232) thanks him and other critics for allowing him to 'engage in discourse by which I [may] clarify some of the obscurities, implicit assumptions and incomplete ideas in my earlier writings'.

In a later paper Mezirow (1997) responds to Michael Newman's (1994) criticism that transformation theory ignores the oppressors in society that prevent transformations from occurring, as well as the importance of social action. Mezirow (1997) argues that when a disorienting dilemma results from oppression an individual must face their oppressor in order to transform. If it is appropriate, this may involve social action.

Newman (1994) suggests that it is important to focus on and understand the oppressor ('the Enemy'), as well as the transforming individual, but as Mezirow (1997) points out it is often difficult to work out who 'the Enemy' is. He adds: 'And Michael, what if we encounter the Enemy and find that they are us?' (*op. cit*, p. 62).

## An alternative model of transformative learning

In contrast to Mezirow's (1981) 10 stage model, Cranton's (1992) model of transformational learning includes reference to context and relationships. However, it ignores the role of unconscious processes, emotion, spirituality, and creative and intuitive processes. An adapted version of Cranton's model, which takes all of these into account is therefore shown below (figure 3).

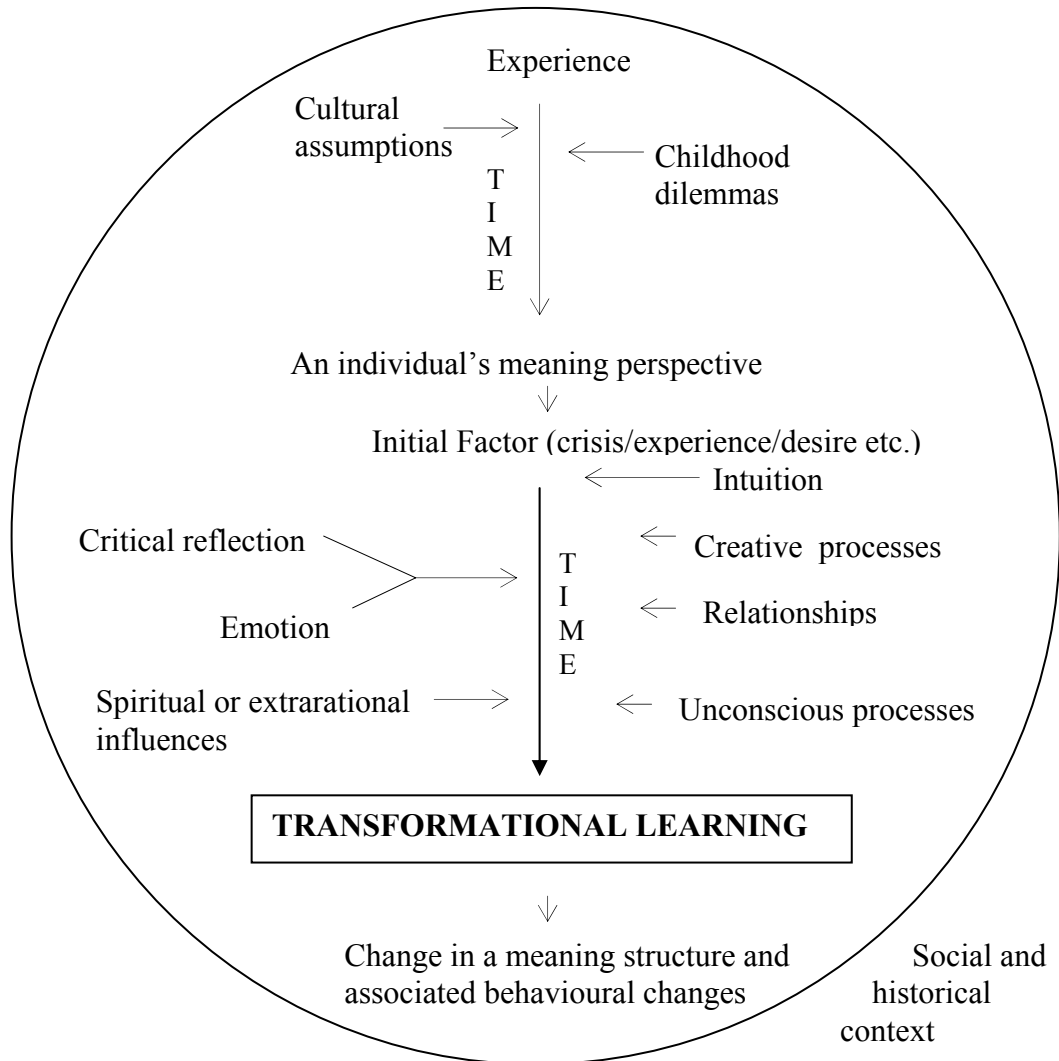


Figure 3: A new model of transformative learning (adapted from Cranton, 1992).

## Transformative learning in children and adolescents

Mezirow (1981) notes that the psychologist John Broughton has gathered evidence which suggests that only adults are capable of his seventh stage of reflectivity: theoretical reflectivity. Since he believes that theoretical reflectivity is necessary for perspective transformation, Mezirow (1981, p. 13) claims that perspective transformation is a

‘uniquely adult learning function’. He also suggests that the facilitation of perspective transformation requires unique educational approaches. Since counsellors and psychotherapists might work with child and adolescent clients, this idea may be of relevance to any future research work that aims to discover whether ideas about transformative learning might usefully be applied to the learning and change that child and adolescent clients experience as a result of their work with therapists.

However, E. Taylor (2000) notes that little research supports Mezirow’s (1981) claim that perspective transformation is an exclusively adult process. Cunningham (1992) argues that children may, in some situations, learn to become as critically reflective as adults. I suggest that one such situation may be the experience of counselling or play therapy. Furthermore, Allsup’s (2003) study suggests that children can also transform without critical reflection. Allsup (2003, p. 11) writes about her experience of promoting transformational learning in children with the use of music:

[A group of ] ‘learning disabled’...students suggested that they create an in-class talent show...LaToya, a withdrawn and overweight girl, who rarely participated in class, volunteered to act as MC. With all eyes on her, and a microphone in her hand, we watched LaToya...turn into a star. It was as if a completely new person transmogrified before us.

Several studies suggest that teenagers, as well as adults, are capable of transformation. Whalley’s (1995) study, for example, found that 17-19 year old students who took part in a student exchange programme experienced a change in their meaning schemes. Additionally, in their five year study of 50 young people in their final year of compulsory schooling, Bloomer and Hodgkinson (1997, 1999, and 2000, cited in Bloomer, 2001, p. 429) ‘witnessed transformations in their lives, including transformations in their dispositions to learning...’ Bloomer, (2001, p. 433) adds that ‘many [of the students] displayed significant changes in their values, attitudes and interests’.

Mezirow (2000) admits that adolescents might be able to transform, but argues that transformational learning is much more likely to occur in adults.

Despite this, Kegan (2000. p.48) advises that, ‘...the concept of transformational learning...needs to be broadened to include the whole life span; transformational learning

is not the province of adulthood or adult education alone'. If this happens, I suggest that some of the methods of facilitating transformative learning, including those outlined by Mezirow (1981, 1990) may have to be adapted for use with children and adolescents.

## **Facilitating transformative learning**

One of my research questions focuses on the implications of my findings for improved practice, training and supervision within the fields of counselling and psychotherapy. Ideas about the facilitation of transformative learning may be applicable here, and for this reason, I have discussed them below.

Mezirow's (1991a) book chapter on 'fostering transformative learning' focuses on the ways in which adult educators can help their learners become more critically reflective, by encouraging them to engage in rational discourse. He lists twelve ways in which educators can promote transformative learning, (for example, 'Foster a self-corrective, reflexive approach to learning...' (Mezirow, 1991a, p. 200), but as Cranton (1994) points out, he does not detail specific strategies for implementing his ideas within classroom and other contexts. However, this may be because specific techniques to facilitate critical reflection are detailed elsewhere (Mezirow and Associates, 1990) - a fact which Cranton (1994) chooses not to mention.

Pohland and Bova (2000, p. 148) argue that 'to foster transformational learning, much time, intensity of experience...and personal exploration are needed'. In addition, K. Taylor (2000) notes that transformative learning is not easy to promote – teaching facts is easier than teaching learners how to think differently. She suggests that educators should design their courses with the potential for transformative learning in mind, and like Taylor (1997), she advocates the use of experiential exercises. Dirx (2000) adds that stories, myths, poetry, art, performing arts and music can be used to evoke emotions and encourage learners to become aware of and give voice to their unconscious processes. In contrast to Mezirow (1990), Cranton (2000) recommends that adult educators should use a range of strategies to foster transformative learning, catering for a variety of learner types:



What we need to keep in mind are people's psychological predispositions and their importance in the way individuals react to various learning experiences. If all activities we use focus on logical, analytical thinking, a good proportion of our students will not be touched by our efforts.

Approaches Cranton (2000) advocates using to facilitate transformative learning include case studies, debates, and critical questioning (for students who enjoy thinking) and groupwork, field trips, simulations, role-plays, games and metaphors (for those who prefer to work with emotions and intuition). It is interesting to note that many of these approaches are used in counselling and psychotherapy training courses.

Good working relationships are also valued highly on such courses. As well as the use of both cognitive and non-cognitive approaches, Taylor (2001) points out that 'the practice of fostering transformative learning includes...the building of trusting relationships' (Taylor, 2001, p. 233). These relationships should be egalitarian, so that learners are given the opportunity to discuss, and if necessary, to make changes in their learning environments (Puigvert and Soler, 2001).

In agreement with Taylor (2001), Gravett (2004) has found that supportive relationships and environments are essential in the process of transformative learning. These can help to reinforce new perspectives and strengthen learner confidence and competence. Bennetts (2003a) writes, '...fundamental to the concept of self is also the concept of 'other', and our relationship with those with whom we interact. It is often within this interaction that learning occurs'. Robertson (1996, p. 42) also highlights the importance of promoting transformative learning within the context of a 'teacher-learner relationship'. However, he notes that adult educators receive little training and support for this.

Helping relationships are complicated and may involve challenges pertaining to confidentiality, transference, counter-transference, sexual attraction and burnout amongst other things. Unfortunately, these issues are largely confined to the fields of the talking therapies, and are barely mentioned within the adult education literature (Robertson, 1996). Since teacher-learner relationships are important in transformative learning, Robertson (1996) recommends that a teacher-learner-centred perspective should replace the purely learner-centred perspective that currently exists within the field of adult education. In line with this idea, Kroth and Boverie (2000), who suggest that a person's life mission (life or

work purpose) is either reinforced or changed as a result of transformative learning, argue that adult educators must make a connection between their work and life mission in order to facilitate transformative learning. They must be passionate about their work.

Robertson (1996) notes that little research work has focused on the experiences of the facilitator in the transformative learning process. Yet even Mezirow alludes to the fact that this process may impact on the educator as well as the learner:

We professional adult educators have a commitment to help learners...to acquire meaning perspectives that are more inclusive, integrative, discriminating, and open to alternative points of view. By doing this we may help others, *and perhaps ourselves*, move toward a fuller and more dependable understanding of the meaning of our *mutual experience* (Mezirow, 1991a, p. 224, italics added for emphasis).

Clients might undergo transformation as a result of seeing a counsellor or psychotherapist (Feltman, 1995). In addition, counselling students are expected to undergo personal change as a result of their studies (Mearns, 1997). Less is known about the experiences of qualified counsellors in terms of transformation. This thesis therefore focuses on the relational impact that clients have on their counsellors.

### **The possible negative effects of promoting transformative learning**

Cranton's (1994) book was written in order to fulfil 'a need...for...guidelines and strategies for working toward transformative learning' (Cranton, 1994, p. xii), and it focuses primarily on promoting critical reflection. In the years that have passed since her book was written other academics have published their own strategies of fostering critical reflection (see, for example, Daley, 1997). In publishing these ideas, many authors have, perhaps, assumed that transformative learning is potentially beneficial to all mainstream adult learners. I am aware of no article that has focused on the negative impacts of this process, yet negative impacts might well occur.

McLeod, (1993, p. 211) points out that the 'intense self-exploration and change' that counselling trainees undergo can have detrimental effects on their relationships with their partners and family members. The changes that adult learners experience as a result of transformative learning could have similar effects.

## **My own experience of transformative learning**

Towards the beginning of my doctoral studies, after reading two of Mezirow's papers (Mezirow, 1981 and 1994a), I wrote about my own experience of what I believed to be transformative learning. I have included what I wrote below, to shed light on my own opinions, ideas, and experiences with regard to this topic.

As a very shy and rather naive A' Level student, I decided to apply to study biology at university so that I could go on to work in medical research and indirectly help people without actually having to talk to anyone. So I left home, moved to London, and studied biology for the next five years. During that time, I learnt to think like a scientist, to work like a scientist, and to communicate like a scientist. I learnt to solve problems logically, to think rationally, to work methodically. I surrounded myself with scientists. And science became a way of life.

Then, about half way through a PhD in virology, I had what Mezirow refers to as a disorienting dilemma: A crisis which led to a change in my career path, and eventually, to studying for this PhD. I noticed how political and competitive medical research could be. My first supervisor asked me to stop communicating with my second supervisor, as the second supervisor's wife, who worked for a competing group, had started to work on one of the first supervisor's pet topics.

As a result, I was cut off from my main source of practical support, and was forced to rely on my first supervisor's postdoctoral workers for help. One of the postdoctoral workers took over one of my experiments and claimed the results for himself. Another asked me to help him to clone a gene, which I did, but he gave me no help in return. I meekly approached my first supervisor and told him about my problems, but found him to be utterly disinterested. Soon afterwards, during the process of writing my first year report, I came to realise that the project I was working on, initiated by a postdoctoral worker who had since left the laboratory, was flawed in its design. Knowing that the project could not lead to a successful PhD, feeling extremely unsupported and no longer enjoying my work I decided to give up the PhD and write up my results as work in progress, for an M.Phil.

Mezirow (1981) suggests that perspective transformations often occur as a series of ten steps, catalysed by a disorienting dilemma. I experienced some, but not all of these during the transformation I underwent after giving up my first PhD. I experienced a period of "self-examination with feelings of fear, anger, guilt or shame" (Mezirow's step two) during which I decided that I was no longer interested in a career in science.

Although no conscious "critical assessment of assumptions" (Mezirow's step 3) occurred, in retrospect, I am aware that my assumptions have changed significantly since giving up the PhD. My world-view has also changed (I no longer see myself as a 'scientist') and I have come to rely more on my feelings and intuition, and less on rational thought.

Mezirow's steps four to ten include (four) the recognition that the problem is reflected in others, (five) an exploration of alternative ways of being, (six) planning a course of action, (seven) acquiring the knowledge and skills necessary for the course of action, (eight) initial trials of the new role, (nine) building

competence and confidence in a new role, and (ten) re-entering society with a new role and perspective. Although at least some of these steps have occurred in my case, they did not occur in this order. I spent a number of years feeling quite lost, rather than actively exploring alternative ways of being. During this time, though, as I became more confident in forming relationships with others, it slowly became clear to me that I wanted to work directly with other people. I did not plan a course of action, but I did decide to undertake counselling training as a first step towards a new career path and way of being. I continue to explore alternative ways of being, whilst also acquiring further knowledge and skills; trying out new roles, and building on my competence and skills in certain areas. I doubt that I will ever 're-enter society with a new role and perspective', since I do not feel that I ever left society. Instead, I expect that I will always have multiple, shifting roles, as well as a wider, flexible perspective.

## **Counselling and Psychotherapy**

As this thesis focuses on counsellors and psychotherapists, background information on the fields of counselling and psychotherapy is presented here. What follows includes some definitions of counselling and psychotherapy, and a brief discussion about the similarities and differences between counselling and psychotherapy. Introductions to the variety of ideas (theoretical orientations) within these fields, the practice of therapy, and training and supervision are also provided. The role of research in counselling and psychotherapy is then briefly discussed and the importance of personal development within these fields is outlined. Transformative learning and personal development are then compared.

### **Definitions, similarities and differences**

Rowan (2001) argues that counselling and psychotherapy have different histories. However, their histories are clearly linked. Sigmund Freud, who developed psychoanalysis, is viewed by many as the 'founding father' of psychotherapy (Sanders, 1994). The psychologist Carl Rogers coined the term 'counselling' in the 1930's, when developing his Person-Centred approach. At the time, in the USA, only medically qualified people were legally allowed to practice psychotherapy. By calling his therapy

‘counselling’, and those that he worked with ‘clients’ (rather than ‘patients’, as Freud did), Rogers overcame this problem (Dryden and Mytton, 1999).

There is no single universally accepted definition of ‘counselling’ and the term is used in a number of ways (Nelson-Jones, 2001). The British Association of Counselling and Psychotherapy (BACP), the UK’s largest membership organisation for counselling and psychotherapy, note that

Counselling takes place when a counsellor sees a client in a private and confidential setting to explore a difficulty the client is having, distress they may be experiencing or perhaps their dissatisfaction with life, or loss of a sense of direction and purpose (BACP, 2006a, paragraph 1).

The BACP’s four paragraph long definition of counselling also includes the fact that a counsellor listens in an accepting and respectful way, allowing the expression of feelings and enabling choice and change without giving advice. Furthermore, it is stressed that counselling always takes place with the consent of the client, so that no one can be ‘sent’ to a counsellor.

The United Kingdom Council for Psychotherapy (UKCP, a membership organisation for psychotherapy) provides a definition of psychotherapy that is similar to the BACP’s definition of counselling:

Psychotherapy is the provision by qualified practitioners of a formal and professional relationship within which patients/clients can profitably explore difficult and often painful emotions and experiences (UKCP, 2006a, paragraph 1).

The similarities between counselling and psychotherapy, as reflected in the definitions they give, are recognised by both the BACP and UKCP. Formerly the British Association for Counselling (BAC), the BACP changed its name in September 2000, recognising that it ‘no longer represented just counselling, but also psychotherapy’ (BACP, 2006b, paragraph 3).

The BACP (2006a, paragraph 6) believe that ‘it is not possible to make a generally accepted distinction between counselling and psychotherapy’, and in agreement, the UKCP

(2006a, paragraph 11) admit that ‘there are many similarities between these disciplines’. Furthermore, in a summary of a recent report on an initial mapping project (carried out jointly by the BACP and UKCP) which addressed the issue of the future regulation of counselling and psychotherapy, it was noted that

The report acknowledges macro-similarities between psychotherapy and counselling... Both fields involve a significant philosophical approach in comparison to other healthcare professions... (Aldridge, 2005, p. 38).

For Lapworth, Sills and Fish (2001, p. 47) counselling and psychotherapy are similar enough to share the same rationale:

The purpose of counselling and psychotherapy is to assist clients in reassessing how they experience their past and present lives such that they can resolve internal conflicts, let go of noxious patterns and recognize and incorporate the nourishing.

In line with this, in her book *The Therapeutic Relationship*, Clarkson (2003) uses the terms ‘counselling’, ‘psychotherapy’, ‘counselling psychology’ and ‘psychological counselling’ interchangeably. Kwiatkowski (1998, p. 5) argues that ‘any differences between counselling and psychotherapy are slight’, and Nelson-Jones (2001, p. 2) points out that ‘Attempts to differentiate between counselling and psychotherapy are never wholly successful’. Hall (1990, p. 269) goes as far as to suggest that ‘the old distinction between counselling and psychotherapy [is] no longer meaningful or practical’.

Some writers, however, argue that there are certain key differences between counselling and psychotherapy (see for example Rowan, 2001; Harvie-Clark 1999). Rowan (2001) suggests that psychotherapy is, in general, more intense and long-term than counselling, perhaps because psychotherapy has been historically associated with medicine, while counselling has been associated with education, the Church, advice and guidance. Furthermore, access to counselling is often immediate, he claims, while psychotherapy often involves a waiting period. As Kwiatkowski (1998, p. 7) points out, though, ‘it is easy to refute these assertions’. Counselling may be intense and long-term, whilst

psychotherapy may be less intense and short-term. What is more, access to a privately practicing psychotherapist may be immediate, whilst a wait may be necessary in order to access counselling through an organisation.

Rowan (1998) claims that psychotherapists are equipped with a wider range of interventions (ways of engaging with clients) than counsellors, but Kwiatkowski (1988, p. 8) also contests this point, suggesting that it is not possible to name 'a single piece of behaviour that a psychotherapist exhibits within a psychotherapy session that could not be seen in a counselling session'. My own view, no doubt reflected in what is written above, is that there are now no differences between the practices of counselling and psychotherapy in general in the UK, and any differences that exist within these fields are differences between practitioner's theoretical orientations (ways of working). However, in line with Rowan (2001), I believe that in the eyes of the public, counselling and psychotherapy are different. According to most people 'Counselling is more ordinary and accessible than psychotherapy which is seen as more to do with serious and long-standing problems and therefore to carry more stigma and more commitment' (Rowan, 2001, p. 24).

My view that the practices of counselling and psychotherapy are not different, is not shared by some of the practitioners I have interviewed for this thesis: Some of those who call themselves 'psychotherapists' noted that they did not wish to be referred to as 'counsellors' (a term I initially used to describe all participants). I therefore refer to 'counsellors and psychotherapists' within this thesis, and for convenience, the terms 'therapists' or 'practitioners' are sometimes used to refer to them both.

### **Theoretical orientations**

Howard (1998, p. 305) points out that 'there is not one language of counselling: there are dozens.' The same is true of psychotherapy. There are many different sets of ideas about the theory and practice of counselling and psychotherapy (also known as 'theoretical perspectives', 'theoretical approaches', 'theoretical models' or 'theoretical orientations'), each of which have unique views about the ways in which people function, and a unique set of terms to describe these ideas.

McLeod (1998, p. 6) notes that a study carried out in the 1980's showed that 'more than 400 distinct models of counselling and psychotherapy' exist. Today there are no doubt many more. In his keynote speech given at the 12<sup>th</sup> annual BACP Research Conference, Salkovskis (2005) noted that 'there are too many therapies, some of which are frankly silly'. As Schon (1995, p. 311) puts it, 'practitioners have to deal with a bewildering variety' of theoretical approaches. Nelson Jones (2001) devotes his book *Theory and Practice of Counselling and Psychotherapy* to a detailed analysis of thirteen of these approaches, including Freud's psychoanalysis, Jung's analytical therapy, person-centred therapy, gestalt therapy, transactional analysis, existential therapy, behaviour therapy and cognitive therapy.

Theoretical orientations within counselling and psychotherapy can be grouped into 'schools'. Nelson-Jones (2001) lists three of these: the psychodynamic school, which emphasises the importance of unconscious influences on people's functioning, the humanistic-existential school, which focuses on people's abilities to develop their potential and make choices, and the cognitive-behavioural school, which focuses on changing people's behaviours and thought patterns. Rowan (2004) adds a fourth type of therapy, which is overlooked by Nelson-Jones (2001): Transpersonal therapy. This may involve a 'willingness to let go of all aims and all assumptions' (Rowan, 2004, p. 21). It is 'concerned with linking with the client' (*ibid.*).

However, 'no one [theoretical] approach is clinically adequate for all problems, patients, and situations' (Dryden and Norcross, 1989, p. 229). Today, many practitioners regard themselves as 'eclectic' or 'integrative', drawing from the ideas and practices of various theoretical orientations and schools (McLeod, 1998).

Fifteen of the 43 counsellors and psychotherapists I interviewed for the grounded theory study presented in this thesis referred to themselves as 'integrative', while another ten said that they made use of two or more theoretical orientations in their client work (see also appendix E).



## **The practice of counselling and psychotherapy**

Beitman (1989, p. 259) notes that therapy is a ‘practical endeavour intended to help people change’, and he defines counselling as ‘a relationship between two people which proceeds over time...’ (*op. cit.*, p. 261). As McLeod (1990, pp. 75-76, original emphasis) puts it, ‘the experience of practicing counselling is very much one of being *in relationship*’. However, ‘[w]hen a counselling relationship is ongoing the counsellor has no idea what the eventual products are going to be’ (Mearns, 1990, p. 102).

Beitman (1989) also argues that within the ongoing therapeutic relationship, counsellors and psychotherapists must be flexible, rather than forcing a client to fit a particular theoretical orientation. In line with this, Casement (1985, p.4) says: ‘By listening too readily to accepted theories, and to what they lead the practitioner to expect, it is easy to become deaf to the unexpected’.

Although trainee counsellors and psychotherapists might, at first, adhere quite rigidly to their chosen theoretical orientations and the ways of working with clients that these orientations prescribe, more experienced practitioners are likely to rely on ‘experience-based generalisations’ rather than theory (Skovholt and Ronnestad, 1992, p. 510). As Yalom (1991, p. 31) says, ‘most of my deeply held beliefs about therapy, and my areas of keenest psychological interest, have arisen from personal experience’. Rogers (1961, p. 10) adds: ‘We had to live with our failures as well as our successes, so that we were forced to learn...I found I began increasingly to formulate my own views out of my everyday working experience’.

Whether they are trainees or highly experienced, counsellors and psychotherapists tend to work within a therapeutic frame. This includes a contract between the client and therapist in terms of where and when therapy will regularly take place, confidentiality agreements and other boundaries (Gray, 1994).

According to Webb (1997) adequate training of counsellors and psychotherapists is necessary for the preservation of boundaries. Supervision may also support the maintenance or sometimes the appropriate crossing of the boundaries that form part of the therapeutic frame.

## **Training and supervision**

Professional counselling and psychotherapy training is usually part-time, and takes place over several years. Trainees are taught in a variety of settings: ‘psychotherapy and counselling training is delivered by a mixture of Higher Education, Further Education (counselling only) and the Private Sector’ (Aldridge, 2005, p. 38). Whatever the theoretical orientation that underpins the training, all professional training courses are currently expected to cover skills practice, theory, personal development activities and some supervision (Dryden, Mearns and Thorne, 2000). Trainees may also be required to undertake personal therapy, as a client, during their training.

Although it begins during training, supervision (in which a therapist monitors her client work by talking about it with another, often more experienced, therapist) is a career-long requirement in the UK. Gray (1994, p. 118) describes its supportive function:

As the therapist provides containment and understanding for the client, so the supervisor performs the same function for the therapist, containing and understanding the feelings evoked in the affiliation with the client, thus protecting and maintaining the primary partnership.

Supervision also encourages a counsellor or psychotherapist to reflect on his work and to learn from it (Wheeler and King, 2000). As Milner, (1992, p. 85) puts it, ‘Supervision is a reward – it supports us in learning about ourselves, our clients and our work in the company of someone who cares about us’.

## **The role of research**

As part of her presentation, ‘Research that makes a difference’, Professor Glenys Parry noted at the 2005 BACP research conference that counsellors and psychotherapists often perceive research as irrelevant to their work. Yet research can potentially empower clients, prevent harm, improve the quality and outcomes of counselling and psychotherapy and enhance the working lives of therapists. Through the development of an evidence base, it can also be used to attract funding for further provision (Parry, 2005).

If the counsellors and psychotherapists that Parry (2005) refers to do perceive research as irrelevant, rather than simply outside of their area of expertise and interests, I suggests that this is because they probably have no in-depth research training. A great deal of the research literature is inaccessible to many practitioners.

In order for practitioners to become ‘intelligent consumers’ of research findings, it has been suggested that research training should be introduced into all diploma level counselling courses (Parry, 2004, p. 21; Turner 2006b, see appendix P). Therapists might then be able to view these findings critically, and in the light of their own experience, and incorporate them into their work where appropriate.

Rowland (2006, p. 46) argues that

Research does indeed matter to clients, practitioners, managers and government, voluntary and charity agencies, all of whom need to know about counselling...so that sensible decisions can be made about accessing, providing and funding services.

Yet some research findings may not give an accurate picture of the therapy that is researched. Western, Novoty and Thompson-Brenner (2004, p. 658) point out that conclusions that are reached based on data gathered from randomised control trails focused on the attempt to identify empirically supported psychotherapies ‘are often underqualified and overgeneralized’. These trails often exclude between one and two thirds of clients that present for treatment, because they have multiple problems.

Since practitioners sometimes view researchers with suspicion, the authors suggest that ideally, competent practitioners who are able to read and understand the research literature should engage in practice and also carry out research. I suggest that the compulsory introduction of research training within all practitioner training courses would support this attempt to link research and practice within the fields of counselling and psychotherapy.

Both the BACP (2006c) and the UKCP (2006b) are devoted to the promotion of research activities and the dissemination of research findings. In line with the ideas of Western, Novoty and Thompson-Brenner (2004), as part of this endeavour, they encourage practice-based research, carried out by practitioners of counselling and psychotherapy. Interestingly, though, Schon (1995) suggests that therapists engage informally in ‘research’ on a regular basis anyway. Practitioner ‘research’ occurs as reflection-in-action takes place: ‘When someone reflects-in-action, he becomes a researcher in the practice context. He is not dependent on the categories of established theory and technique, but constructs a new theory of the unique case in front of him’ (*op. cit.*, p. 68).

### **Personal development in counselling and psychotherapy**

Although they imply that personal development and self-development may be the same, Donati and Watts (2005) suggest that these are different from personal growth: Personal development arises from deliberate engagement in a specific activity, its effects can be transitory and they may be positive or negative. In contrast, personal growth is an incidental process that may or may not occur as a result of personal development. Its effects are permanent and positive.

Personal growth may occur at any time in life. In the eyes of Donati and Watts (2005), then, Johns’s, (1996, p. xi) description of personal development is actually an account of personal growth: ‘Personal development is not an event but a process, lifelong and career-long: it must and will happen incidentally before and after any training course, through all aspects of life and work.’

Similarly, although he names it ‘development’, Daloz (1987, p. 22) refers to Donati and Watts (2005) conception of personal growth when he writes:

...development is more than simply change. The word implies *direction*. Moreover, development seems to happen not in a gradual linear way but in distinct recognisable leaps – in a series of spiralling plateaus rather than a smooth slope.

Donati and Watts (2005) also make a distinction between personal and professional development: Professional development is seen to be more concerned with skills and

knowledge, while personal development involves a person's ways of being. However, they stress that personal and professional development 'are not mutually exclusive concepts or processes' (*op. cit*, p. 476).

### **Personal development in counselling and psychotherapy training**

It is generally agreed that the promotion of personal development is a crucial part of training in counselling and psychotherapy. Training courses incorporate opportunities for personal development which may allow trainees to identify their strengths and weaknesses, as well as their prejudices, receive and give feedback, and learn about the ways that their previous life experiences have impacted on them (Wheeler, 2002). These types of learning opportunities are designed to lead to increased self-awareness, and this self-awareness may be seen as both a goal of personal development and a tool that enables the process to take place (Donati and Watts, 2005).

Hall (1990, p. 277) argues that trainee therapists must increase their self-knowledge in order to help future clients work towards self-actualisation (their full potential):

It seems to me essential that those who want to work as counsellors must first explore an extensive view of the self – and, most importantly, of him or her self. How else can we fit ourselves to facilitate another in the process of self-actualisation?

In order to communicate the importance of personal development in their counselling training, most course booklets and brochures mention this element of training. For example, one of the central components of the two-year counselling diploma offered by the Gestalt Centre is 'the development of awareness of self and self in relation to others both personally and professionally' (Gestalt Centre, 2002, paragraph 2).

Mearns (1992) suggests that self-awareness is also important in the training of person-centred practitioners. He writes:

The person-centred practitioner is expected to be able to work at great depth within both the affective and cognitive realms of the client's experience, and to use his, the practitioner's, *self* fully in that work. Such working makes great demands of training and self-development (Mearns, 1992, p. 70).

However, Williams and Irving (1996) suggest that personal development is more than an increase in self-knowledge – it may also involve a change in a person’s way of being.

### **Methods of promoting personal development in training**

In line with the ideas of Williams and Irving (1996), Mearns (1997a) suggests that personal development in counsellor training involves three steps: awareness of a self-development need, understanding of that need and experimentation with self. He suggests that the challenge for training courses is to ‘create learning contexts where the trainee can move through all three stages’ (Mearns, 1997a, p. 113). The most common methods of self-development used in counselling and psychotherapy training are personal therapy, personal development groups and personal journals (Dryden, Horton and Mearns, 1995).

Many training courses insist that counsellors and psychotherapists in training should undergo personal therapy as part of their studies. For example, in order to gain a diploma in Existential Counselling from the New School of Psychotherapy and Counselling, trainees are required to be in personal therapy, at least once weekly, for the two-year duration of the course (NSPC, 2005).

However, according to Makaskill (1999) there is no real evidence in the research literature to suggest that undergoing personal therapy leads to an increased self-awareness or that it ultimately makes someone a more effective therapist. Furthermore, Dryden, Horton and Mearns (1995, p. 24) note that alone, personal therapy is not adequate for the personal development needs of counselling trainees:

There is a danger in presuming that on-going personal therapy is sufficient to cover the range of personal-development that is required in training. A lot depends on how closely the personal therapy is linked to the training...Simply requiring on-going personal therapy in this way can mean that the therapy focuses only on the most pressing needs of the trainee. It may go to great depth in relation to those needs but it may not cover sufficient breadth for counselling training.

Personal development groups may be used for identifying personal development needs (Dryden, Horton and Mearns, 1995), and they are a safe place where trainees can express negative emotions (Mearns and Thorne, 1990). However, there is debate about whether personal-development groups should be facilitated by core staff members, or by staff not involved in coursework assessment. In addition, there is debate about whether these sessions should be facilitated at all. Dryden, Horton and Mearns (1995) argue that although it may be difficult for students to open up to staff who assess their academic work, since self-development is such an important part of counsellor training, this should not be left to peripheral training staff.

Writing a personal journal is recommended on many counselling and psychotherapy courses, and some courses require trainees to keep a reflexive journal as part of the course assessment. A journal may be used to explore important issues and record personal development (Dryden, Horton and Mearns, 1995, Wheeler, 2002). However, Wheeler (2002) points out that trainees may focus on their strengths and minor weaknesses in these journals, avoiding discussing important difficulties and major areas for further development.

Dryden, Horton and Mearns (1995) note that many other parts of a counselling or psychotherapy course can also contribute to the self-development of a trainee. These include structured experiential exercises such as artwork, drama, story writing, discussions, or guided imagery. In addition, supervision of a trainee's work can be used to catalyse personal development. As Mearns (1992, p. 77) notes: 'From supervision I know that facing my own blocks helps the client to move on'.

### ***Problems***

The potential problems associated with personal development in training are not always made explicit to prospective trainees. One possible problem, though, is that personal development is likely to impact on a trainee's close relationships (Mearns, 1997a). McLeod, (1993, p. 211) writes:

The personal meaning of counsellor training for many trainees is that it is a time of intense self-exploration and change...which has implications for partners, family and pre-existing personal roles.

### **Personal development for qualified practitioners**

As well as engaging in personal development during training, Page (1999, p. 30) notes that qualified counsellors must continue to try to develop themselves:

If we are to be fresh in our attitude to the work then our development must continue. Indeed we might take this a step further and allow the possibility that the continuing development of the counsellor is in itself a necessary ingredient in the facilitation of the client's development.

In line with this, the BACP (2002, p. 4) states that practitioners should 'seek opportunities for personal development as required'. Many of the theoretical approaches in counselling and psychotherapy recognise the importance of personal development work (McLeod, 1993). However, personal development means different things within different theoretical approaches (Donati and Watts, 2005). McLeod (1993, p. 209) writes about its meaning within the psychodynamic and person-centred approaches:

In psychodynamic work...the counsellor must be able to differentiate between counter-transference reactions that are triggered by client transference, and those that are projections of unresolved personal conflicts. In person-centred work the congruence of the counsellor, her ability to be aware of and act appropriately upon personal feelings [is important]...

Wheeler and McLeod (1995, p. 286) conclude that 'In both person-centred and psychodynamic counselling, there is a requirement that the counsellor undertakes a significant amount of work on self'.

### **Personal development and transformative learning**

Although they refer to different but related processes, the terms 'personal development' (or 'self-development') and 'personal growth' are sometimes used interchangeably. In addition, as discussed earlier, there is little agreement about what transformative learning (sometimes also referred to as perspective transformation, transformational learning or



transformation theory) actually is. Though it is therefore a difficult task to attempt to compare and contrast personal development and transformative learning, what follows makes use of some of the ideas presented in the section titled 'Transformative Learning' within this chapter in order to highlight a number of similarities and differences between these two concepts.

Keegan (2000) argues that transformative learning refers to a change in a person's way of thinking, rather than just a change in behaviour or an increase in knowledge. In contrast, personal development is often referred to in terms of gaining increased self-knowledge. Williams and Irving (1996), however, suggest that personal development is more than an increase in self-knowledge: it involves a change in a person's way of being. Whether this includes a change in thinking, though, remains unclear.

In line with Mearns's (1997a) three step model of self-development (awareness of a self-development need, understanding of that need and experimentation with self), Mezirow's (1981) ten stage model of perspective transformation includes self-reflection (stage 2), and an exploration of alternative ways of being (stage 5). According to Mezirow (1981), though, perspective transformation might begin with a 'disorienting dilemma' (catalysing crisis), whereas personal development requires no such crisis, just deliberate engagement in a specific activity (Donati and Watts, 2005).

Clark (1993), however, has found that 'integrating circumstances' (periods in which a person consciously or unconsciously searches for something which is missing in their life) can also trigger transformational learning. It may be argued that some trainees might engage in counselling or psychotherapy training because they feel that something is missing in their life.

As stated earlier in this chapter, although Mezirow's (1981) 10 stage model of perspective transformation is linear, some studies have found the process to be 'more recursive, evolving and spiralling in nature' (Taylor, 1997, p. 44). Similarly, Daloz (1987, p. 22) has suggested that 'development seems to happen not in a gradual linear way but in distinct recognisable leaps – in a series of spiralling plateaus rather than a smooth slope'.

Transformative learning may occur through critical reflection, perhaps through discourse (Mezirow, 1994a), but it may also occur without this, as long as emotion and/or unconscious processes, intuition, spiritual (or extra-rational) influences, and relationships are present (Taylor, 1997). Similarly, engagement in an activity that leads to personal development may include critical reflection (through discourse in personal therapy or a personal development group, for example) or emotion (perhaps a catalyst for writing in a personal journal) (Donati and Watts, 2005). Relationships and reflection upon these may be seen to be an important part of all therapy training courses, which might also address and make use of unconscious processes, intuition and spiritual influences.

Finally, Courtenay *et al.* (2000) and Baumgartner (2002) found that the perspective transformations that had occurred in the people with HIV that they interviewed were irreversible. Interestingly, Mearns (1997b, p. 108) notes that ‘Personal development is like that – it is possible to go forwards and sometimes we can pause for a while, but it is impossible to go backwards’. However, Donati and Watts (2005) argue that the effects of personal growth are permanent, while the effects of personal development may be transitory.

It can be seen that transformative learning and personal development are similar in several ways. I suggest that although Donati and Watts (2005) conception of personal growth seems to be more like transformative learning than their idea of personal development, their conception of personal growth is what many others seem to call personal development. Agreement on the nature of transformative learning and on a universal definition of personal development is needed before any firm conclusions about the similarities and differences between these two processes can be reached.

## **HIV and AIDS Counselling**

The grounded theory study presented in this thesis focuses on the similarities and potential differences in the learning and change experienced by therapists who have had a significant experience of working with one or more clients with HIV, compared with the

learning and change experienced by therapists with no such client experience. To provide some context in which the findings of this study can be viewed, a brief discussion of HIV and AIDS has therefore been presented here, together with a review of some of the literature on HIV and AIDS counselling.

## **HIV and AIDS**

It is estimated that there are over 80,000 people infected with the Human Immunodeficiency Virus (HIV) in the UK (Avert, 2006a), with thousands of new infections being reported each year (Rogers-Saliu and Lipman, 2005). HIV weakens the immune system of an infected person, leaving him/her vulnerable to many infections and diseases. It is known to be transmitted from person to person in four bodily fluids - blood, semen, vaginal fluid and breast milk. The most common routes of transmission are unprotected vaginal or anal sex, sharing any instrument which punctures the skin, having transfusions of infected blood or blood products, and mother to baby transmission.

When an individual first becomes infected with HIV they may experience a mild influenza-like illness. This is known as the *acute stage* and lasts up to four weeks. After about 8-12 weeks, when antibodies to the virus start to appear in the blood, some people develop a glandular-fever-like illness (a *seroconversion illness*). An HIV blood test looks for the presence of these antibodies, rather than the virus itself, and, if they are found, the person tested may be known as HIV antibody positive, or HIV positive.

After seroconversion, most people who are infected with HIV show no symptoms at all (*asymptomatic infection*) although they can still pass the virus on to others. Some individuals have persistent generalised lymphadenopathy (PGL), which means that they have persistently swollen lymph glands throughout the body (*PGL stage*).

People with HIV often stay in the asymptomatic or PGL stage for years after infection, in good health. Eventually though, if drug treatments are not provided, as their immune systems weaken, most people go on to develop illnesses such as diarrhoea, oral thrush, bleeding gums and fever. They may also experience heavy and prolonged night sweats, chronic fatigue and unexplained weight loss, as part of the *symptomatic infection stage*. In

the final *AIDS* (Acquired Immune Deficiency Syndrome), *stage* life-threatening infections and tumours attack the person's severely damaged immune system and ultimately cause death (Green, 1989a; Tavanyar, 1992).

## **The development of drug treatments**

Tavanyar (1992) notes that since the virus was first discovered, in the early 1980's, important scientific advances have been made in the field of HIV research, including the development of anti-viral treatments, and drugs to control the effects of related illnesses. As a result, people infected with HIV now live longer.

In 2003, a UK BBC news web page reported research showing that most people with HIV are surviving for over 10 years, thanks to the effects of 'highly active retroviral therapy', the most advanced drug treatment available (BBC News, 2003). A more recent article, written by a clinician who has been working with people with HIV since 1981, goes further, arguing that HIV is now 'a manageable problem' (Slotten, 2005, p. 1), which, if treated correctly, results in what can be considered a chronic disease, like diabetes: As long as people with HIV adhere to their drug therapy, they can live 'near-normal, productive lives' (*ibid.*).

During their interviews, four of the nineteen therapists who had worked with one or more clients with HIV, who took part in my phase one study, talked about the changes that drug treatments have made for people living with HIV. Three are quoted below.

...its been an unusually cruel challenge in the sense that you get a population of people who have had to accommodate themselves to a terminal illness, which has then proved to be not as terminal as they thought. And they then had to come back to life, start having a life again, and working again. And I think I have been absolutely through the epicentre of that journey myself. I was one of the generation of people who's lives were essentially saved at the last minute by the antiretroviral drugs (Fergus).

People with HIV will say this, that it has very much changed in recent years, and HIV is not a death sentence [now]...So we have gone away from images of death and tombstones to it being something that people live with (Soren).

...in the early 80's it was completely different, it really felt like a death sentence. I am [now] really talking about my more recent experience where people have said 'it has made me look at my life' (Tom).

With the advent and continued improvement of medical treatments, people infected with HIV now live relatively long and normal lives. This change in the way that HIV infection is experienced by those infected may account for the fact that many of the books and articles on counselling people with HIV and AIDS-related issues that I was able to find were written in the 1980's and 1990's: There may now be less need for these specialist books and articles.

Since some of the therapists interviewed for my phase one study talked about clients they had worked with years ago, the following literature review makes use of relevant material written within the last 25 years, so that an in-depth and historical understanding of the topic of counselling people about HIV and AIDS-related issues may be gained.

### **Counselling people about HIV and AIDS-related issues**

Silverman (1997, p. 3) notes that 'there is no simple answer to the question: what is HIV counselling?' In line with this, Balmer (1992) distinguishes between two very different aims which the World Health Organisation has previously given to HIV and AIDS counselling: To prevent the spread of HIV infection and to provide psychosocial support for those affected by the virus.

These two aims reflect two different definitions of counselling, and these do not necessarily complement each other: Counselling is sometimes seen as the giving of advice and information, and sometimes seen as a means of support for people experiencing problems (Balmer, 1992).

Although the aim of providing support to those affected by HIV, through counselling, may have been met, counselling has not prevented the spread of the virus (*ibid.*), and the number of infected people continues to rise (Rogers-Saliu and Lipman, 2005). Balmer (1992) has therefore proposed a new set of aims for HIV and AIDS counselling, which focus counsellors on providing people infected with HIV with information and psychosocial support, without giving advice.

These aims include working to improve the individual's self-concept, supporting her changing relationships, helping to plan for changes in her career path and providing reliable information. In line with Balmer's (1992) suggestions, pre and post HIV-test counselling - which has been offered for many years (see for example, Terrence Higgins Trust, 2005) - has involved both the provision of support and information.

Pre-test counselling aims to ensure that informed consent has been given for an HIV antibody test. It may give the client information on the HIV virus and the antibody test, as well as information on personal, social, medical and legal implications of a positive result. It may also prepare the client for the possibility of testing positive and allow any questions he has to be discussed (McCreaner, 1989).

In the first post-test counselling session, the test result is given and the client's immediate concerns are discussed (Green, 1989b). At this stage, Bor *et al.* (1991, p. 130) warn that 'assumptions about reactions to diagnosis on the part of the counsellor may impede rather than facilitate the client's management'. Berry (1996, p. 308) adds that 'Most practitioners would agree that there is no singular standard response to HIV diagnosis. Each individual's response is unique and personal and the goal of the helper is to respect that'.

Referral for ongoing counselling therefore depends on the individual, rather than the outcome of the HIV test *per se*. Dworkin and Pincu (1993) note that the 'worried well' (people who are HIV negative but who are worried about becoming infected with HIV and who suffer from anxiety, panic attacks and/or somatic complaints) may need further counselling.

Ongoing counselling usually focuses on the provision of support, and, in contrast to pre- and post-test counselling, the focus of each session is usually determined by the client. This counselling may be carried out by a trained counsellor, a psychologist, a social worker or a health professional (Bennetts, 1992; Miller and Bor, 1989). As Miller and Bor (1989, p. 3) point out, for those infected with HIV, counselling is important because '[it] can help patients to adjust to their condition, prepares them for bad news...and contributes to the co-ordination of medical and social care'.

During ongoing counselling, a variety of different issues may be discussed. The findings of Gordon and Shontz's (1990) case study of one 21 year old HIV positive male suggest that HIV positive people may be concerned with being infectious, facing death and dying, living with uncertainty and keeping their diagnosis a secret. They may also feel ambivalent. Although, as Gordon and Shont (1990, p. 292) suggest, their case study tells us 'what it might be like to carry the AIDS [sic] virus', other clients may have different or additional concerns.

A counsellor working with clients with HIV must therefore be ready to address a variety of themes like homophobia, drug abuse, sexuality, intimacy and existential issues such as the meaning of life (Dworkin and Pincu, 1993), as well as those issues identified by Gordon and Shont (1990). Furthermore, a client may also want to discuss her anger, low self-esteem, health concerns, and issues around her possible disclosure to friends, family and significant others, (Dworkin and Pincu, 1993), work and financial worries (Hunt *et al.*, 2003) drug abuse, depression and perhaps childhood sexual abuse (Taylor *et al.*, 1996), as well as other issues.

In addition to being prepared to talk to a client infected with HIV about a variety of concerns, counsellors must be ready to talk to a variety of people who have been indirectly affected by an individual's HIV status. Gurney's (1995) case study of the counselling received by an HIV positive person's step-mother 'highlights the impact of HIV disease beyond the infected individual' (*op. cit*, p. 24).

Family members, partners, spouses and close friends may all be deeply affected by an individual's HIV positive status. Buki *et al.* (2005) point out that caregiver spouses of people with AIDS have specific counselling needs, both singly and as part of a couple living with the disease. In addition, Lack (1996) also highlights the importance of bereavement counselling for the surviving partners of gay men who have died of AIDS, and Springer and Lease (2000) note that gay men may be especially vulnerable to multiple AIDS-related bereavements, so may have a particularly great need for counselling.

HIV and AIDS counselling has been carried out in a variety of ways, using a variety of theoretical orientations. Bor *et al.* (1991) list seventeen tasks for a counsellor working with an HIV positive client. Although these were developed within the systemic theoretical approach, the authors suggest that they ‘may be as applicable to other counselling approaches’ (*op. cit.*, p. 131). However, on close inspection, some of the tasks outlined by Bor *et al.* (1991) are somewhat directive and would not be suitable for, for example, person-centred counsellors.

Task 10, for instance, suggests that the counsellor should ‘talk with the client about the concept of unpredictability, which is a reality for him or her’ (Bor *et al.*, p. 134). Yet the client may not wish to talk about unpredictability. Other tasks are unclear or presumptuous, and several unhelpful examples are given. Task 13, for example, involves examining ‘the difficulties that arise from the client’s apparent isolation’ (*op. cit.*, p. 135). However, it is not necessarily helpful to presume that all clients with HIV are isolated. As a result of being HIV positive, a client may actually feel very much part of a community.

### **Clients with HIV**

At the end of 2006, it was estimated that 46% of HIV diagnoses in the UK have been among men who have sex with men (Avert, 2006a). As Martin (1989, p. 67) notes, ‘[t]he gay community has been and continues to be disproportionately affected by...AIDS and...HIV...’ This has led to a great deal of prejudice.

When doctors first came across patients with AIDS, in 1981, they were found to have unusual illnesses, such as rare forms of pneumonia and skin cancers that were hardly ever seen in healthy people. The doctors noted that all of the patients they saw with these unusual illnesses were young gay males, and they therefore named the condition ‘gay-related immune deficiency syndrome’ (GRIDS). Tavanyar, (1992, p. 15) notes that ‘By the time [the name] GRIDS was changed to AIDS...in 1982, significant damage had been done to public understanding and attitudes to people affected by the virus’.

She adds:



Although the arrival of AIDS had not *created* an atmosphere of hostility and prejudice towards gay men...that was already there...it had certainly provided bigots and moralists with material to back their beliefs (Tavanyar, 1992, p. 19, original emphasis).

When it became clear that HIV could be transmitted through blood as well as sexual fluids, the notion of 'AIDS as punishment' arose: While children infected by their mothers and those who became HIV positive by being given contaminated blood and blood products were considered by many to be 'innocent victims', gay men (as well as drug users and sexually promiscuous people) were considered by some as 'guilty' (Tavanyar, 1992). For some people, this notion may still exist today.

Prejudice and homophobia may therefore be an issue that an HIV positive gay man might wish to discuss during HIV and AIDS counselling. In line with this idea, McManus (1989) notes that gay men may be forced to 'come out' (to disclose their sexuality to others) as a result of their HIV status. He adds that:

This can lead to an especially stressful course of events and counsellors will need to be aware that their clients will need help not only in adjusting to their antibody status but also in coping with others knowing that they are gay. Rejection by the family, because of homophobia rather than because of HIV status is common. Further problems will arise if the man is married or bisexual (McManus, 1989, p.112).

As well as issues of prejudice and homophobia, gay men may need to discuss suicidal feelings, guilt and shame with regard to their sexual behaviour or the pain caused to their families, anger directed at themselves and their sexual partners, and loss of libido (Martin, 1989). Furthermore, gay men who test negative for the HIV virus may feel relieved, but also guilty. Martin (*op. cit.*, p. 68) notes that '[a]ll of these feelings should be...validated as normal responses'.

At the end of 2006, women accounted for 48% of all adults living with HIV, worldwide (Avert, 2006b). Despite this, only a few papers have been written on the subject of

counselling women with HIV and AIDS. In the first decade in which the HIV virus was known to exist, '[w]omen's concerns regarding [HIV and] AIDS...[were] ignored or minimized by most writers and AIDS educators' (Ybarra, 1991, p. 285). Because, at first, HIV and AIDS were thought to affect only gay men, this idea not only stigmatised members of the gay community, it also led to an avoidance of the problem of HIV infection in women (*ibid.*).

In an attempt to address this problem, Ybarra (1991) writes about the unique concerns that women may have with regard to AIDS, as well as the implications of these unique concerns for counselling. She notes that intimacy may be a concern for women infected with HIV, as they may feel dirty or unloved and fear rejection and abandonment. Pregnant women who have HIV may be concerned about transmitting the virus to their children, and they may blame themselves if their children do become infected. If their offspring are healthy, however, they may feel guilty about the possibility of dying at a relatively young age, and they may worry about becoming too ill to fulfil their role as a parent. Furthermore, women who decide not to have children as a result of their HIV status may experience a great sense of loss.

Taylor *et al.* (1996) list other concerns which may be specific to some women with HIV. They note that a 'significant number of HIV-infected women have histories of sexual or physical abuse' (*op. cit.*, p. 345). These women may also abuse alcohol or other drugs and suffer from depression.

Issues such as these may affect counselling: Clients who have been subjected to personal boundary violations, Taylor *et al.* (1996) note, are unlikely to notice when they violate the boundaries set in counselling. They may therefore arrive for sessions hours late, attempt to continue sessions after their time is over and they may phone their therapists at inappropriate times.

Simoni *et al.* (2002) have studied the impact of spirituality on women with HIV or AIDS. Questionnaires were given to 230 predominantly African American and Puerto Rican women who lived in New York City, were HIV positive, and had low incomes. According to the researchers (*op. cit.*, p. 143) the analysis 'indicated high levels of spirituality and

spiritual based coping, both of which were positively related to psychological adaptation [to being infected with HIV]’.

The authors suggest that their findings have important implications for counselling, and propose that counsellors should collaborate with religious professionals to address the spiritual needs of women with HIV. However, Simoni *et al.* (2002) also admit that their findings are subject to some methodological limitations: As their sampling was not random, it is unclear whether the findings would generalise to other groups of women, such as those with high incomes or those from other areas. So spirituality may be a cultural rather than HIV-related issue for the women who took part in this study.

In addition, an HIV negative group of women was not included in the study, and respondents may not have been truthful in filling out the questionnaires they were given. Furthermore, Simoni *et al.* (2002) fail to acknowledge that religion and spirituality are two different things – several of the questions they used to assess their participant’s spirituality (such as those referring to denominational affiliation and church membership) were actually questions referring to religion. I suggest that the implications they draw for counselling women with HIV are therefore inconclusive.

In response to a recent increase in the number of people from African countries affected by HIV, the Terrence Higgins Trust (a UK charity set up in 1983 in memory of Terrence Higgins, who was one of the first people in UK to die of AIDS (Tavanyar, 1992)) has set up an ‘African Emotional Support’ service (Rogers-Saliu and Lipman, 2005).

Rogers-Saliu and Lipman (2005) note that potential African clients they spoke to identified several counselling needs for this client group: They wanted African counsellors who shared their cultural understanding, provided a flexible appointment system, and gave advice on practical issues as well as emotional support. The authors also point out that it may be a relief for those infected with HIV to be able to tell their story, in confidence, in their own language.

### **The counsellor**

As the number of people infected with HIV rises, many counsellors will find themselves working directly or indirectly with HIV and AIDS-related issues, regardless of their work settings (House, Eicken and Gray, 1995). As Phillips *et al.* (2005, p. 425) point out, a client with HIV ‘may or may not come to treatment to focus on issues specifically related to his [or her] HIV-positive status’. However, counsellors’ preparedness for working with clients with HIV is an important issue (Hayes and Erkis, 2000), and it has been suggested that it is crucial that counsellor training programmes adequately prepare counsellors to work with these clients (Britton *et al.*, 1999; Hunt, 1996).

Britton *et al.* (1999) suggest that training courses focusing on HIV counselling should include an exploration of trainees’ attitudes to HIV and AIDS, as well as an examination of the type of countertransference issues (feelings stirred in the counsellor in response to the client) that may arise when working with clients with HIV.

Bond (1995, p. 46) points out that it is important not to think in terms of ‘fixed categories of people with HIV as clients and people without HIV as counsellors’. In reality, some counsellors know that they are HIV positive, and others know that they are negative or have not been tested. A therapist’s knowledge (or lack of knowledge) about the HIV antibody test and his own HIV status will affect the relationship that he forms with HIV positive clients (McKusick, 1988).

Whatever their HIV status, though, in working with people with HIV, counsellors must work through a variety of countertransference issues in order to prevent their work from being impeded. Personal therapy and supervision may be used for this purpose (Bond, 1995). A counsellor’s personal anxiety about death and dying may, for example, lead to avoidance or over-focusing on death during sessions. It may also lead to a denial of the client’s feelings and an attempt by the counsellor to reassure the client (Holt, Houg and Romano, 1999). However, as Grey (1996) warns, counsellors should not ignore their clients’ anguish and should avoid raising false hopes.

Linked to the theme of death and dying, and to the theme of existential issues, clients with HIV may wish to talk about their spiritual and religious beliefs. Holt, Houg and Romano (1999) therefore argue that counsellors should avoid imposing their own beliefs on their clients, and should accept their clients' beliefs non-judgementally.

Countertransference issues may also be linked to particular client groups. When counselling women with HIV, Ybarra (1991, p. 287) suggests that 'counsellors must become aware of their own assumptions and prejudices regarding women with HIV and the way these women contracted the virus'. Similarly, in working with gay, lesbian and bisexual clients, counsellors must work through any homophobic feelings they may have. With regard to gay male clients, Hayes and Erkis (2000, p. 76) write:

...it is not clear at what point one's homophobia becomes therapeutically problematic in working with gay male clients. Consequently, therapists should continuously examine their attitudes and beliefs about men who are gay, and encourage their students, supervisees and colleagues to do the same.

Hayes and Gelso (1993) have studied 34 male counsellors' reactions to gay clients and those infected with HIV using videotapes of actors in the role of clients. Their findings indicate that male counsellors are more comfortable with HIV negative clients than HIV positive ones and that 'homophobic counsellors' are generally uncomfortable working with gay clients while those who are not homophobic are more comfortable with this client group. However, as this study was laboratory based and included a relatively small number of therapists, it is not clear if these findings are transferable to counselling settings.

In contrast to the study carried out by Hayes and Gelso (1993), Hayes and Erkis's (2000) survey study of therapists' reactions to clients with HIV included a large number of female as well as male therapists, and a total of 425 therapists took part in the study. However, all therapists included in the study were clinical or counselling psychologists, and 94 per cent were white. Furthermore, it is unclear whether the therapists' opinions, as recorded on paper in response to given statements, would reflect their reactions to actual clients. Yet, despite the limitations of this study, the findings, which suggest that homophobic therapists

may see HIV as a 'gay disease' and blame gay clients for their HIV positive status, confirm the importance of working through homophobic countertransference for therapists.

Other countertransference issues that those responsible for counselling people with HIV and AIDS may need to work through include judgements about clients' sexual practices, their lifestyle choices and drug-using habits. If counsellors have strong beliefs about the lifestyle choices of people with HIV that may impede their work, Holt, Houg and Romano (1999) suggest that they should not counsel this client group.

Finally, in working with clients with HIV and AIDS, counsellors must also look after themselves. As McKusick (1988, p. 935) points out, this work 'can induce stress, burnout and psychological distancing from their patient[s]'. Yet the work is also likely to be rewarding. Bond, (1995, p. 50) writes, 'I have yet to meet a counsellor who has not been profoundly affected by working with people with HIV. Most would say that they feel enriched and privileged...'

## **Transformative Learning in People with HIV**

No known studies have focused on transformative learning in therapists who work with clients with HIV. A few studies, have, however, been carried out on the transformative learning experienced by people with HIV. The findings can be compared to anecdotal evidence and research findings on the change experienced by people with other diseases.

Yalom (1980, p. 35) notes that over many years of working with terminally ill cancer patients, he has 'been struck by how many of them use their crisis...as an opportunity for change. They report startling shifts, inner changes that can be characterized in no other way than "personal growth"'. Yalom (*ibid.*) goes on to describe a study in which he constructed a questionnaire to measure personal growth changes and administered it to seventy patients with metastatic breast cancer (breast cancer which has spread elsewhere in the body and can't be cured). The majority of patients reported no changes, but of those

that did, most said that they had positively changed as a result of cancer. For example, eighteen patients felt they had gained something of value to teach others about life, while only three said they had less to teach.

Yalom (1980) also describes changes in a patient who had kidney failure and was, at one point, very close to death. After successful treatment, the patient felt that her old personality had died, and in its place, someone who appreciated life much more was born.

Recognition of death contributes a sense of poignancy to life, provides a radical shift of life perspective and can transport one from a mode of living characterised by diversions, tranquilization and petty anxieties to a more authentic mode (Yalom, 1980, p. 40).

A handful of studies have shown that, like some of Yalom's patients, people with HIV may change as a result of their diagnoses. There is also anecdotal evidence that this occurs: Holt *et al.* (1999) note that in working with people with HIV, one of them (Holt) came across a person living with AIDS who had been an intravenous illegal drug user for 20 years but was able to stop abusing drugs after being diagnosed with HIV. He went on to become political activist for others with HIV. 'He commented, "Ironically, this disease has given me my life's purpose and at the same time, it is taking my life away"' (Holt *et al.*, 1999, p. 161).

Similarly, two of the therapists that took part in my grounded theory study mentioned that HIV can have a positive effect on someone's life. One noted that being HIV positive can be 'a difficult journey that doesn't always lead to something worse and can lead to something better'. He added:

That has been absolutely fascinating, to work with people who then, because of HIV, make positive changes in their lives, where HIV can become the catalyst for something better...what is interesting is that people can use the problem and have something better through it. (Soren, group A).

In the cases described by Soren, Yalom (1980) and Holt *et al.* (1999), transformative learning may have occurred. In support of this idea, three studies have been carried out, at

different time points, on the transformative learning experiences of a group of HIV positive men and women (Courtenay *et al.*, 1998; Courtenay *et al.*, 2000 and Baumgartner, 2002).

Courtenay *et al.* (1998) interviewed ten men and eight women with HIV who were recruited from four different community-based organisations that work with HIV positive people in Atlanta, America. All participants were under 45 years of age, and all had weak immune systems. The findings suggest that after an initial reaction to their diagnoses (which often included shock, numbness and despair), a catalytic experience occurred for participants, which may have been a decline in health, a realisation that life had to change, or a discussion with someone else. In particular, talking was found to be an important part of this process. Courtenay *et al.* (1998, pp. 78-79) note that:

Talking was mentioned by almost all respondents as helpful in the initial period of learning about their status or as part of the catalytic event...Our study underscores the important role that others play in transformational learning...

The catalytic events led to adjustments in the participant's perceptions and later to a heightened sensitivity to life and compassion for others. The participants then engaged in activities that helped other people, including others with HIV.

Courtenay *et al.* (2000), re-interviewed fourteen of the original eighteen participants two years after the first study took place. The researchers found that in all cases, the participants' perspective transformations had remained, suggesting that the transformations that they had reported two years earlier were irreversible. Baumgartner (2002) then re-interviewed eleven of those participants who had taken part in the second study another year later and again found that their perspective transformations had held.

The studies of Courtenay *et al.* (1998) Courtenay *et al.* (2000) and Baumgartner (2002) clearly indicate that transformative learning may occur as a result of HIV infection, but they do not indicate how common transformative learning is in people with HIV. Yalom's (1980) study indicated that most of the patients with incurable cancer to whom he gave questionnaires reported no changes in their perspectives. Similarly, it is conceivable that most people who become infected with HIV do not undergo a perspective transformation.



Furthermore, the studies carried out by Courtenay *et al.* (1998), Courtenay *et al.* (2000) and Baumgartner (2002) included only adult participants who lived in one area of America. It is therefore not clear whether adults infected with HIV who live in other places, (such as third world countries), and children infected with HIV can undergo perspective transformations as a result of being HIV positive. Further research is needed in this area.

I suggest that research on the learning and change, and the possible transformative learning that the therapists who have worked with HIV positive people experience is also needed. As detailed below, the research presented in this thesis aims to address this need as well as the need for research on the learning and change that therapists experience as a result of their work with all clients.

## **Aims and Research Questions**

The aims of my research were:

- To find out about the ways in which counsellors and psychotherapists learn and change as a result of their work with clients.
- To determine whether the theory of transformative learning can be usefully applied to these experiences.
- To find out if working with clients infected with HIV impacts on therapists in any unique way.

To this end, the following research questions were formulated:

- How do therapists perceive that they have learnt and changed as a result of working with their clients?
- What factors do therapists perceive are involved in the learning and change process?

- How do the learning and change experiences that therapists who have worked with HIV positive clients perceive they have had differ from the learning and change experiences that therapists who have not worked with this client group perceive that they have had? In what ways are they similar?
- Can the theory of transformative learning be usefully applied to the learning and change experiences that therapists perceive that they have had?
- What are the implications of my research findings for improved practice, training and supervision?

In the following chapters, I attempt to provide detailed answers to these questions.

## **Chapter 2: The Grounded Theory Study (Phase 1)**

‘...most of our counselling is learned in practice...  
We can’t do it out of books or by listening to a lecturer  
*because* this learning takes place in our involvement  
in the working relationship, with the client’s process’

(Maggie, research participant, 2004).

### **Methodological Issues**

For convenience, within this chapter, I have detailed the methodological issues relevant to my phase 1 part of grounded theory study (see figure 1, p. 16), before discussing the

findings. The sections that follow on the interpretive paradigm and qualitative research, judging the quality of interpretive research and reflexivity in interpretive research are also relevant to my phase 2 and 3 studies. The sections on constructivist grounded theory, in-depth interviewing and ethical issues are relevant to phase 2, but not to phase 3.

### **The interpretive paradigm and qualitative research**

McInnes *et. al.* (2004, p. 213) note that ‘Research is a process of knowledge generation, produced through description, analysis and critique’. They add that ‘Knowledge depends on position and viewpoint’ (*op. cit.*, p. 213). Within educational research, there are three main viewpoints: the explanatory paradigm (in which both positivist and post-positivist researchers work), the interpretive paradigm, and the critical paradigm (Biesta, 2003a). These can be distinguished in terms of their ontological assumptions (theories about the nature of reality), epistemological ideas (ideas about the nature of knowledge), and methodologies (views about the ways in which we can obtain knowledge) (Crotty, 1998; Biesta, 2003a).

The set of qualitative studies presented in this thesis was conducted from the viewpoint of an interpretive researcher. In order to provide a broader paradigmatic context in which my research can be viewed, a short description of the explanatory and critical paradigms follows. The interpretive paradigm is then considered in more detail and within this context, qualitative research is discussed.

### **The explanatory paradigm**

The explanatory paradigm is based on the ontological assumption that reality consists of entities related to each other in a series of causal links. Traditionally, this paradigm has been linked with objectivism – an epistemology that suggests that all objects have intrinsic meaning. When this meaning is found, knowledge is created. ‘There is an assumption that

the world is structured by law like generalities that can be identified, predicted, manipulated or controlled to yield universal statements of scientific theory' (Laverty, 2003, p. 12). However, nowadays, many researchers working within the explanatory paradigm take a constructionist epistemological stance, believing that meaning and knowledge are constructed as they engage with the subjects of their research (Biesta, 2003a).

The aim of research in the explanatory paradigm is often to find causal explanations, and results are usually quantitative and generalisable. Positivist researchers working in this paradigm may gather data 'objectively', in the same way as natural scientists, in an attempt to try to prove a hypothesis and perhaps also formulate a theory (Crotty, 1998). In contrast, post-positivist researchers acknowledge that objectivity can never be achieved since all observations are theory-laden and biased by the culture and world-view of the observer (Trochim, 2002). As Robson *et. al.* (2000, p. 535) put it:

Any piece of research is value-laden, in the sense that it is carried out by an individual who has certain values, and these values will suggest certain interpretations of the data as well as having methodological implications.

With reference to counselling and psychotherapy, as a criticism of positivism, West (2005) notes that in the same way that therapy cannot be objectified, we can not detach ourselves from data collected in researching therapy, however much we may wish to do so.

### **The critical paradigm**

In contrast to the explanatory paradigm, critical research involves action as well as the gathering of knowledge. The aim here is emancipation: to create a more free, equal and just democratic society by exposing how power structures perpetuate inequality. This is based on the ontological idea that reality is constructed by human beings and can therefore be changed by them.

Critical forms of research call current ideology into question, and initiate action, in the cause of social justice. In the type of inquiry spawned by the critical spirit, researchers find themselves interrogating commonly held values and assumptions, challenging conventional social structures, and engaging in social action (Crotty, 1998, p. 157).

### **The interpretive paradigm**

Etherington (2004d, p. 34, original emphasis) notes that ‘Within academia, the dominant stories of positivism still hold enormous influence that can be hard to challenge as simply *one* of the ways of doing research’. Yet interpretive studies are more open, organic and flexible than positivist ones, allowing complex and rich data to be generated.

Van Kaam (1966) believes that a rigid experimental and statistical study design, conceived within the explanatory paradigm, and imposed on human ‘subjects’ ‘may distort rather than disclose a given behaviour through an imposition of restricted theoretical constructs on the full meaning and richness of human behaviour’ (*op. cit.*, p. 14). In contrast to positivists, exponents of the interpretive paradigm believe that social reality is different from natural reality, so should be studied in a different way. As Pring (2000, p. 32) points out, ‘There is a world of difference between the sort of enquiry appropriate for understanding physical reality and the sort of enquiry for understanding the mental life of individual persons’.

Researchers within the interpretive paradigm believe that the social world is a world of meaning and interpretation and the aim of educational research should be to gain an understanding of these (Biesta, 2003a). This perspective acknowledges that social reality is viewed in many diverse ways by individuals and does not privilege any one single truth. ‘In studying human behaviour, [then,]...it is not possible, and probably not desirable, to be anything but subjective’ (Robson *et. al.*, 2000, p. 535).

### ***Interpretivist ontology, epistemology, methodology and method***

As stated earlier, paradigms in educational research can be distinguished in terms of their ontological assumptions, epistemological ideas, and methodologies (Crotty, 1998; Biesta, 2003a). The methodology chosen for a research study needs to follow from and reflect the philosophy of the project in terms of its underlying ontology and epistemology.

The studies I have presented within this thesis are underpinned by a constructivist epistemology – the view that knowledge is constructed as a result of the interactions between people and their environment. There is no ‘true’ or ‘right’ interpretation, since an object can be made sense of in different ways. Constructivism is linked to a relativist

ontology, which recognises that “the way things are’ is really just ‘the sense we make of them” (Crotty, 1998, p. 64)

Silverman (2001, p. 4) notes that

A methodology refers to the choices we make about cases to study, methods of data gathering, forms of data analysis etc. in planning and executing the research study. So our methodology defines how we will go about studying our phenomenon.

He adds that ‘Methods are techniques which take on a specific meaning according to the methodology in which they are used’ (*op. cit.*, p. 11). Similarly, Laverly (2003, p. 16) explains that ‘method focuses the researcher on exact knowledge and procedure whereas methodology uses good judgement and responsible principles rather than rules to guide the research process’. Methodologies, then, are the designs or ways of doing research that inform the researcher’s choice of method, while methods are the techniques or procedures used to gather data. Methodologies include grounded theory, co-operative inquiry and heuristic inquiry, all of which I have made use of to carry out my own research. Methods include interviews and journaling, both of which I have also used (Crotty, 1998, Heron, 1996).

### **Qualitative Research**

Within the social sciences two broad categories of research methods are used: quantitative methods and qualitative methods. Quantitative research involves careful measurement and analysis of variables (McLeod, 1993). With reference to the field of counselling, Goldman (1978, p. 10, original emphasis) notes that ‘Traditionally, research in counselling deals with *numbers* of people and their *central tendencies* (means, medians and modes) and their *variation* (standard deviations and ranges)’.

In contrast, McLeod (1994) describes qualitative research as words rather than numbers and Tesch (1990) suggests that it is all data that cannot be expressed in numbers. In qualitative research, participants are able to provide a wider range of reactions than in quantitative studies, thereby adding to the depth and richness of the data.

Researchers might utilize qualitative methods in ‘recognition of the limitations of addressing many significant questions in the human realm’ with quantitative methods (Lavery, 2003, p. 2). McLeod (quoted in Etherington, 2004d, pp. 246-247) identifies the limitations of some quantitative studies within the fields of counselling and psychotherapy: ‘I mean the mainstream...all that crap, randomised control trials and all that is a bubble that could burst because its not actually producing useful knowledge’.

Upton and Asch (1999, p. 192) add that:

In recent years the increase in more qualitative methodologies of counselling research serves as a beacon to highlight the belief that the area is too complex to be reduced to simple quantitative or laboratory-based experiment.

In agreement, Berrios and Lucca (2006, p. 182) write:

Qualitative research designs...(because of the in-depth perspective they allow), are most appropriate to investigate some of the more pressing problems of today, namely adolescent pregnancy, alcohol and drug abuse...and mental problems.

They therefore conclude that ‘As helping professionals commit themselves to their profession, they should devote more time to...qualitative research’ (*op. cit.*, p. 181).

### **Why I chose to do qualitative research within the interpretive paradigm**

Etherington (2004d, p. 25) notes that ‘personal views and beliefs...guide our choices between paradigms and methods...’ My decision to engage in qualitative research within the interpretive paradigm arose as a result of my view that this type of research is both interesting and important.

I expected that any qualitative research I carried out would give rise to findings that might be useful to practitioners, trainees, trainers and supervisors. Having previously carried out positivist research within the field of biology, I also wanted to experience carrying out



educational research in a different way. Since no known theories of therapist learning and change exist, I chose to begin with a grounded theory study.

## **Ethical issues**

### **Definition**

Bond (2004a, p. 4) notes that all quality research 'should be ethical'. 'Ethics' is referred to a great deal in the literature on research in counselling and psychotherapy, but this term is often not clearly defined. Dictionary definitions of 'ethics' often confuse the term with 'morals' (Ecclestone, 2003). The Oxford Dictionary and Thesaurus III (Elliott, 2001, p. 254), for example, notes that ethics is 'moral philosophy...(set of) moral principles'.

Some books on research methodology also use the terms 'ethics' and 'morals' interchangeably (see for example, Cohen, Manion and Morrison, 2003). However, Pring (2003) argues that morals are concerned with right or wrong action whereas ethics constitutes the philosophical enquiry into the basis of morals. In contrast, Ecclestone (2003) suggests that morals are ideas and ideals about what is right and wrong, while ethics constitutes action based on these. For the purposes of this thesis, Ecclestone's definitions will be used.

### **Ethical issues that arose in my grounded theory study**

Laine (2000, p. 16) argues that ethical considerations are often more pressing in qualitative fieldwork than any other type of research:

The conditions of fieldwork (paradoxes, ambiguities and dilemmas) that is qualitative, by way of contrast to quantitative research enquiry (positivistic-orientated and impersonal) that puts the researcher in direct contact with people to form various types of relationships (power, personal and social) make fieldwork inherently problematic.

I have carried out qualitative fieldwork and ethical considerations were an important part of the research design in the studies presented in this thesis. McLeod (1994, p. 165) suggests that, 'it is necessary to give careful consideration to ethical issues at all stages of the research process: planning, implementation and dissemination of results'. In

agreement, Kvale (1996, p. 110) writes, 'Ethical decisions...arise throughout the entire research process'. Ethical issues were therefore considered before, during and after the fieldwork was carried out, and throughout the research I remained open to any ethical issues that arose.

### ***Ethical issues considered at the outset***

Christians (2000) outlines four guidelines for carrying out ethical research: gaining informed consent, avoiding deception, respecting participant's privacy and confidentiality, and ensuring accuracy. Before starting my grounded theory study, I sought and was given clearance from Exeter University's School of Education and Lifelong Learning Ethics Committee (see appendix N). In line with both Christians (2000) and the School's ethics policy, I gained informed written consent from all counsellors and psychotherapists who decided to take part in my research, without deceiving them. I also attempted to ensure confidentiality for all participant therapists by carrying out the interviews in a safe and private environment and by avoiding using real names or revealing distinguishing information about them in my research reports.

In addition, I wanted to guarantee anonymity for their clients by asking counsellors and psychotherapists not to disclose their real names or give any distinctive descriptions of them. At the outset, I planned that if, in talking to me, a counsellor inadvertently revealed personal client details, this part of the interview would not be transcribed and the recording would be destroyed after the transcription stage had been completed. In order to ensure accuracy, participants would be given the chance to read their interview transcripts, and if necessary, to alter quotations used in my research reports. One participant later noted that she had valued this:

It has been really thought provoking for me to read through what I have said and consider it being read by other people. I think I have learned a lot about how I want to conduct my own research project in the future and how important it is to give participants some control over what happens with their info.

In agreement with Robson *et al.* (2000), I gave prospective participants the option to refuse to take part in my research without asking for an explanation. Furthermore, I made it clear to participants that they were free to withdraw from the research at any time.

### ***Problems that arose***

Although most of the ethical procedures detailed above were put into place, some problems were encountered. One such problem involved training. Bond (2004a) argues that researchers should have received sufficient training in order to carry out a research project. Similarly, the *Ethical Framework for Good Practice in Counselling and Psychotherapy* (BACP, 2002, p. 3) states that the ethical principle of beneficence ‘directs attention to working strictly within one’s limits of competence’.

The MSc in Educational Research I completed before starting my doctoral studies provided me with suitable background information for the successful planning and implementation of the studies presented in this thesis. However, as a PhD is itself a research training (Phillips and Pugh, 2000), it was inevitable that at the outset I would not be a sufficiently trained researcher and that I would be working within my own personal limits of competence.

Since I had never carried out a research interview before beginning my PhD, my nervousness may have prevented me from cultivating as safe an atmosphere as I would have liked to during my first few meetings with participants. On several occasions, it seemed as if the therapists I spoke to helped to make me feel comfortable rather than me putting them at ease.

Another problem was linked to confidentiality. Christians (2000, p. 139) notes that, ‘Despite the signature status of privacy protection [in research ethics], watertight confidentiality has proved to be impossible. Pseudonyms...are often recognised by insiders’. Some of the pseudonyms used in the grounded theory study reported in this thesis may be recognisable. In line with the ethical principle of autonomy, which supports freedom of choice (Robson *et al.*, 2000), all participants I interviewed were given the opportunity to choose their own pseudonyms. However, some insisted on using their real names.

In an attempt to address the problem of recognisability, all research participants were given the opportunity to change their pseudonyms twice: when they were sent transcripts of their interviews, and again when they were sent a draft copy of my research findings. One counsellor who had originally decided to use her real name took up this opportunity.

Furthermore, in research reports other than this thesis, and in correspondence with participants, it was stated that all names used were pseudonyms, only first names were used, and the fact that some pseudonyms were also real names was not mentioned.

Hollway and Jefferson (2000) suggest that confidentiality can be one of the least problematic of ethical issues. However, I did not find this to be the case. Although confidentiality was never knowingly broken, I noticed that our relationship was affected when, after our interview, one counsellor asked me which other counsellors in the area had agreed to participate in my research. I told her that this was confidential information, yet asked her, during the interview, to share intimate details of her client experiences with me: experiences which she had not shared with anyone other than her supervisor before.

Pseudonyms were used, confidentiality was never broken and all distinctive details were omitted or altered in my research reports. However, since I have used some lengthy quotations in findings reported within this thesis, I cannot guarantee that participants will be unidentifiable. As Etherington (2004b, p. 64) points out, 'It is notoriously difficult to disguise a person's identity...because personal stories highlight the uniqueness of a person's life'.

Robson *et al.* (2000, p. 540) note that confidentiality may become a particular problem if participants make 'revelations of abuse or of being an abuser'. One therapist did mention abuse, adding that without the contract of confidentiality we had engaged in, she would not have mentioned this. As the issue had been previously resolved, I did not break confidentiality by reporting it outside of this thesis.

Like confidentiality, gaining consent was also found to be problematic in that consent from the clients that the counsellors spoke about could not be obtained without compromising their anonymity. The focus of the study was therefore firmly placed on the participant counsellors' and psychotherapists' experiences, and, as stated above, no client names or distinguishing details were used in this thesis or in research reports.

A further ethical problem was linked to the ethical principle of nonmaleficence, which states that research participants should not be harmed. According to Robson *et al.* (2000), though, emotionally harming participants might, in some circumstances, be unavoidable. Bond (2004b, p. 11) therefore notes that all researchers in the field of counselling and

psychotherapy 'are expected to have given careful consideration to any risks arising from the research'. These risks, I believe, should be communicated to potential participants. At the outset of my grounded theory study, it was anticipated that talking about their learning experiences might bring up difficult issues and painful memories for participants. I therefore informed all prospective participants that the project focused on their learning and change experiences, to highlight the fact that they would be asked to talk about learning experiences that had affected them on a deep level.

Participants were also warned that difficult issues or painful memories may arise. However, the eventuality that a therapist may, after recalling an incident, be too upset to continue the interview was not planned for. This happened in one case, in which a participant began to cry after recalling a particularly painful memory. In line with Robson *et al.* (2000) I followed my gut reaction in this case: I asked the participant if she wished to end the interview at that point, and she said that she did, adding that she was happy for me to use the fifty minutes or so of dialogue that had been recorded on the tape up until then.

I left the participant's house (where the interview had taken place) soon afterwards because she wished to be alone. As Elliston (2002, p. 18) points out, 'the needs of the research participant should always come before the objectives of the study'. In retrospect, in line with the ethical principle of nonmaleficence, I am now aware that it would have been appropriate to contact this participant at a later date, to communicate my concern that the interview had evoked painful feelings. Although I did write to the participant soon after the interview, inviting her feedback on the transcript I had enclosed, I did not express my concern about the feelings that the interview had evoked: Feeling unconfident and inadequately equipped to give it, at the time, I thought that this type of follow-up communication may have been intrusive or patronising.

### ***Other considerations***

Bond (2004b) outlines a number of ethical considerations which appear to be absent in most other texts. He notes, for example, that a researcher should be supported by regular and ongoing supervision. In addition, she should receive adequate personal and professional support throughout a research project. Researchers should combine:

...a robust personal ethical commitment to being trustworthy with actively striving to secure a place within the network of professional relationships and organisational systems that will enable this ethical commitment to be honoured (Bond, 2004b, p. 17).

I attended regular supervision meetings with my academic supervisors throughout the period in which I engaged in the research presented in this thesis, and during these meetings, I was given the opportunity to talk about any ethical issues that had arisen. However, as I felt that I would benefit from the contact with a wider group of people during my doctoral studies, I enrolled first on an 'intermediate certificate in counselling skills' course and later on a 'diploma in integrative counselling' course. These courses gave me access to the counselling arena, and therefore a greater insight into the work of practitioners. Enrolling in the diploma course also made me eligible to become a student member of the BACP.

As well as ongoing supervision and adequate personal and professional support, Bond (2004b) also discusses the importance of researcher reflexivity in considering ethical issues in research. Reflexivity should be used so that the impact of the researcher's values and experiences on the research is made clear. This thesis contains sections of reflexive writing in which my experiences, ideas and values are outlined. In addition, some of the possible impacts of these experiences, ideas and values on the research findings are noted within chapter 5.

In line with Bond (2004a), I have also discussed the difficulties I encountered in carrying out my research within this thesis and have outlined the ontology, epistemology and methodologies used.

Finally, Bond (2004b, p.15) suggests that it is

...an ethical expectation...that [researchers]...seek opportunities to communicate any learning from research that is relevant to participants, practitioners, policy makers, academics and others with valid interest in the research.

A draft of my research findings was therefore sent to all participants, who were asked if they wished to comment or make any further changes. No further changes were required, but a few noted that they found the findings interesting. Furthermore, I have presented my research findings at the 2005 annual BACP research conference, and will present at the 2007 conference (Turner, 2005b; 2007, see also appendix L1 and L2). I have also given talks on my work at conferences at Exeter University (Turner, 2004a; 2005a; 2006a), and have written about my findings in a letter published in *Counselling and Psychotherapy Research* (Turner 2005c, see also appendix M).

West (2002) raises an ethical issue. He notes that researchers should ‘avoid the possibility of research being experienced as what has been called ‘hit and run’’ (West, 2002, p. 264). In ‘hitting and running’, a researcher gains deep and personal data from a research participant, then leaves without attempting to close down the interview process. To avoid this, after carrying out my interviews, whenever possible, I chatted informally to participants, asking how they had experienced the interview, and answering any questions they had, for as long as seemed necessary. Some wanted to know more about me, including my background and personal reasons for deciding to carry out this research. Their questions were freely answered.

## **Reflexivity**

### **The meaning of reflexivity**

‘Reflexivity’, Etherington (2004d, p. 21) writes, ‘means different things to different people’. Some people refer to it as ‘critical reflexivity’, and others call it ‘critical subjectivity’ (Etherington, 2004d). Moreover, the term has been used for a variety of purposes.

Edwards, Ranson and Strain (2002), for example, point out that major life disruptions, such as separation, ill health, significant loss, unemployment or retirement are likely to trigger reflexive questioning. They argue that a reflexive theory of lifelong learning is therefore needed that includes reactive informal learning, as well as the way in which structures of thought, feeling and belief may be altered through reflexivity. In contrast, building on the

work of Bourdieu, Schirato and Webb (2003, p. 551) suggest that ‘reflexivity is best understood as a collective, rather than individual, process’.

Bourdieu highlighted the importance of reflexivity for sociology, arguing that all sociologists must conduct their research with conscious attention on the effects of their own position, biases, ideas and interests on their work (Fowler, 1997). Similarly, with regard to qualitative research, Lincoln and Guba, (2000, p. 183) note that reflexivity ‘is the process of reflecting critically on the self as researcher’. However, in line with postmodernist thinking, it may be argued that the researcher has multiple and changing ‘selves’ rather than a single fixed ‘self’ (Crotty, 1998). Lincoln and Guba, (2000, p. 183) therefore refer to ‘the multiple identities that represent the fluid self in the research setting’.

This idea resonates with my own experience of carrying out the studies reported in this thesis: I have experienced myself to be slightly different with each participant I met during my grounded theory study, and with each client that I worked with as part of my co-operative self-study inquiry. And as I formed relationships with my clients, over a number of sessions, I began to feel differently about them, and about myself.

McLeod (2001) suggests that reflexivity is of particular significance for qualitative researchers working in the areas of counselling and psychotherapy because these activities encourage self-reflection. As one such researcher, for the purposes of my research, my own understanding of reflexivity is closest to that of Etherington (2004d, pp. 31-32): ‘I understand researcher reflexivity as the capacity of the researcher to acknowledge how their own experiences and contexts (which might be fluid and changing) [might] inform the process and outcomes of inquiry’.

‘...everything that happens is constructed by those involved in it, and therefore, *not* to be reflexive, not to self-examine and not to put that process and the results of that process out there is to withhold some of the information that exists about the context which you’re examining’ (Sue Webb, quoted in Etherington, 2004d, p. 48).



My previous and present contextualised experiences have no doubt had some impact on what I have written here. I have therefore deliberately and overtly included pieces of writing about some of these experiences within my thesis.

### **The purposes of reflexivity**

Morrow (2005, p. 254) notes that:

In order to deal with biases and assumptions that come from their own life experiences or in interactions with research participants, which are often emotion-laden, qualitative researchers attempt to approach their endeavour reflexively.

Similarly, Etherington (2004b, p. 46) writes:

I explain my interest in the topics and how I had gone about trying to discover new knowledge. By doing so, you as reader are provided with information about the values and principles that underpin the way I conduct research and you can use that knowledge to judge its rigour and validity.

‘Biases’, ‘assumptions’, and ‘validity’, though, are perhaps words associated with the explanatory paradigm, in which researchers might strive for an objective understanding of their topic. These positivist ideas have been challenged by those who believe that all researchers bring their cultural context, previous experiences and prior knowledge into their research, even if they are not aware of doing so (Trochim, 2002). I believe that I cannot escape from affecting the outcomes of my research. Rather than striving for an objective understanding of the learning and change that therapists experience as a result of their client work, through the use of reflexivity, I have aimed for critical subjectivity.

As well as highlighting the ways in which the researcher may impact on the processes and outcomes of a research study, reflexivity may also be used to make explicit ethical dilemmas that arise during a study, or it may be an important part of the methodology used, as in autoethnography, heuristic enquiry and co-operative inquiry (Etherington, 2004b; Heron, 1996; Moustakas, 1990). I have made use of reflexivity in all of these ways

in carrying out my co-operative self-study inquiry, and have reflected on the ethical problems that arose during my grounded theory study through the eyes of a reflexive researcher.

Reflexivity can be used to create a bridge between practice and research. Etherington (2004d, p. 16, original emphasis) notes that:

Reflexive methodologies seem close to the hearts and minds of practitioners who value using themselves in *all* areas of their practices (including research) and who also value transparency in relationships.

These practitioners include many counsellors and psychotherapists, who develop their reflexivity skills through their client work and training. These skills improve their abilities to notice their responses to the environment, other people and events, and they can later be utilised used in carrying out reflexive research (Etherington, 2004d). For me, though, the opposite may have occurred: I carried out reflexive research (for my grounded theory study) before starting to work as a counsellor (which I did as part of my co-operative self-study inquiry), so that the skills I learnt as a result of carrying out my grounded theory study may have later been applied to my client work.

### **Ways of being reflexive**

According to Etherington (2004b, p. 46), in terms of the way in which researchers impact on their research, reflexivity is about ‘being aware of what influences our relationship to our topic and our participants’, and also ‘being aware in the moment of what is influencing our internal and external responses’. She suggests, therefore, that reflexive researchers must be able to operate at these different levels.

For me, Etherington’s (2004b) two levels of reflexivity are linked: During the interviews I carried out for my grounded theory study, for example, I needed to be aware of what was affecting my responses in the moment in order to work out what was influencing my relationship with the participants.

After one interview, I wrote in my research journal, 'I felt very nervous during this interview and quite inadequate, whilst he seemed really confident' (Turner, research journal, 2004-2007, entry 19). As a result of my feelings in the moment, I was not able to form a trusting relationship with this participant. I noted that, 'He didn't seem to say much about his own experiences at all' (*ibid.*). After a different interview I wrote in my journal, 'I felt fine and it went well' (Turner, research journal, 2004-2007, entry 21). My internal and external responses in the moment were therefore affected by the way I felt with each participant (which was no doubt linked to the way they felt with me). This, in turn, affected the relationship I formed with each participant and the extent to which they felt safe enough to talk about their personal experiences.

What is more, my relationship with my topic, which I have experienced as changing rather than fixed, affects and is affected by my internal and external responses in the moment. Towards the start of my grounded theory study, for example, I became disheartened when only two people responded to an advertisement for participants that I had placed in a counselling and psychotherapy journal. Next, I tried e-mailing potential participants to invite them to take part in my study. This proved to be more successful. I wrote in my research journal, 'I'm getting quite a few responses from the e-mails, which is great, and a relief. I feel excited about the study now' (Turner, research journal, 2004-2007, entry 5).

Morrow (2005) believes that qualitative researchers working within all paradigms should attempt to be reflexive, and he suggests that one of the best ways of doing this is to keep a self-reflexive journal throughout an investigation. Etherington (2004d) devotes a chapter of her book *Becoming a Reflexive Researcher* to research journal writing, which she suggests can be used by a researcher to reflect upon her relationships with participants, changing and developing understanding of methods and findings, and positive or negative feelings about the research process.

Throughout my doctoral studies, I have kept a research journal, in which I have regularly reflected on all of these. I have used a number of quotations from my journal within this thesis.

Lincoln and Guba (2000, p. 184) refer to the reflexive potential of writing in general:

Writing is not merely the transcribing of some reality. Rather, writing – of all the texts, notes, presentations, and possibilities – is also a process of discovery: discovery of the subject...and discovery of the self.

For me, writing this thesis has been a creative process and a learning experience: I have not simply written down what I have learnt; instead, I have formed ideas and learned about both therapists' learning and change and about myself in the process of writing.

### **Potential problems**

Attempting to be reflexive may be problematic. Etherington (2004d) lists several potential problems in using reflexivity in research within the social sciences. She notes that others in a reflexive researcher's field of study may see their reflexive writing as self-indulgent or narcissistic. Several people she interviewed, who had undertaken PhDs, had been asked to take sections of reflexive writing out of their theses by examiners or supervisors who viewed these as superfluous to their findings. Etherington (*ibid.*) therefore suggests that what is included of the self of the researcher in a study should be well thought out in terms of its relevance: 'a means to an end, not an end in itself' (Etherington, 2004d, p. 31).

As a research student, a trainee counsellor, a lifelong learner, and person, I am clearly visible within my thesis. Yet I have tried to include of myself only what I believe to be of relevance to the research studies I have undertaken, so that my relevant experience, thoughts and ideas are made explicit. What I have deliberately included of myself in this thesis is intended to be nothing more than a means to an end.

Etherington, (2004b) notes that some researchers may be anxious about being personally exposed within their work, and may fear possible judgement by other academics. This is, to some extent, true for me. Writing reflexive pieces for this thesis has been a challenging and sometimes emotional experience. But in my view, it has been a necessary part of the work rather than a self-absorbed and self-indulgent diversion.

Seale (1999b, p. 163) alludes to another problem, which Etherington (2004d) ignores. He points out that many of a researcher's values, prejudices and other potential influences on research findings are subconscious and 'by definition not available for explanation by the person who has been influenced by them'. In addition, Brookfield (1995b) distinguishes between three types of assumptions that we have: paradigmatic, prescriptive and causal. Only causal assumptions are easy to uncover.

Buckner (2005) also refers to the limits of an individual's self-awareness, but suggests that working as a team may help to expose relevant unconscious material. However, Seale (1999) notes that once a researcher's assumptions are brought to light, they are no longer assumed, and instead become beliefs if the researcher decides to keep them. So assumptions cannot simply be 'dealt with' through reflexivity, as Morrow (2005) has suggested. 'There seem to be inevitable limits to the possibilities of reflexive accounting' (Seale, 1999b, p. 164).

Although I worked with a co-researcher during the CSSI, who was able to help expose some of my subconscious views and preferences, I have worked alone on my grounded theory study. In addition, while I have been well supported by my supervisors, I have also worked alone in writing this thesis. Some of my relevant experiences, ideas and views may therefore remain unconscious and undocumented. Furthermore, I am aware that the experiences, ideas and views that I have documented have not been 'dealt with' through this process, they have simply been highlighted as potentially having an effect on the process and outcomes of the two research studies presented.

### **My use of reflexivity within this thesis**

Many social science studies are catalysed by the researcher's personal observations or experiences (Etherington, 2004a). In chapter 1, I have written about the way in which my personal history has led to my interest in the learning and change that counsellors and psychotherapists experience as a result of their work with clients. I have also included

background details about myself and my previous counselling training, as well as a subjectivity statement, detailing what I thought some of the findings of the grounded theory study might be. The ways in which my expectations of that study may have influenced the outcomes is discussed in chapter 5.

In addition, this thesis incorporates reflexive statements about my personal experiences: As part of a brief account of some relevant aspects of education and learning that I have included, I have written an account of some of my own teaching and learning experiences to date, in order to illustrate how these experiences have affected my personal views about learning, as well as how these views might have affected the way in which the account was written.

In a section of writing on transformative learning, I have included a piece of writing on a transformative learning experience that I have had, to indicate how this experience might have affected my personal views of the theory of transformative learning. Since ‘reflexivity is about how the research impacts on the researcher as well’ (Jeremy, quoted in Etherington 2004d, p. 204) I have also included a piece of writing on the ways in which I have learnt and changed as a result of working on my PhD, in chapter 5. My material also forms a large part of the findings of the CSSI. What is more, I have given detailed accounts of my research experiences both within relevant sections on the methodologies and methods I have used and also in the research journal extracts that I have included in the appendix (appendix J).

Although each piece of reflexive writing included in this thesis contributes to the meaningfulness of my research work as a whole, these pieces of writing are no more ‘true’ than anything else I have written. As McLeod (2001, p. 201) puts it, ‘the subjectivity of the researcher does not command a privileged position. Personal statements made by researchers are themselves positioned within discourses’.

It is important to note that my views and ideas are also included more covertly within this thesis. They form part of critiques of others’ work that I have added to the literature reviews, and they are also present in the choices I have made in terms of the literature I have referred to, and the literature that has been left out. My views are also present in

terms of the participant quotations that I have chosen to include within the findings sections, as well as the participant material I have decided not to use.

### **Quality criteria**

‘Rigor is needed in all kinds of research to ensure that findings are to be trusted and believed’, notes Merriam (1995, p. 51). She adds that practitioners ‘want to feel confident incorporating research findings into [their] practice, for what [they] do affects the lives of real people’ (*ibid.*). In agreement, Lincoln and Guba (2000, p. 178) suggest that we should ask of all research outcomes, ‘Are these findings sufficiently authentic...that I may trust myself in acting on their implications?’ Below, I have discussed some of the measures of rigor used within the explanatory paradigm, and contrasted these with some interpretative measures. The quality of the studies presented in this thesis is then addressed.

### **Measures of quality used within the explanatory paradigm**

Within the explanatory paradigm, the quality of a research study is often assessed in terms of three different measures: internal validity, reliability and generalisability (Kirk and Miller, 1986). Reality, for positivist researchers, is viewed ‘objectively’ as fixed and stable, and the internal validity of a research finding is a measure of its match with this reality. Merriam (1995) argues that this measure of quality is, however, unsuitable for use in interpretivist studies, in which reality is viewed as constructed, multiple and ever-changing. Here, ‘in a sense the researcher offers her interpretation of someone else’s interpretation of reality’ (*op. cit.*, p. 54).

The reliability of a test carried out within the positivist paradigm ‘is the extent to which the test is measuring something consistently’ (Preece, 1994, p. 5). However, like internal validity, this measure of trustworthiness cannot be applied to interpretivist research because within the interpretivist paradigm, it is recognised that it is not possible to repeat a qualitative measure (for example, an interview) with the same participant, and obtain

exactly the same data each time. As Merriam (1995, p. 55) points out, ‘Human behaviour is never static’.

Generalisability (or external validity) in the positivist paradigm, is a measure of the extent to which it is possible to generalise from research results which are based on a randomly selected sample of respondents. However, most interpretive researchers that carry out qualitative studies use purposeful rather than random samples, so that particular cases can be studied at depth (Patton, 1990). As Merriam (1995, p. 57) points out, ‘The goal of qualitative research, after all, is to understand the particular in depth, rather than find out what is generally true of many’. Furthermore, interpretive researchers ‘would claim the potential uniqueness of every local context’ (Seale, 1999a, p. 468), so that generalising is not possible anyway.

### **Quality in interpretative research**

‘Notions of validity and reliability must be addressed from the perspective of the paradigm out of which the study has been conducted’ (Merriam, 1995, p. 52). These positivist measures of rigour, then, cannot be applied to qualitative research within the interpretive paradigm. As Seale (1999a, original emphasis) writes, ‘Quality does matter in qualitative research, but the modernist headings of *validity* and *reliability* no longer seem adequate to encapsulate the range of issues that a concern for quality must raise’.

Lincoln and Guba (1985) have suggested that the trustworthiness of interpretive research should be assessed in terms of the parallel criteria of ‘credibility’, ‘dependability’, ‘confirmability’ and ‘transferability’.

Credibility is the interpretivist equivalent to validity and is concerned with whether or not a study’s findings make sense for its participants and for the context in which it was carried out. Erlandson *et al.* (1993) suggest that it can be assessed through the use of six different measures. The first of these, member checks (in which both raw data and



interpretations of it are verified by a study's participants), is, according to Lincoln and Guba (1985, p. 314), 'the most critical technique for establishing credibility'.

The other measures include peer debriefing (in which a researcher's colleagues give him feedback on his work), triangulation (in which a variety of participants and points of view are gathered, perhaps using a variety of different methods of data collection), and prolonged engagement (whereby a researcher spends a significant amount of time in the context being studied).

Persistent observation (constantly pursuing interpretations in different ways) and the collection of referential adequacy materials (including documents, photographs, and other materials that provide a deeper understanding of the context of the study) may also be used (Erlandson *et al.*, 1993). Erlandson *et al.* (1993) fail to point out, however, that some of their six measures of credibility are applicable only to ethnographic inquiries. Prolonged engagement, persistent observation and collection of referential adequacy materials may not, therefore, be relevant to interpretive research that makes use of other methodologies.

Lincoln and Guba's (1985) measure of dependability corresponds to the positivist notion of reliability. This refers to the researcher's consistency in carrying out the research, which can be communicated through the provision of an audit trail (documentation including extracts from a research journal, interview notes, samples of raw data, data reduction and analysis products, information about instrument development, and findings) (Erlandson *et al.*, 1993).

Confirmability is the equivalent of the positivist notion of objectivity, and refers to the extent to which the findings of a research study are the result of what has been discovered rather than the impact of the researcher's biases. Within the interpretive paradigm, it is recognized that a researcher will, in some way, impact on her research. Confirmability of

the findings of a study therefore refers to the extent to which they can be traced back to the raw data (Erlandson *et al.*, 1993). Erlandson *et al.* (1993) suggest that confirmability can be communicated with an audit trail, whilst Morrow (2005, p. 252) refers to ‘the management of subjectivity’, which includes making the researcher’s assumptions and biases explicit within the research.

Finally, transferability refers to the extent to which a study’s findings can be applied to other contexts, which may have similar characteristics. It is equivalent to generalisability within the positivist paradigm. Transferability may be addressed by the researcher or left for the consumers of the research to think about (Merriam, 1995). In either case, though, it is recognised within interpretive research that contexts and participants change with time (Erlandson *et al.*, 1993), and therefore, so might transferability.

Morrow (2005, p. 252) suggests that to be able to judge transferability, reflexivity and thick (detailed) descriptions are necessary. The researcher must provide

sufficient information about the self (the researcher as instrument) and the research context, processes, participants and researcher-participant relationships to enable the reader to decide how the findings may transfer.

Erlandson *et al.* (1993) add that purposive sampling may give rise to rich detail about a context, which supports assessments about transferability. Theoretical sampling (further data collection used to expand or improve on the emerging theory), as used in grounded theory research (Glaser and Strauss, 1968), may support assessments of transferability in a similar way.

### **Quality as an important consideration throughout a study**

Erlandson *et al.* (1993), Merriam (1995) and Morrow (2005) advocate the use of techniques such as member checks, peer debriefing, triangulation, prolonged engagement, persistent observation, the collection of referential adequacy materials, researcher

reflexivity, negative case analysis, creating an audit trail, thick description, and purposive sampling to improve the trustworthiness of an interpretive study. In contrast, Brinberg and McGrath (1985, p. 13, original emphasis), warn against focusing on the use of techniques to attain trustworthiness:

*Validity is not a commodity that can be purchased with techniques. Validity, as we treat it, is a concept designating an ideal state – to be pursued, but not to be attained...validity is...to be assessed relative to purposes and circumstances.'*

Focusing on the positivist concept of validity, they suggest that this measure of trustworthiness takes on different meanings at different stages of the research process: In the 'prestudy stage' (in which data collection decisions are made and the project is set up) validity refers to the value or worth of a study. In the 'central stage' (in which data is collected), validity is concerned with goodness of 'fit' (internal validity), and in the 'follow-up stage' (in which data is analysed and conclusions are drawn) validity is concerned with generalisability (external validity).

Although their work is now over 20 years old, Brinberg and McGrath's (1985) ideas still stand. I suggest that they can also be adapted for application within interpretive studies in which the potential usefulness of a study is one of the most important considerations as it is set up, credibility is significant during the data collection period (as are dependability and confirmability), and transferability is an important consideration in the drawing of conclusions. The trustworthiness of an interpretive study, then, is an important consideration throughout.

### **Alternative measures of quality in interpretive studies**

Although Lincoln and Guba's (1985) notions of credibility, dependability, confirmability and transferability have often been used to measure the trustworthiness of both postpositivist and interpretivist research studies, these are by no means the only measures

of trustworthiness available (Morrow, 2005). In fact, 'A variety of conceptions of qualitative research exist, with competing claims as to what counts as good quality work' (Seale, 1999, p. 465).

For Lincoln and Guba (2000), for example, ethics and quality may be seen as interlinked. Laverty (2003) therefore points out that 'Issues of rigor in interpretive inquiry are confusing to discuss, at times, as there is not an agreed upon language used to describe it or one universal set of criteria used to assess its presence'. In agreement, Guba and Lincoln (1994, p. 114) write, 'The issue of quality criteria in constructivism is...not well resolved and further critique is needed'.

Morrow (2005) argues that within the arena of counselling psychology, researchers should move away from Lincoln and Guba's (1985) parallel trustworthiness criteria towards standards that are more fitting for constructivist research. She suggests that Guba and Lincoln's (1989) authenticity criteria are more relevant. Like counselling psychologists, I suggest that researchers in the fields of counselling and psychotherapy may also benefit from viewing their research in terms of these criteria.

Morrow (2005) outlines four of Guba and Lincoln's (1989) criteria: 'Fairness' (a variety of participant understandings should be presented), 'ontological authenticity' (the improvement and expansion of participant's understandings), 'educative authenticity' (the enhancement of participant's knowledge of the understandings of others), and 'catalytic authenticity' (action that is stimulated by the research). Morrow (2005), however, makes no mention of Guba and Lincoln's (1989) 'tactical authenticity' criteria, which refers to the extent to which research empowers action, perhaps because, for her, it overlaps to a large extent with 'catalytic authenticity'. Unlike catalytic authenticity, though, tactical authenticity may include the training of participants, in certain ways of engaging in social and political action, by researchers.

What is more, Morrow (2005) adds two more of her own criteria to Guba and Lincoln's (1989) list: The extent to which participant meanings are understood deeply and the extent to which meaning is mutually constructed by researchers and participants. These criteria, she believes 'go deeper' than ontological authenticity and educative authenticity, respectively (Morrow, 2005, p. 253).

Morrow (2005) suggests that it is important to be aware of context and culture in attempting to gain an understanding of participant's meanings, and that rapport building is important here. However, she makes no suggestions as to how mutual constructions of meaning might best be achieved, nor does she acknowledge that many different mutually created meanings are possible (Charmaz, 2000). Seale (1999a) critiques these types of authenticity criteria, arguing that the view that fairness, expansion of understandings, action and empowerment are desirable is value-laden and culturally bound. Seale (1999b, p. 49) himself seems to prefer 'criteria for improving quality...that preserves the enterprise of qualitative research as a creative and exploratory enterprise that cannot be contained by the strict imposition of methodological rules'.

What, then, is the best way to judge the quality of interpretive research studies, such as those presented in this thesis? 'To that question' Lincoln and Guba (2000, p. 180) say, 'there is no final answer'. I have therefore considered the quality of my research in terms of several different sets of criteria.

### **The quality of the studies presented in this thesis**

In the sections of this thesis addressing the methodologies I have used, I have discussed the quality of my research in terms of both Lincoln and Guba's (1985) trustworthiness criteria and Guba and Lincoln's (1989) authenticity criteria, as well as the ideas of the people associated with the specific methodologies I have used.

I have used both interviews in the grounded theory study, and journal writing and discussion with a co-researcher in the CSSI, in an attempt to triangulate both methods and methodologies. But as Flick (1998, p. 230) points out, 'Triangulation is less a strategy for validating results and procedures than an alternative to validation...which increases scope, depth and consistency'.

### **A constructivist approach to grounded theory**

The grounded theory methodology was formulated in the 1960's by the sociologists Barney Glaser and Anselm Strauss, and was first published as *The Discovery of Grounded Theory*, in 1967.

In this book, Glaser and Strauss note that grounded theory methodology was created in opposition to the hypothetico-deductive practice of verifying the theories of ‘great men’ like Weber, Durkheim, Marx and others, which was prevalent at the time. They argued that the sociological field lacked theory and that theory should be ‘grounded’ in data collected by researchers, rather than being imposed on the data:

So often in journals we read a highly empirical study which at its conclusion has a tacked-on explanation taken from a logically deduced theory. The author tries to give his data a more general sociological meaning, as well as to account for or interpret what he found...[In contrast,] grounded theory is derived from data and then illustrated by characteristic examples of data (Glaser and Strauss, 1968, pp. 4 and 5).

In the forty or so years that have passed since Glaser and Strauss’ seminal text was published, many articles and books have been written on grounded theory, and researchers within a variety of fields other than sociology have made use of and adapted the methodology (see for example Babchuk, 1996; Calloway and Knapp, 1995; Haig, 1995 and Harris, 2003).

Glaser and Strauss’ ideas have evolved separately (Glaser 1978, 1992, 2002; Strauss, 1987; Strauss and Corbin 1990, 1994, 1997, 1998) while other researchers have developed novel ways of viewing and using grounded theory (Harris, 2003). McLeod (2001, p. 88, original italics used) suggests that ‘maybe there are *many* grounded theory methods?’, and this is not surprising given the deliberately vague and flexible way in which *The Discovery of Grounded Theory* was written (Glaser and Strauss, 1968). In addition, in the first chapter of their book, the authors stress that ‘Our principal aim is to stimulate other theorists to codify and publish their *own* methods for generating theory’ (*op. cit.*, p. 8, original italics used).

The grounded theory methodology that has been employed in the analysis of the phase one study data presented in this thesis is based on Kathy Charmaz’s constructivist approach (2000). Approaches to grounded theory have traditionally been positivist. However, Seale (1999, p. 104) notes that:

Although grounded theory emerged in an era of scientism, and its more technical explications are sometimes unwelcome reminders of this, the spirit that lies behind

the approach can be simply explained, and does not have to be attached to a naively realist epistemology, or indeed to an oppressive urge to force readers to regard its products as true for all time.

Charmaz (2000, p. 510) extends Seale's point, arguing that researchers can use grounded theory methods in constructivist studies which are based on interpretive approaches:

Constructivist grounded theory celebrates firsthand knowledge of empirical worlds...assumes the relativism of multiple social realities, recognises the mutual creation of knowledge by the viewer and the viewed, and aims toward interpretive understanding of subjects' meanings.

Charmaz (2000) suggests that Glaser's (1978, 1992) position on grounded theory is closest to traditional positivism, assuming an objective external reality, and a neutral observer. In contrast, Charmaz notes, Strauss and Corbin's (1990, 1998) view is postpositivist, because although they assume that an external objective reality exists, they propose 'giving voice' to respondents and recognizing how their own and respondent's views differ. In addition, in the second edition of their book *Basics of Qualitative Research* (Strauss and Corbin 1998), they recognise that grounded theory is both art and science. In contrast to Charmaz (2000), I suggest that while Glaser remains firmly objectivist (2002), Strauss and Corbin (1994, 1998) have moved towards a more constructivist approach.

Charmaz (2000) acknowledges that since the first edition of *Basics of Qualitative Research* (1990) Strauss and Corbin's ideas have become more flexible. However, she appears to fail to recognise just how similar their views are to her own. For example, in 1994, Strauss and Corbin claimed to reject the positivist position in favour of pragmatism (Strauss and Corbin, 1994). And like Charmaz (2000), they acknowledge that the researcher has an effect on the outcome of a study:

A theory is not the formulation of some discovered aspect of a pre-existing reality 'out there'...theories are interpretations made from given perspectives as adopted or researched by researchers (Strauss and Corbin, 1994, p. 279).

In contrast, in a reply to Charmaz (2000), Glaser (2002) suggests that participants tell a researcher how to view the data and that the researcher's own interpretations should somehow be kept out of the study. 'Most researchers, I have worked with, take great pains

to not introduce their own views in the data' Glaser (2002, paragraph 14) notes. However, how they manage 'this feat of cognitive evasion' (Bryant, 2003, paragraph 9) is not detailed. I suggest that since researchers choose the categories in their grounded theory studies, they cannot help imposing their own interpretations on the data. Glaser seems to have forgotten what he co-wrote in *The Discovery of Grounded Theory*:

Still dependent on the skills and sensibilities of the analyst, the constant comparative method is not designed (as methods of quantitative analysis are) to guarantee that two analysts working independently with the same data will achieve the same results; it is designed to allow, with discipline, for some of the vagueness and flexibility that aid the creative generation of theory (Glaser and Strauss, 1968, p. 103).

The constructivist approach to grounded theory is discussed in greater detail below, in the context of other approaches to grounded theory, and with reference to specific components of the methodology. The way in which I used this methodology to carry out the phase one and two studies presented in this thesis is then detailed.

### **Useful data**

Glaser and Strauss (1968) devote two chapters of *The Discovery of Grounded Theory* to the discussion of sources of data for use in generating a grounded theory. They suggest that although qualitative researchers have traditionally relied on data collected during interviews and observations for theory generation, many other types of data, including letters, memoirs and novels could potentially be used in producing a grounded theory.

However, Brown (1978, cited in Seale, 1999) notes that data used in a grounded theory study must be easily accessible and have a repetitive character, so that something missed can be 'picked up' and recorded later. This, he argues, limits the type of research problem and data that grounded theory can be used with.

Glaser and Strauss (1968) stress that quantitative, as well as qualitative data can be used for grounded theory. Although little attention is devoted to the use of quantitative data in



the first books they went on to write after *The Discovery of Grounded Theory* (Glaser 1978; Strauss 1987), Strauss later suggested that ideally, both qualitative and quantitative data should be used in grounded theory work:

Quantitative and qualitative forms of research both have roles to play in theorising. The issue is not whether to use one form or another but rather how these might work together to foster the development of theory...what we are advocating is a true interplay between the two (Strauss and Corbin, 1998, p. 34).

Interestingly, though, many of the grounded theory studies carried out to date, including all ten studies detailed in the book *Grounded Theory in Practice* (1997), edited by Strauss and Corbin, have made use of exclusively qualitative data. In addition, many have used only interview data. Like Glaser and Strauss (1968), Charmaz (2000) advocates the use of many methods of data collection in generating a constructivist grounded theory. However, she acknowledges that several successful studies have relied exclusively on interviews, and cites her own work as examples (Charmaz 1991; Charmaz 1995).

The manner in which a method of data collection is used may also be important. In their article comparing two different grounded theory interview studies, Calloway and Knapp (1995) conclude that theory can be made regardless of the way in which data collection was carried out. However, McLeod (2001, p. 82) points out that the researcher's approach to data collection has an effect on the quality of the theory produced: 'The richness and relevance of findings may depend more on the quality of the relationship between the researcher and informant than it does on the rigour of the analysis of the data.' Charmaz (2000, p. 525) notes: 'A constructivist approach necessitates a relationship with respondents in which they can cast their stories in their terms. It means listening to their stories with openness to feeling and experience'.

Hollway and Jefferson (2000) point out that if participants do not feel positive about their relationship with the interviewer they will disclose less of themselves. In line with this, in carrying out my phase one study, I found that the quality of the relationship I formed with therapists I interviewed affected the quality of their responses. As I gained experience and became more confident in interviewing I was more able to put participants at ease and encourage them to tell their stories.

### **Constant comparison and coding**

Glaser and Strauss (1968) point out that comparative analysis is a general method, like experimental and statistical methods, which also rely on the logic of comparison. In grounded theory analysis, data are coded, unit by unit (normally line by line or sentence by sentence) in order to identify conceptual categories and their properties (subcategories). In generating categories, data are at first compared with other data, and later, when it has begun to emerge, data are compared to theory. Charmaz (2000) notes that this process may also involve comparing different participants, comparing data from the same individual and comparing categories with each other.

Glaser and Strauss (1968) suggest that the analyst should initially code the data for as many categories as possible by noting category names in the margins of data records. This step was later referred to as ‘open coding’ (Glaser 1978; Strauss 1987; Strauss and Corbin 1990, 1998). As the coding takes place, the researcher should compare incidents of the same category with each other, so that theoretical properties of the category can surface. Glaser and Strauss (1968) note that two types of categories will emerge: those constructed by the researcher and those that arise from the language used by the research participants. Strauss and Corbin (1990) add a third category type, which makes use of technical terms drawn from theoretical or professional literature. Codes used in the phase one study presented in this thesis make use of all three types of categories.

The next step involves integrating categories and their properties so that a theory begins to form. This then leads to the penultimate step of ‘delimiting the theory’ which involves reducing the number of categories by combining categories or disposing of those that seem to be irrelevant to the emerging theory.

The final step in generating a grounded theory is writing about it with the aid of memos generated throughout the process. The theory may take one of a variety of different forms, and will either be a substantive or a formal theory. Substantive theories are developed from an empirical area of enquiry, whereas formal theories are developed from a conceptual area (Glaser and Strauss, 1968). The theories presented in this thesis are substantive.

Both Glaser (1978) and Strauss and Corbin (1990, 1998) have adapted the procedure detailed above in different ways. Glaser (1978) suggests that after the open coding stage, the researcher should choose a core category and code around it so that only categories relating to the core are recorded. He suggests that the core category should also guide further data collection through theoretical sampling (discussed below). According to Glaser (*ibid.*) ‘theoretical coding’, which involves theorising about how substantive codes relate to each other then takes place, and finally a model of best fit is chosen and integrated into a theory. However, Glaser and Strauss (1968, p. 109) suggest that such theoretical coding may not always be necessary: ‘If the data are collected by theoretical sampling at the same time that they are analysed (as we suggest should be done), then integration of the theory is more likely to emerge by itself.’

Strauss and Corbin (1990, 1998), in contrast to Glaser (1978), make use of ‘axial’ and ‘selective’ coding (terms first introduced by Strauss (1987), but which Seale (1999) points out are misleading since these activities do not actually involve coding and are instead simply further elaborations of open codes). After the open coding step, Strauss and Corbin (1990, 1998) advise researchers to make statements about how a category relates to its subcategories (including the circumstances in which the category occurs, its context and its outcomes), and to look for clues about how categories relate to each other (‘axial coding’). ‘Selective coding’ involves choosing a core category and relating other categories to it to form a theory then refining the theory by disposing of unwanted categories and filling in gaps through theoretical sampling.

Strauss and Corbin (1990) also introduce the procedures of dimensionalising (dividing up the properties of a category so that they lie along a continuum) and the use of a conditional matrix (a diagram that maps conditions and outcomes related to a category) in order to make theories more intricate and accurate.

Glaser (1992), however, criticises their methods, arguing that they are overly technical and lead to forcing data into categories without allowing creative insights to emerge. In line with this, Charmaz (2000) suggests that grounded theory methods should be used as adaptable, heuristic strategies rather than formulaic procedures. She argues that the complex procedures introduced by Strauss and Corbin should not be used as they focus on codes, draw attention away from participants’ experiences, and can obscure understandings.

In addition, Charmaz (2000) notes that like data collection, analysis is interactive. She points out that the researcher's interpretations shape the codes that 'emerge', and at the same time argues that through line-by-line coding, the researcher remains in tune with participant's realities and is deterred from imposing his own ideas onto the data. The result is a set of mutually constructed codes.

### **Memo writing**

In grounded theory, memos are visual or written notes relating to data analysis (Strauss and Corbin, 1998). They contain elaborations of the 'processes, assumptions, and actions' contained in codes (Charmaz, 2000, p. 517). Glaser and Strauss (1968) devote little attention to memo writing in *The Discovery of Grounded Theory* because, according to Glaser (1978, p. 17) it 'was assumed that everyone knew' about the nature of memoing when the book was written. However, the authors later became aware of the need to explain the process to novice researchers and each devoted a chapter to memoing in their subsequent books (See Glaser 1978, and Strauss, 1987).

According to both Glaser (1978) and Strauss (1987), memoing is an indispensable part of the process of theory generation. It begins at the same time as coding and only ends when a study has been completed. Glaser (1978) suggests that a researcher should write a conceptual memo about a code or the relationship between two or more codes *when an idea arises*: 'As he is "sparked" by his work...the prime rule [for the researcher] is to stop and memo...' (*op. cit.*, p. 83, emphasis added). In contrast, Strauss (1987) advises that grounded theorists should write memos regularly, especially during later phases of a study. Charmaz (2000) and Strauss and Corbin (1998) both recommend including raw data in memos, as illustrations, so that theory can be linked to empirical reality.

Glaser and Strauss (1968) suggest that memos should be written on copies of raw data, as these provide illustrations of the idea. In contrast, their later books (Glaser 1978, Strauss and Corbin 1998) advise against this, since it restricts the length of memos and prevents them from being easily accessible and sortable. Memos should be written separately, on note cards, pieces of paper or perhaps with the aid of a computer programme and should be clearly referenced to the data they relate to (Glaser, 1978; Strauss, 1987 and Strauss and Corbin, 1998).

Memos promote thinking with regard to data and keep analysis focused (Charmaz, 2000). In addition, they slow the pace of analysis so that so that decisions on a core category and a final theory are not prematurely reached (Glaser, 1978). Strauss and Corbin (1998) point out that memos evolve, so that later memos negate, amend, support, extend, or clarify earlier ones. And according to both Glaser (1978) and Charmaz (2000) memos can point to gaps in an emerging theory and provide direction for theoretical sampling (discussed below).

### **Theoretical sampling and saturation**

Theoretical sampling is the deductive component of an otherwise inductive methodology (Glaser, 1978). According to Glaser and Strauss (1968, p. 45),

Theoretical sampling is the process of data collection for generating theory whereby the analyst jointly collects, codes, and analyses his data and decides what data to collect next and where to find them, in order to develop his theory as it emerges.

Glaser and Strauss (1968) point out that only the initial data collection process can be planned in a grounded theory study, and that further data collection is dependent on what findings of the initial data collection period. After this initial period, the researcher should ask, ‘*what* groups or subgroups does one turn to *next* in data collection? And for *what* theoretical purpose?’ (*op. cit.*, p. 47, original emphasis used). Glaser and Strauss (1968) do not recommend exactly how much initial data to collect before carrying out theoretical sampling.

Charmaz (2000) recommends conducting theoretical sampling later in the research, so that relevant data can emerge without being forced. In contrast, Strauss (in a personal communication to her, 1993, cited in Charmaz, 2000) believes it should be carried out early. In addition, while Glaser and Strauss (1968) advocate accessing both new and previously sampled participants in theoretical sampling, Charmaz (2000) concentrates on returning to her original sample. The aim, she suggests, should be to perfect ideas rather than increase the sample size.

Glaser and Strauss (1968) suggest that for each category, theoretical sampling should continue until ‘saturation’: until no further data can lead to new insights about the properties of a category.

As he sees similar instances over and over again, the researcher becomes empirically confident that a category is saturated. He goes out of his way to look for groups that stretch the diversity of the data as far as possible, just to make certain that saturation is based on the widest possible range of data on the category (*op. cit.*, p. 61).

Strauss and Corbin (1998, p. 212) suggest that a category is saturated when it is ‘well developed in terms of its properties and dimensions demonstrating variation’. However, Charmaz (2000) questions the meaning of saturation, suggesting that it seems elastic. She points out that some researchers never define their categories as saturated. In addition, Glaser (1978, p. 53) warns that a researcher’s ‘feeling of theoretical saturation’ may be premature and due to fatigue.

### **Theoretical sensitivity and bias**

A researcher must be theoretically sensitive enough to produce a useful theory from the data collected (Glaser and Strauss, 1968). Strauss (1987, p. 27) defines theoretical sensitivity as being ‘sensitive to thinking about data in theoretical terms’, and suggests that in order to achieve this, a researcher should read widely within her field and in related disciplines. Theoretical sensitivity is enhanced over many years of researching and ‘once started, theoretical sensitivity is forever in continual development’ (Glaser and Strauss, 1968, p. 46).

Strauss and Corbin (1998) argue that complete objectivity in any research study is impossible. In agreement Glaser and Strauss (1968, p. 3) admit that:

Of course, the researcher does not approach reality as a *tabula rasa*, he must have a perspective that will help him see relevant data and abstract significant categories from his scrutiny of the data.

However, Glaser and Strauss (1968) note that theoretical sensitivity is lost when the researcher commits herself completely to one particular theoretical framework. In this case, the researcher can no longer see past her pet theory and does not allow theory to ‘emerge’ freely from data collected. Similarly, as McLeod (2001) points out, if the researcher has a background in one theoretical orientation within counselling and psychotherapy, this can also affect theory outcome. In reviewing the grounded theory studies on psychotherapy carried out by David Rennie, McLeod (2001) draws attention to the humanistic terminology used by this person-centred researcher. He points out that ‘It could well be imagined that a psychoanalytic researcher might come up with quite different terminology if faced with the same data’ (*op. cit.*, p. 83).

McLeod (2001) notes that hiding the fact that a piece of research might be being carried out from within a particular perspective makes it difficult for practitioners to evaluate. In line with this idea, Charmaz (2000) notes the importance of reflexivity in writing up the findings of a grounded theory study. It may therefore be important to state that my initial training in counselling (MA in counselling studies) was largely person-centred. My subsequent trainings (an ‘intermediate certificate in counselling skills’ course a ‘diploma in integrative counselling’) have been integrative.

## **Writing**

The writing process in a grounded theory study can aid theory generation by helping to clarify thoughts and point to breaks in logic (Strauss and Corbin, 1998). In addition, feedback on a report can provide a good evaluation of the theory produced from a study (Glaser, 1978).

Memos provide useful ideas for writing (Strauss and Corbin, 1998). Glaser (1978) suggests that as with memos, the researcher should write the first draft of a research report without worrying about the use of good English, to ensure that all his ideas have been written down. Grammar can be edited, redundant sentences can be removed and clarifications can be added later. Glaser (*ibid.*) points out, though, that it is important to write conceptually, rather than simply writing descriptive accounts.

Using examples from her study of chronic illness, Charmaz (1991) shows how the use of story, analogies and metaphors can be applied to grounded theory research reports. And in line with Charmaz's (2000) point that simple language and straight-forward ideas make reports readable, Strauss (1987) notes that reports should be understandable to both academic *and* other audiences.

Glaser and Strauss (1968) stress the importance of including participants' voices in research reports, and Charmaz (2000) stresses the importance of including multiple voices in a piece of writing. In response to Richardson (1994, cited in Charmaz, 2000), who points out that researchers selectively choose which participants' voices to include in their writing, Charmaz (2000) suggests that researchers should make the criteria for their choice explicit.

In contrast to other research reports, in a grounded theory report, a literature review on the subject studied follows the presentation of the theory, and is only carried out after the theory has been formulated. It can then be used to test the theory, and to modify and/or expand it. Instead of a literature review, the introduction of a grounded theory report includes a rationale for the study and sets the scene (McLeod, 2001).

Finally, as Glaser and Strauss (1968) note, theory is never a finished product and can continue to develop even after it has been published. Similarly, Charmaz (2000) points out that the theories produced in grounded theory studies are temporally limited, and this should be stressed in the writing. In the light of new data, theories can and should be modified (Glaser, 1978). As Glaser and Strauss (1968, p. 28) point out, '...evidence and testing never destroy a theory...they only modify it. A theory's only replacement is a better theory'.

## **The constructivist grounded theory methodology used**

### **Phase one**

The phase 1 study reported in this thesis has made use of data derived from interviews with two cohorts of therapists: A group of therapists who had had one or more significant experiences of working with a client who was HIV positive (group A) and a group of therapists who had had no significant experiences of working with this type of client (group B). Data was collected from both the group A and group B therapists simultaneously, and both data sets were analysed during the same time period, so that if



relevant, categories that arose from one data set could also be applied to the other data set. In this way, some of the similarities and potential differences which existed between the two data sets became clear.

The interviews were first transcribed, then analysed by coding. Although she notes that coding and developing categories are likely to differ between objectivist and constructivist grounded theory, Charmaz (2000) does not outline any procedures for carrying out coding in a constructivist grounded theory study. In carrying out the phase 1 study presented in this thesis, I therefore devised my own procedure which was developed during the study itself. This involved immersing myself in the data during an open coding stage in which the interview transcripts were analysed sentence by sentence. Resulting categories were continually modified, integrated and further abstracted during a process of comparative analysis which involved comparing data to data, participant to participant, data to categories, and categories to categories.

In line with Strauss and Corbin (1990), Charmaz (2000) suggests that codes should be 'active' in order to conserve images of experience. Active codes may be useful in studies reporting the current experiences of participants. However, as my studies involved gaining an understanding of therapist's perceptions of experiences that had already occurred, active codes were not used. Instead, categories referred to the changes and learning that had occurred.

After the open coding stage, categories were related to each other and a core category was identified in a creative and intuitive process in which links were allowed to emerge through my interaction with the data, without forcing. As Glaser (1978, p. 18) points out: 'Generating grounded theory *takes time*...Significant theoretical realisations come with growth and maturity in the data, and much of this is outside the analyst's awareness until it happens' (original emphasis used).

Strauss (1987) advises that grounded theorists should write memos regularly, especially during later phases of a study. In contrast, Glaser (1978) suggests that a researcher should write a conceptual memo *when an idea arises*. Glaser's (1978) advice was followed in carrying out the studies presented in this thesis. In an attempt to allow creative and intuitive ideas to emerge, memos were written to record any thoughts that surfaced as the analysis took place. Although Glaser (1978) suggests that memos can be forced, by simply starting to write on a code, this strategy was not used as it was felt that it might block unconscious processing of the data.

Memos were written in a computer word document, were dated (Strauss and Corbin, 1998) and titled (Glaser, 1978) and included raw data (Charmaz, 2000; Strauss and Corbin, 1998). Later memos made reference to any earlier ones they had evolved from (Strauss and Corbin, 1998) (see appendix K).

In carrying out the phase 1 study, I noticed that many ideas came to me as I was involved and engaged in other areas of my life. I recorded in my research journal, how, for example, I suddenly identified a core category whilst riding my bike one Saturday:

Whilst riding my bike today, noticing baby rabbits running around in a grassy area by the side of the road and vaguely thinking about what I had been reading about grounded theory analysis, I suddenly thought, "Could 'Relationship' be the core category in my study?" It seems to fit... (Turner, research journal, 2004-2007, entry 47).

For the data obtained from each of the therapist cohorts, after a core category had been identified, related clusters of categories were then connected to the core category. This gave rise to two theories of therapist learning and change: one for the group A therapists and the other for the group B therapists.

McLeod (2001) suggests that grounded theory research should be carried out with between eight and twenty participants. Fewer than eight, he says, results in something similar to a case study, whereas involving more than twenty participants can produce redundant data. Glaser and Strauss' (1968, p. 30) approach is more flexible: '...the number of cases, is also not crucial. A single case can indicate a general conceptual category; a few more cases can confirm the indication.'

A fixed number of participants was not decided at the outset of the phase one study presented in this thesis. Instead, interviews were carried out until further data collection did not add anything new to the emerging theories: until it seemed to me as if saturation had occurred. This happened after 16 interviews for group A and 17 interviews for group B. Three more interviews were then carried out for each group to ensure that saturation had really occurred. Nothing new was added to the emerging theories after 19 interviews for group A and 20 interviews for group B, and interviewing was stopped at this point.

Coffey *et al.* (1996, cited in Seale, 1999) criticise grounded theory's heavy reliance on coding, suggesting that it fragments and decontextualizes the data. In addition, it attempts to impose a single meaning on the data rather than recognising multiple meanings. In attempt to overcome these issues in my phase one study, I sought participants' permission to use their decontextualised quotations as evidence for a category.

At this stage, participants were also given the opportunity to modify their quotations. (Several participants did decide to alter their quotations, but none refused to allow me to use them.) Furthermore, as Charmaz (2000) suggests, I acknowledge that the theories I have produced represent only one of many possible mutually created meanings.

## **Phase 2: The theoretical sampling study**

In the second phase of the research project (the findings of which are presented in chapter 3 of this thesis), both theoretical sampling and a literature review were used to test, clarify and expand the grounded theories that were produced in phase 1. Glaser and Strauss' (1968) chapter on theoretical sampling focuses on processes which involve collecting data from different organisations, cities and countries, each of which might, it is presumed, add to the emerging theory.

This process of data collection is potentially limitless, since the possibility that another case could lead to new insights always exists (Seale, 1999). However, the authors admit that 'Most often, however, the sociologist's strategy will be constrained by such structural conditions as who is available to be observed, overheard, interviewed, or surveyed, and at what times' (Glaser and Strauss, 1968, p. 67).

Since the focus of my studies was on counsellors and psychotherapists' learning and change experiences, following Glaser and Strauss' (1968) theoretical sampling procedures would not have been useful. It could not be presumed that two therapists working in different geographical locations, for different organisations are any more likely to have had different experiences than two therapists working for the same organisation in the same geographical location. Therefore, for my phase one study, I carried out theoretical sampling in a different way.

In line with Charmaz's (2000) ideas, theoretical sampling was carried out only during the final stage of my grounded theory study (in phase 2), after 'saturation' had been achieved, to ensure that all relevant categories had been allowed to emerge. However, rather than focusing on previously interviewed participants so that further insights could be gained into statements they had already made, as Charmaz (2000) suggests, in line with Glaser and Strauss (1968), I interviewed new participants during this phase of the research. In this way, I hoped to find out if the two categories found to be of most relevance to the group A therapists in the first phase of the research could be applied to other therapists.

Since I was only able to find four therapists who were willing to be interviewed about the two very specific and challenging topics linked to these categories, the findings of the theoretical sampling should perhaps be viewed 'at a more intuitive, impressionistic level than [findings produced using a more] objectivist approach' (Charmaz, 2000, p. 526).

### **The writing**

In line with Glaser's (1978) suggestion, the research findings detailed within this thesis were first written quickly, then reworked and edited several times. They have been written at a conceptual level, focusing on categories rather than participants.

I have attempted to make all writing in this thesis understandable by avoiding unnecessarily complex language and by defining any professional or academic terms used (Charmaz, 2000; Strauss, 1987). I have made use of metaphor in presenting the theories that emerged from the phase 1 study (Charmaz, 2000), and I have written about the findings in the past tense to highlight the fact that they are temporally limited, and could be modified in the future (Charmaz, 2000; Glaser, 1978).

Included in the findings, as Charmaz (2000) suggests, are many participant voices. Each quotation was chosen because, in my view, it best exemplified the category being discussed. However, I also ensured that at least one quotation from each participant therapist was used, so that to some extent, all the participant's voices could be heard. Speedy (2005) suggests experimenting with font, layout and spacing in writing up research findings. Although I am limited by academic conventions in terms of layout and spacing, I have experimented with font style, so that participant's voices stand out in my writing.

### **Judging the quality of my grounded theory study**

Glaser and Strauss (1968) argue that the traditional scientific notions of internal validity, reliability, objectivity and generalisability cannot be used to judge a grounded theory study which is based on interpretive research. In line with Glaser and Strauss (*ibid.*) the quality of my grounded theory research may be assessed in terms of the parallel criteria of credibility, dependability, confirmability and transferability (Lincoln and Guba, 1985).

Credibility refers to the extent to which the findings of a study fit the context and make sense for the participants. Glaser and Strauss (1968) suggest that criteria used in judging the credibility of a grounded theory study should be based on the strategies used for collecting, analysing and presenting data. I have therefore outlined my data collection and analysis strategies in this thesis in detail (see also the section titled 'procedure' within this chapter), and in presenting my findings, I have quoted directly from interview transcripts in order to show how the categories I have devised fit the data (Glaser and Strauss, 1968). Strauss and Corbin (1994) recommend cross-checking the credibility of grounded theory analysis with the aid of member checks (asking participants if they agree with the findings of a study). As detailed in the section on interviewing, this was carried out at several stages of the research process.

In line with Erlandson *et al.* (1993) prolonged engagement occurred, as I spent over a year arranging interviews and collecting data from a total of 43 participants. Furthermore, opportunities for peer debriefing occurred as I gave talks (Turner, 2004a, 2005a and 2006) and a poster presentation (Turner, 2005b) about my work to colleagues in the fields of education and counselling and psychotherapy. With regard to confirmability (the extent to which the findings of a research study are the result of what has been discovered rather

than the impact of the researcher's biases [Erlandson *et al.*, 1993]), I acknowledge that the theories presented in this thesis are constructions rather than objective products, as Charmaz (2000) suggests. However, I have followed some of the techniques Strauss and Corbin (1998) have developed to help researchers minimize the effects of bias on their research: I have tried to remain open to the data and to periodically step back and ask if my emerging theory really fits the data.

In addition, in order to avoid imposing pre-existing assumptions on the data, McLeod (2001) notes that a detailed literature review on the topic of study should only be carried out after the data collection and analysis has been completed. Glaser and Strauss (1968, p. 37) also write:

An effective strategy is, at first, literally to ignore the literature of theory and fact on the area under study, in order to assure that the emergence of categories will not be contaminated by concepts more suited to different areas. Similarities and convergences with the literature can be established after the analytic core of categories has emerged.

In contrast, Morrow (2005, p. 254, original emphasis) says:

Although it has been asserted that the researcher is least biased by avoiding an in-depth foray into the literature prior to investigating...I would argue that investigators *always* believe something about the phenomenon in question and that a greater grounding in the literature militates against bias by expanding the researcher's understanding of multiple ways of viewing the phenomenon.

Like Morrow (2005), I believe that researchers always have ideas about their findings at the start of their studies, and I have therefore detailed my initial expectations within the introduction of this thesis. However, at the outset of my grounded theory study, I felt that reading the relevant literature may have affected the outcomes of my research, since I might lack confidence in naming a category, for example, and prefer to use a term used in the literature. For this reason, a literature review on therapist learning and change was not

carried out until after the first phase of my study had been completed, and is presented after the findings within this chapter. A literature review on transformative learning has been included in chapter one, in order to provide context for the study, but most of my data had been collected and analysed before this was written.

With regard to transferability, I have included vignettes and brief background details of each participant in the appendices section of the thesis (appendices E and F), to make it possible to judge whether my results might be applicable to other therapists. Finally, according to Seale (1999) and Erlandson *et al.* (1993), the dependability of a qualitative enquiry can be judged using an ‘audit trail’. In line with this, I have provided details of the methodology, method and procedure that I have used in carrying out my grounded theory study, as well as information on the way in which my data analysis was carried out.

In addition, I have also presented some of my data reduction and analysis products: Two examples of interview transcripts (appendices G and H) and analysis have been included. My original research proposal is shown in appendix A1, and extracts of my research journal are presented in appendix J, to give an indication of my interview experiences and the way in which decisions were made during the study. In order to protect the anonymity of my participants, each entry within the journal is numbered, rather than dated, so that it is not possible to tell which interviews were carried out on the same day, and therefore which participants lived within travelling distance of each other.

In line with Guba and Lincoln’s (1989) authenticity criteria of ‘fairness’, I have represented a variety of participant understandings and experiences in my findings sections, and all participants’ voices have been included.

With regard to ontological authenticity (the improvement and expansion of participant’s understandings) five therapists independently, and of their own accord, reported that as a result of being interviewed they were able to reflect on and learn from their work (see phase 1 findings section).

I am not able to evidence educative and catalytic authenticity (the enhancement of participant's knowledge of the understandings of others, and action that is stimulated by the research, respectively), although shifts may have occurred for participants in these areas. Enhancement of knowledge may have occurred for some or all of my participants as a result of being given the opportunity to read a draft of my research findings (sent as an e-mail attachment), which contained quotations taken from others' transcripts. In addition, action may have been catalysed for participants as a result of being interviewed although noone specifically reported this afterwards. I did not attempt to promote tactical authenticity (empowerment of action through the research), as this did not seem appropriate.

## **In-depth interviewing**

### **Rationale**

Maykut and Morehouse (1994, p. 46) state that:

The data of qualitative inquiry is most often people's words and actions, and thus requires methods that allow the researcher to capture language and behaviour. The most useful ways of gathering these forms of data are participant observation, in-depth interviews, group interviews, and the collection of relevant documents.

In-depth interviewing was chosen as the method of data collection for my grounded theory study. Since I wanted to gain data on the learning and change experiences that therapists had had as a result of their client work throughout their careers, participant observation was not appropriate. Client confidentiality prevented me from collecting relevant documentation, such as therapists' process notes (notes written after meetings with clients); and it was felt that individual rather than group interviews would provide the safest environment in which the counsellors and psychotherapists could talk about their learning and change.

Questionnaires, completed in the privacy of their own home, may have also given the research participants the safety they required to consider their experiences honestly and openly. However, questionnaires often give rise to a low response rate (Cohen, Manion and Morrison, 2003). In line with this, one participant told me that she would not have filled in a questionnaire if I had sent her one, yet she was willing to be interviewed,



because I had ‘made the effort to meet her in person’. In addition, when completing my MSc in Educational Research dissertation study, which made use of questionnaires (Turner, 2004b), I became aware that I was not able to clarify answers given by respondents or ask for elaboration using the questionnaire method. Furthermore, questionnaire data did not give rise to an adequately in-depth understanding of the topic studied.

### **Interviewing**

In-depth, individual interviewing is now a widely used methodology (Berry, 1999) and it is one of the most powerful tools we can make use of in our attempts to understand others (Fontana and Frey, 2000). However, carrying out an interview may be difficult and tiring: An interviewer must listen carefully to the participant, remember what the participant has said and what they have asked him or her. In addition, the researcher may need to pick up and interpret non-verbal cues, formulate further questions, keep an eye on the time, ensure that recording equipment is working and deal with distractions (Mason, 2002).

Interviewing has been used successfully in many grounded theory studies (Charmaz, 2000). Fassinger (2005) notes that the approach to interviewing most often reported in the grounded theory literature is the use of open-ended questions and a flexible style, allowing respondents to tell their stories in their own words. Hollway and Jefferson (2000) note that overall, their participants enjoyed telling their stories. However, eliciting stories may not always be easy. People’s story-telling abilities vary enormously and some may not think that their experiences are sufficiently interesting to justify a story. Hollway and Jefferson (*op. cit*, p. 35) therefore suggest that researchers should turn questions about given topics into ‘story-telling invitations’. For example, instead of asking, ‘What do you most fear?’, a researcher should say, ‘Tell me about your experiences of fear’.

According to Mishler (1986), the question-and-answer method of interviewing can suppress participant’s stories. Therefore, ‘why’ questions should be avoided as they may lead to intellectualisation, and follow-up questions should be as open as possible and framed to elicit further narratives (Hollway and Jefferson, 2000).

Although Hollway and Jefferson (2000) make several suggestions as to how researchers may elicit stories from their participants, Kvale (1996, p. 13) notes that ‘There is no common procedure for interview research. Interview research is a craft that, if well carried out, can become an art’. Fontana and Frey, (2000, p. 657) add: ‘Interviewing and interviewers must necessarily be creative, forget how-to rules, and adapt themselves to the ever-changing situations they face’.

Whatever method an interviewer uses to draw out an participant’s story, this story reflects the participant’s experiences, filtered through their present perceptions. Researchers might assume that their participants ‘tell it like it is’ (Hollway and Jefferson, 2000, p. 2). However, people may tell their stories in a confused way, or may tell a different story to a different audience and at a different time.

Kvale (1996, p. 2, original emphasis) notes that ‘An interview is literally an *inter view*, an inter change of views between two persons conversing about a theme of mutual interest.’ Therefore, if an participant talked about her experiences with a different researcher, she might say something different. In my interview with Teresa, she told me that, ‘If somebody else came with the question, I hate to say this to a researcher, but it [the answer] would be different. It’s the same in therapy as well’. In agreement, Hollway and Jefferson (2000, p. 79) write:

Contrary to the view of positivist science...the situations that we are analysing are never replicable...Meanings are not just unique to a person (although more or less shared as well); they are also unique to a relational encounter.

Furthermore, Hollway and Jefferson (2000) argue that another person’s subjectivity can only be known through your own. In order to make sure that what they have heard is correct, Kvale (1996, p. 132) therefore suggests that researchers should check their understandings with participants during the interview:

Interviewers who know what they are asking about, and why they are asking, will attempt to clarify the meanings relevant to the project during the interview, obtaining a disambiguation of the statements made...such a process of meaning clarification during the interview may also communicate to the subject that the interviewer actually is listening to and interested in what they are saying.

Member checks are also often used to ensure that researchers have recorded participants' responses accurately and analysed them appropriately (Strauss and Corbin, 1994). These involve giving participants copies of their interview transcripts and drafts of the study findings to read and comment on. Charmaz (2000, p. 531) notes that 'By making our early drafts available to those subjects who wish to read them, we make it possible for them to challenge and correct our views'.

Holloway and Jefferson (2000) point out that it is necessary to build up rapport with an participant in order to gain more honest, in depth answers. Similarly, Moustakas, (1990, p. 26) points out that:

If one is to know and understand another's experience...One must create an atmosphere of openness and trust, and a connection with the other that will inspire that person to share her experience in unqualified, free, and unrestrained disclosures.

Establishing rapport includes the researcher's use of their tone of voice, facial expressions and gestures, as well as what is said (Berry, 1999). However, building a good rapport with participants may lead to them disclosing deep material. Fassinger (2005) notes that the more difficult the issue being discussed, the more likely that unexpected disclosures will occur. He warns that it may be tempting for the researcher to fall into the role of a therapist or educator when a participant self-discloses. Yalom, (1991, p. 121) admits that, in interviewing one woman, this has happened to him:

I was determined to pursue my research plans: to learn as much as possible about chronic bereavement and to design a structured interview protocol. Nonetheless, possibly because there was so much therapy to be done, I found myself forgetting the research and, little by little, slipping into therapeutic mode.

## **Procedure**

Making reference to the literature on interviewing which has been detailed above, I have outlined the procedure that was used in carrying out my grounded theory study interviews, below.

### **Recruiting participants**

Participants self-selected for the phase one study detailed in this thesis by replying to an advertisement in the *Counselling and Psychotherapy Journal* (now known as *Therapy Today*, see appendix A2), to letters sent to relevant counselling organizations (appendix B1) or to e-mail invitations (appendix B2). E-mail addresses were chosen from two directories which were accessed via the BACP website ([www.bacp.co.uk](http://www.bacp.co.uk)) and the Pink Therapy website ([www.pinktherapy.com](http://www.pinktherapy.com)).

Participants for the theoretical sampling study were sought from attendees at the 2005 BACP annual research conference and through e-mail invitations to counsellors listed on the BACP website (appendix B3). A total of forty-three therapists were interviewed (thirty-nine for the phase one study and four for the theoretical sampling study).

Participants lived and worked in various parts of England and Wales, and were found to have a variety of theoretical orientations, including those within the humanistic, psychodynamic, cognitive behavioral and integrative schools. They also had various amounts of client experience, ranging from recently qualified therapists to those who had ten or twenty years of experience (appendix E).

### **Interview questions used in the phase one study**

Kvale (1996, p. 130) points out that:

One research question can be investigated through several interview questions, thus obtaining rich and varied information by approaching a topic from several angles. And one interview question might provide answers to several research questions.

In the interviews that were carried out for the first phase of the grounded theory study reported in this thesis, one main, predetermined interview question was used to generate data that would provide answers to three of my research questions. However, further questions, which arose in each interview in response to what participants told me, gave rise to further data that added depth to my understandings. In this way, several interview questions were also used to answer each of my research questions.

Interviews may either be structured (in which all the questions to be asked by the researcher are decided upon before the interview takes place), semi-structured (in which some questions are predetermined while others arise during the interview) or unstructured (in which no predetermined questions are used) (Cohen, Manion and Morrison, 2003). However, Mason (2002, p. 62) argues that unstructured interviews are ‘a misnomer because no research interview can be completely lacking in structure’. She suggests that since all researchers make decisions and judgements whilst carrying out interviews, these decisions and judgements impose some form of structure on the interview.

I used a loosely semi-structured interview approach, allowing ‘the interview process to stay as close to the lived experience [of the participants] as possible’ (Lavery, 2003, p. 19). I made use of only four predetermined interview questions in the first four interviews carried out for the phase one study, and these questions were also used in subsequent interviews. The first question was presented partly as a statement: “Could I start by asking you for a bit of background information? Tell me about your theoretical perspective, and the type of client groups you have worked with.” Following the participant’s response, the second pre-determined question was asked: “I ask this question just for background. If you don’t want to answer it, that’s fine. What were your reasons for deciding to work as a therapist / with HIV positive people?”

As mentioned within the questions themselves, these first two predetermined questions were used to gather background data. Since only factual answers were required in answer to it, the first question was also asked in order to put the participants at ease. Therapists answered the second question in whatever way they wished, many mentioning personal issues that had led them to become clients and later train as therapists (appendix F).

The third predetermined question used in the first phase study interviews was asked after the participants had responded to the second predetermined question. This main interview question was used in order to prompt participants to tell their stories, beginning with whatever they considered to be most important in terms of their learning and change experiences:

“During this interview, I would like to ask you about any important learning experiences you have had as a result of working with clients / HIV positive clients, and how these experiences have affected you. Does anything immediately spring to mind?”

Further questions were then asked in response to answers given. I gave the participants plenty of opportunity to talk about what was most important to them, often asking “Can you think of anything else?”, when they had finished talking about a particular learning experience. In line with Kvale (1996), at the end of each interview, I also asked, “Is there anything else you want to say about your learning experiences?”

Kvale (1996, p. 5-6) points out that ‘An interview is a conversation that has structure and purpose...The research interview is not a conversation between equal partners, because the researcher defines and controls the situation’. However, in placing an emphasis on the third, main interview question, and allowing participants to talk about whatever they considered to be of most importance with regard to their learning and change experiences, I hoped to empower participants by allowing them to define and control much of what was talked about. In using follow-up questions, I attempted to ask for further details or clarification without changing the topic of conversation.

The fourth interview question was only used with the group A counsellors and psychotherapists interviewed: “Have you experienced any differences between counselling HIV positive clients and clients who are not positive or are not aware that they are positive?” This question was only asked when each group A therapist had said all they wanted to say in response to my third question, and when I had asked all the follow-up questions I wished to ask in response to their answers.

Since two of the nineteen group A participants spent a great deal of time responding to the third question, and since we had agreed a maximum time length for the interview at the start, there was no time left in which I could ask them the fourth question. Therefore only seventeen group A participants were asked the fourth interview question.

Mason (2002, p. 67) notes that ‘the qualitative interviewer has to...be able to ‘think on their feet’ in the interview...’ Unfortunately I was not able to think on my feet as easily as I would have liked during the first four interviews I carried out, and as a result I found it very difficult to keep some of the participants talking. Two of the interviews lasted less than the hour I had told the participants that they would take because I was not able to think of any further questions to ask. For this reason, I felt that I would benefit from a list of further interview questions, on which to fall back.

As I wished to influence what the participants decided to talk about with my own agenda as little as possible, a list of interview questions was formulated from some of the categories that had arisen as a result of the analysis of the first four transcripts. (Two of the first four interviews were carried out with group A therapists, and two with group B therapists.) The categories that had arisen from my analysis of the two group A transcripts were compared with those that had arisen from the group B transcripts and a list of categories that were only present in either one of the groups was made. This list was used to formulate interview questions, since it was assumed that the topics from which the categories arose would be least likely to have been discussed by a participant in any interview I subsequently needed to make use of the formulated interview questions in. However, categories that seemed to give rise to leading questions were not used. A list of the formulated interview questions is presented in appendix I.

I introduced these formulated questions only when the participants couldn’t think of anything else to say, and I couldn’t think of anything else to ask in response to what they had already said, so that their own telling of their stories was given priority. I chose the questions intuitively (Kvale, 1996), trying to fit them well to what the particular counsellor or psychotherapist I was interviewing had previously said. These questions encouraged the counsellors to talk more, often about things unrelated or only loosely related to the question I had asked, but of importance to their learning and change experiences.

During some interviews I found myself relying heavily on the questions, in others I did not use them at all. However, during the analysis, for each question used, the answer given was not coded for the category that originally gave rise to the question. The phase one findings, presented later in this thesis, therefore indicate numbers of therapists that talked about each category of their own accord.

### **Interview questions used in the phase two study**

The first and second predetermined questions used in the first phase study interviews were also used in the interviews carried out for the theoretical sampling study. Since this study focused specifically on therapists' experiences of addressing their own death and working within flexible boundaries as a result of their work with clients, the third and main predetermined question used encouraged participants to talk about these areas: "During this interview I would like to ask you about your learning experiences in relation to addressing your own death and or working within more flexible boundaries as a result of your client work."

All other questions asked during the theoretical sampling study interviews were formulated in response to what the participants' told me. These interviews were therefore relatively unstructured. At this stage, my confidence had increased and I was able to think on my feet during the interviews and ask relevant responsive questions. However, two of the four interviews I carried out took less than an hour because the participants had no more to say with regard to the two areas of learning I had asked them to focus on.

Responses to the relatively unstructured nature of the interviews varied. Steven said:

I wasn't sure if it was going to be completely unstructured or semi-structured. I wondered if it was going to be a bit semi-structured to help me along a bit...I think I half expected it would be semi-structured, where I would be responding to questions a bit more, which would be easier for me on a Friday afternoon!

In contrast, in response to an e-mail I sent her after our interview (also conducted on a Friday afternoon), Delilah wrote, 'I enjoyed meeting you too and it was such a pleasure to rabbit on! I am so used to listening...'

### **The way in which the interviews were carried out**

Most of the interviews were carried out in the participant counsellors' and psychotherapists' own homes, as this was most convenient for them. Occasionally, however, I interviewed therapists in their workplaces or in an otherwise unused room at Exeter University. At the start of each interview, participants were reminded what the



interview was about, told that it would be an informal interview lasting approximately an hour, and given the opportunity to ask questions. They were also asked to sign consent forms (appendix C) and asked if they objected to a tape recorder being used during the interview. (No-one objected, but one participant asked for the tape to be sent to her after it had been transcribed).

The interviews were ended after an hour, as initially agreed, or earlier when the participants could no longer think of anything else to say in answer to my questions, or when the participants wanted to finish early, for whatever reason. It is important to note, therefore, that the interview data obtained for each participant was not, and could not be full and complete representations of their perceptions of their learning and change experiences. Follow-up interviews would have no doubt led to further useful data, and ‘the conversations...might have continued indefinitely’ (West, 1996, p. xi). Furthermore, since many of the participant therapists will no doubt continue to learn and change as a result of their ongoing client work, interviews with them simply provided ‘stories and speculations without endings’ (*ibid.*)

After each interview, participants were told that they would be sent their transcripts and my analysis of them, together with a covering letter explaining how the analysis had been carried out (appendices D1 and D2), as soon as possible. Finally, when the tape recorder was switched off at the end of the interviews, participants were given the opportunity to debrief by talking about how they had experienced being interviewed. They were also given the opportunity to ask further questions.

### **The transcripts**

I transcribed the interviews, in order to immerse myself in the data and gain a sense of it in preparation for analysis. Mason (2002) warns that it is important not to over-estimate the representational qualities of transcripts because judgements are made about the way in which the recording is turned into text at the transcription stage. Transcripts are therefore

not objective records. Furthermore, as Kvale (1996, p. 50) points out, 'The transcribed interview text renders an incomplete account of the wealth of meanings expressed in the lived interview situation'.

Kvale (1996) therefore suggests that in reports, researchers should state how transcriptions were made. I made the following decisions in creating the interview transcripts used in the first two studies presented in this thesis: I summarised participants' responses to the first two predetermined questions, which detailed their background characteristics, and omitted any distinguishing details. Only verbatim was recorded in the transcripts, with pauses indicated by three dots (...). All distinguishing details about counsellors and their clients were removed and replaced with generalised details which were positioned inside two square brackets.

### **Member checks**

I checked my understanding of what the participants had said at various points during the grounded theory study: During the interviews, paraphrasing and asking questions was used to check my perception of participants' meanings, and to negotiate a shared meaning. The interview transcripts and analysis were later sent to participants who were given the opportunity to alter these, as necessary (see also appendix D).

Fassinger (2005) warns that research participants sometimes react negatively to seeing their own words on paper and want to correct 'unimportant' grammatical errors etc. Several of the eighteen therapists who responded after I they had received their transcripts, told me that they felt embarrassed about their use of English during our interviews. Three insisted on making changes to the transcripts, whilst two others decided not to. Although participants were invited to change any of their verbal responses, as they liked, any changes they wished to make to category names were negotiated with me. One participant suggested adding another category to her transcript, and I agreed to this.

In following Charmaz's (2000) suggestion, participants were also sent an early draft of my findings so that they could challenge and correct my interpretations of the data put forward in them. Again, all changes were to be negotiated, resulting in a shared and agreed meaning. However, at this stage, all of the (nine) participants who replied said that they were happy with the way that their quotations had been used.

Some participants added that the findings were interesting to them. One participant suggested that I should refer to her clients as ‘people with HIV’, rather than ‘HIV positive people’, putting the person before the infection to appear more respectful. I agreed to this and made relevant changes within my writing.

### **Problems encountered**

My nervousness and lack of experience at interviewing led to a number of problems. However, these were resolved, at least in part, as I gained more experience and my confidence grew. As Kvale, (1996, p. 147) notes:

Learning to become an interviewer takes place through interviewing. Reading books may give some guidelines, but practice remains the main road to mastering the craft of interviewing...An interviewer’s self-confidence is acquired through practice...

During the interviews, I intended to build up rapport with each participant in order to gain more honest, in depth answers (Holloway and Jefferson, 2000). However, perhaps as a result of my nervousness and lack of experience, in some cases I may not have succeeded. A few participants in the first phase study were defended in their answers to questions, talking generally rather than about themselves, and focusing on their opinions and beliefs rather than their experiences. For example, during an interview with one participant, I asked: “Did it [working with HIV positive clients] affect your outside life in any way?” The participant avoided talking personally in his response:

I think it made me aware of the lack of education that was desperately needed, especially in London. Of course we are now faced with an HIV epidemic again, and we were at that point as well. I think it is interesting how people who were too young then to take on board the significance of what was actually happening and really, I think, took the opinion that its something that affects older people. So now they are of the age where they are sexually active, there is a lot of unsafe sex, which certainly I think was arrested at that period.

It is within the context of the relationship between the interviewer and participant that data are generated (Laverty, 2003). However, Hollway and Jefferson (2000) point out that during an interview, the researcher may be nervous and might therefore fail to create a safe environment in which the participant can talk openly and honestly. In addition, the participant may guard against talking about personal, emotive experiences by sticking to safe, comfortable and well-rehearsed generalisations. It is therefore important for researchers to be aware of the feelings brought up in interviews, because information about one's feelings is useful in understanding the dynamics of the research relationship.

Interestingly, after my interview with the therapist mentioned above, I wrote in my research journal: 'I felt very nervous during this interview and quite inadequate. The participant didn't seem to say much about his own experiences' (Turner, research journal, 2004-2007, entry 19). In contrast, when an interview went well, when rapport was built up, and the participant talked honestly and openly, I felt more confident and enjoyed the interview more. I wrote in my research journal: 'I enjoyed listening to the counsellors speak and felt privileged to be able to learn from them. I came out of nearly all of the interviews with a sense of calm and well-being' (Turner, research journal, 2004-2007, entry 42).

Other problems, unrelated to my nervousness and lack of experience also occurred during the interviews. Fontana and Frey (2000, p. 656) note that 'Being out in the field does not afford researchers the luxury of...soundproof rooms, and high quality recording equipment'. Due to financial constraints, as well as an inability to carry bulky, heavy equipment during fieldwork, I purchased a small, cheap tape recorder for use in the interviews. I felt that this would seem less imposing to participants than larger, more expensive recording equipment.

However, being of low quality, it also proved to be problematic: Although I checked the recording system with participants before starting each interview, three tapes were later found to be faulty part way through, so that only part of the interviews that were recorded on them could be played back. These could not be used as part of my study.

In addition, in one interview, the participant's cat was rather vocal, making transcription more difficult, and in another, noise from traffic on a road outside the participant's window made it difficult for me to hear what had been said when the tape was later played back. Etherington (2004c, p. 64) has also experienced this type of problem:

I set out my recording equipment in Paula's lounge and we began. On one side of the room was an imposing grandfather clock with a loud ticktock. I moved the microphone, but later, when I was trying to transcribe their tapes, this ticktock was the loudest sound on the tape, drowning their voices.

Another problem revealed itself as I began my first set of transcriptions. In transcribing the first few interviews I had carried out, I became aware that really listening to participant counsellors and psychotherapists during the interviews is very important, so that follow-up questions and questions used to check my understanding are asked appropriately. I noticed many 'holes' in the first four interview transcripts, which arose as a result of my nervousness preventing me from listening properly. However, later transcripts contained fewer 'holes'.

### **Other Issues**

A variety of other issues, including power relations in the interviews, the willingness of participants to correct my interpretations, my knowledge of the counselling terms used by participants, participant self-disclosures and the participants' experiences of the interview process were also of importance.

Feminist researchers have criticised unequal power relations in interviews, which may be based on gender, race, class or something else (Holloway and Jefferson, 2000). Although unequal power relations may have existed, it did not feel as if I had power over my participants, as I felt younger, less experienced and less confident than all of them.

In addition, as stated above, I attempted to empower participants by using one main predetermined interview question which encouraged them to talk about whatever they considered to be of most importance with regard to their learning and change experiences.

With regard to the willingness of participants to correct my interpretations, Strauss and Corbin (1998) suggest that although some respondents are polite and will tell the researcher what they think she wants to hear, there always are those who are willing to tell the investigator just how wrong her interpretations are. As previously mentioned, I made use of my paraphrasing and questioning skills to clarify my understanding of what participants had said. I noticed that many of my respondents weren't afraid to correct what seemed to be my mistaken understandings, as the dialogue quoted below illustrates:

***Me:** You mentioned that you 'let go'. Does that mean that you stopped trying to help him to change and the relationship became more focussed on the acceptance he wanted?*

**Maggie:** No. He came to counselling because he wanted change – doesn't everyone? Doing what I did allowed him to bring about change for himself.

Concerning my knowledge of the counselling terms used by participants, Fontana and Frey (2000, p. 654) stress the importance of 'understanding the language and culture of the respondents' in interviewing. During the interviews I became aware that the knowledge of counselling terms (such as 'congruence', 'transference' and 'projection') that I had gained as a result of studying counselling was invaluable in gaining an understanding of what participants talked about.

As regards participant self-disclosures, Fassinger (2005) warns that it may be tempting for the researcher to fall into the role of a therapist or educator when a participant self-discloses. Only a few self-disclosures that were not of direct relevance to my research topic were made. In each case, I allowed the participant to talk, drawing them only slowly and gently back to the topic of interview.

Finally, Kvale (1996, p. 11) points out that 'The [interview] subjects not only answer questions prepared by an expert, but themselves formulate in a dialogue their own conceptions of their lived world'. He later adds that:

...a common experience after research interviews is that the subjects have experienced the interview as genuinely enriching, have enjoyed talking freely with an attentive listener, and have sometimes obtained new insights into important themes of their life world (Kvale, 1996, p. 128).

In line with this, it was found that several participants experienced the interview process as useful as it gave them an opportunity to think and talk about what they had learnt from, and how they may have changed as a result of their client work. The interviews themselves may have therefore catalysed further learning and change for the counsellors and psychotherapists who took part in them.

## **Phase 1: Study Findings**

The findings of the first phase study are detailed overleaf. Quotations from the participants have been used to illustrate the findings and to give the participants' a voice (Charmaz, 2000). These voices are shown in a different font from the rest of the text, so that they stand out (Speedy, 2005). In general, one quotation from each of the two groups of participants has been used as an illustration for each category discussed.

However, where several quotations were needed as examples of a more complex category or where a category refers to only one of the therapist groups, a different number of quotations have been used as illustrations. Numbers of therapists in each group who talked about each of the categories detailed are noted, to indicate the minimum amount of participants who have a particular viewpoint or have had a particular experience that the category symbolises: Some participants, who made no mention of certain categories during their interviews, perhaps due to time constraints, may share the views and experiences of those who did talk about them when they were interviewed. Although numerical values are included no statistical significance or generalisability is claimed.

### **Few differences**

The group A therapists interviewed as part of the phase 1 study had all had one or more significant experience of working with a client who was HIV positive and had also worked with clients who were assumed to be HIV negative. Most of the seventeen therapists in

this group who were asked about it reported that they had experienced few differences between working with people who were HIV positive and those that were HIV negative. Zoe, for example, pointed out that 'the counselling skills and techniques are the same', and Carl added:

...there aren't that many differences. You are working with the same things, at least my experience has been that you are working with the same things that everybody comes to counselling with.

Differences that were mentioned include the impacts of politics (one therapist), public opinion (three therapists) and media images (one therapist) on clients who are HIV positive, as well as the particular relevance of illness (three therapists), death (five therapists) and existential issues (one therapist) for these people. Sexual health issues (one therapist), the physical and psychological effects of their medication (three therapists), and the possible negative effects of being infected on self-esteem (one therapist) were also seen as being more likely to be restricted to clients who are HIV positive. Interestingly, though, Tom suggested that HIV is potentially an important issue for everyone:

I only think that HIV is really an important issue for anybody examining how they relate to the world these days. And its obviously particularly important for gay men, but nevertheless impacts on different communities in important ways. There is something archetypal in its importance for me in that it brings sex and death together in such a collision that any one of us will respond to that in different ways. And I think that sex and death is what therapy is about, so in some ways HIV makes material what our fantasies hopes and dreams are all about. And it's a very interesting way of exploring those things. Its an issue for gay men who aren't positive and might want to stay that way. And its an issue for straight people. More so currently, but obviously with less intensity.

In support of my finding that many group A therapists felt that there is little difference between counselling clients who are HIV positive and those that are assumed to be HIV negative, I found that most of the categories that arose from the group A data set could also be applied to the group B data set. (Group B therapists had not had any significant



experiences of working with clients who were known to be HIV positive). One such category is the mutually beneficial relationship that therapists form with their clients.

### **A mutually beneficial relationship**

Therapists in both groups (one from group A and three from group B) talked explicitly about the mutually beneficial relationships they formed with their clients. Through these, they were able to learn, be healed and be affirmed:

...people who are moving towards death, I'm really interested in, if they want to talk about it, tell me. Because I have got to get there, I don't know what its about. So they may be able to help me, indirectly. [But] they don't know its helping me. (*Clare, group A*).

The training that I've had basically teaches that change happens in contact, if we allow where we hurt to come into contact with the client's bits that hurt. And of course if we do that, the process doesn't just work one way, it works both ways, so every time I manage to do that something happens for me. So this is what my work is about – I try to constantly do that. And of course I don't really use clients in that sense to do my therapy, I also have my own therapist...But I'm aware that I can't really do therapy without being changed by it...If I have a particular bit in me that really hurts, every time I manage to bring that into contact with somebody, if something changed for the client then my own wound undergoes a bit of healing each time. (*Catherine, group B*).

...there's something about being seen, heard, recognised, appreciated, loved. And actually this is not just from me, the counsellor. It is actually a mutual thing. So whenever it happens, it re-emphasises to me that I'm not just in it to help the client. There is another motivation, and that is to help myself. Although primarily its about me being there for the client. But sometimes its more mutual than that. So whenever it happens, its like a reaffirmation of...I don't know how you would say it...of the goodness of the universe or something. A reaffirmation of faith, belief and that things are OK really. Despite all the pain and the hurt, things are OK. (*Richard, group B*).

Five therapists (one from group A and four from group B) also stressed the importance of the therapeutic relationship:

When you're seeing people in a more clinical setting its about being able to scoop them up, in a sense of forming a strong alliance. So it taught [me] to hopefully be able to form a good therapeutic alliance. (*Louise, group A*).

I always say at the beginning when I meet a client, you know, we are working together. And I invite them to challenge or confront me at any time. I say, "if you are not sure what I'm saying or if I don't make something clear, say that". And they do...As long as the therapeutic alliance is very strong. And I work hard at

that. Other counsellors will have almost certainly said it...you can have all the training in the world, but if the working alliance with the client isn't right, if the relationship isn't there, it won't work. (*Rose, group B*).

### **The change process**

The mutually beneficial relationships that therapists form with their clients may be a catalyst for therapist change. For therapists in both groups, the change process was found to be linked to both the ways in which therapists learn and the ways in which their learning experiences affect them. For many therapists in group A, their personal and professional experiences of HIV also played a part.

### **The ways in which therapists learn**

Many participants (seven from group A and nine from group B) explicitly stated that they had learnt as a result their client experience:

I'm glad I had that experience. I would say that whatever experience you have, it's a learning experience. (*Zoe, group A*).

...I will be better in three years time than I am now, just in the nature of experience...the usefulness of experience I think, something like that... (*Angela, group B*).

While a few therapists talked about the ways in which they had learnt *from* their clients, (two from group A and one from group B) more felt that they had learnt as a result of interacting *with* their clients (four from group A and six from group B). Zoe and Eve, for example, stated that they had learnt from clients:

...quite often, when people have had HIV for a while, you learn from them. When it comes to their medical drugs, they'll come in and say, "I'm taking this and doing this"....It's a learning from them as well. But that's with all clients isn't it? They bring things into the session that's part of your learning as well. (*Zoe, group A*).

...there was one person who was finding out that the various parts of themselves that disturbed them, they could picture - its my word when I say sticky out bits, this particular client used a different word - but what she drew was up and down bits, like this [draws on a piece of paper] and then less up and down, and then a straight line. And that was how she pictured herself in society. And she put a bold but fluid line underneath and said that's what she is living. And when she wrote to thank me, when the counselling was over, she said that the best thing was: and then she drew that wiggly line and then the straight line underneath. So that is her

picture and I think that it stayed with her for a long time to support her. And it has certainly stayed with me for a long time and supports me because I would have never come across her way of putting a living being... (*Eve, group B*).

In contrast, Susan and Nicola talked about learning that had occurred as a result of interacting with clients:

Well, its not that I'm learning from the client, its that I'm learning from my work with the client. Its not that I transfer learning from one client to another, I don't think....Its more that in the interaction I might learn something. But its not necessarily that I've learnt it from the client. (*Susan, group B*).

...if I look back over my development as a psychotherapist as I say its all been learning through clients...what I heard, what I did, how it felt, how the whole relationship evolved. (*Nicola, group B*).

A few therapists (one from group A and two from group B) also talked about the importance of discussion in their learning:

What I found really useful was talking with colleagues in my team which was a specialist social work team for people with HIV, so between us we saw very many people with HIV; that was very supportive and very much part of the learning. (*Jill, group A*).

I think talking with people is a really good way of learning and its really useful to talk through ideas. Even if you read a book, its really useful to talk through those ideas with somebody else. (*Susan, group B*).

Therapists in both groups (three from group A and one from group B) mentioned that some of their learning seemed to be outside of their conscious awareness:

I'm just very much aware that...I do not know how much I learn. (*Claire, group B*)

I'm sure it [counselling a client with AIDS] did have some effect, but to be able to precisely delineate what that effect is would be really hard. Because all clients have an impact on you to a certain extent, and if you believe it's the effect of unconscious processes, then some things might affect what's going on in here, in your unconscious, and then be played out in the way that you work with subsequent clients. (*Tristram, group A*).

And some practitioners (one from group A and six from group B) reported that they learn by reflecting:

...my self-reflective process is very established... (*Finn, group A*).

And I suppose the other thing that counselling has taught me is to stop and think before I open my mouth too much. So stop and think, 'who am I doing this for, what am I trying to achieve from it, is it for me, is it for the client, what are the benefits?' And if I completely process that and work out an answer then I'll go ahead. (*Alice, group B*).

Interestingly, though, one therapist mentioned that through her work she has learnt to consciously reflect less and experience more:

I think I've learnt to feel the feelings and the motivation and intention and everything will come naturally. There won't be like a conscious act of will...I mean you can do it like that, I used to think that there's no way the intention is ever going to come naturally, I have to make myself do it. But now on the whole, if I feel the feelings and get my life into a balance where I know how I am, then it works. And I've learnt that over the years. Rather than trying to work it out and decide what to do in my head. (*Wilma, group B*).

Three counsellors and psychotherapists (two from group A and one from group B) also reported the importance of re-learning in their development:

...it might be something that I need to learn over and over again. Because that's the idea about learning, isn't it? That you kind of learn something and then you move on. And I don't think learning is quite like that. I think we tend to go round in circles. And I think that the issues that are most difficult to learn and we tend to keep coming back to them in various forms and guises, over and over and over again. (*Susan, group B*).

...the most difficult thing, I find, is to go with the flow. With the client's flow... that's something I'm forever relearning. (*Andrew, group A*).

For several of the therapists interviewed (one from group A and eight from group B), the learning process was gradual:

You know its really odd, because I don't think there was ever an epiphany moment, I think what happened was a gradual process... (*Louise, group A*).

I was trying to think if I had had any learning experience, and it would be difficult to come up with any one thing. Its much more of a process. (*Elly, group B*).

Yet although it was found to often be a gradual process, in some cases, learning began in a very dramatic and disorienting way. As Lauren (a group B therapist) pointed out:

I have been working for twenty-five years as a therapist and I think that changes can happen in very, very subtle ways over a long period or shocking ways and very, very sort of immediate...

She went on to tell a story about a learning experience which began in a very striking way:

In twenty five years as far as I know I have only had one client who has committed suicide but it was very huge...Very tragic, a whole team approach – the GP was involved, a psychiatrist was involved, we were all very busy and she committed suicide, in a very horrible way, which is unusual for a woman. That had a huge impact in terms of the inevitable kind of reflection, ‘what more could I have done? What should I have done? I should have done this, that and the other’. I’d seen her the day before, and I actually saw her with her partner. Yes we could have sectioned her. And I think that is a reality, we could have done more. I recall getting the call from the GP when I was just in between clients, in the 10 minutes I give between clients, I got this call and having to work with the next client after that. That affected me greatly. I became very over-fearful that every client could commit suicide. I had to work through over-compensation there. The huge loss of trust in myself in judgements, and something about the learning was moving it away from that intellectual bit that we can’t be responsible for our clients. I think we need to be responsible for ourselves as ethical and appropriate practitioners...I was very twitchy for a long time after that. And the learning, it needed time. There was the immediacy of the shock, but [there was also] the kind of ongoing learning, rebuilding that.

Finally, many therapists in both groups (six from group A and nine from group B) reported that they were aware that there is always more to learn:

I suppose in a sense every client I learn from. I sort of go in with anticipation and look forward to learning about them... (*Bryony, group A*).  
...I think its being in here, doing the work with so many other people that you really reinforce these things. It’s a major growth thing for me. And you know, it never stops. Some days I think, “Oh I’ve done really well, learnt all this, blah, blah, blah” and then the next week something comes up, “oh another lesson to learn”! It never stops. (*Alice, group B*).

I think I’ll continue learning... (*John, group A*).

Every session is different with every client and I never stop learning. Even when I'm tired I will still learn something about myself, and even when I've got lots of energy after a holiday or something, I will still learn from the clients. So long as I am open and remain open to the work that's going on. (*Lynne, group B*).

### **The nature of learning experiences**

Perhaps linked to the finding that for some therapists interviewed, learning seemed to be outside of their conscious awareness, the phase one findings also indicated that the effects of therapists' learning experiences were sometimes unclear. Five therapists from group A and two from group B said that this was the case for them:

I'm not sure exactly how it has changed me. But in a general sense I have been changed. Its something difficult to put my finger on... (*Andrew, group A*).

Its not necessarily very specific, its more a change of feeling and a change of being. (*Nkeiru, group B*).

In addition, learning catalysed by one therapeutic relationship was found to sometimes be difficult to untangle from learning catalysed by another relationship or from learning that was catalysed by other experiences. Five counsellors and psychotherapists from group A and four from group B reported this to be true for them:

Its also something that's difficult to pull apart, because when I finished my training I started working [with an HIV organisation], so working with people with HIV and doing formal counselling were happening at the same time. Sometimes its difficult to pull apart the anxiety that comes from starting psychotherapy and counselling and the anxiety that comes form working with people with HIV. (*Soren, group A*).

...with these perfectionist sort of clients...I do think in the last sort of 6 months I have been a lot more tolerant of perceived imperfections...But how to tease that out of the other things that have changed my life: I'm the mother of a one year old, so the last 6 months have been about juggling lots of things and accepting that I can't do everything to the best of my ability...So that's also in the pot. (*Nicola, group B*).

Where the effects of learning experiences were more clear, therapists (one from each group) reported that learning catalysed by counselling relationships can impact on other areas of their work, such as their teaching:

I certainly learnt something that was missing in my training...and in training other people...it does influence how I do that. (*Ruth, group B*).

I think it [counselling clients who were HIV positive] certainly helped me to develop the ability to talk about awkward things...death, sex, which often people find quite difficult. I occasionally run workshops for counsellors teaching them how to talk about sex, because its one of those things that is terribly left out in most trainings. It gave me an ease, to speak the unspeakable. In a way, if you can say the word, it helps the client to be able to say the word. (*Louise, group A*).

And as seven participants pointed out (five from group A, and two from group B), learning with one client type may be transferred to work with other client types:

In my work now with [an organisation], with people who have been severely abused and tortured, again I am in a position of not knowing at all at first hand the kind of experiences people have survived, a similar position to the HIV work I did. I don't know if it has got any easier to cope with that level of not knowing and having to try to understand another person's experience, but thinking about it now, it is a similar sort of process and being open to learn from the client. So I'm not saying I find it easy, the not knowing, but I've done it before and have to trust a way of finding a path into it. (*Jill, group A*).

Well, something happened yesterday...I was with a client who was thinking about losing their long-term relationship....And the client said, 'maybe if I bite the bullet something good will come of it'...And I suddenly thought when my client used this phrase 'biting the bullet' that's what's wrong in this belief is that it's a self-constructed promise somehow. There's a belief that if I suffer now it will get better. And actually that doesn't work. I really hadn't been aware of that, I had shared the belief until I heard it reflected back to me. And I think that for me it will be relevant in all sorts of ways. It's a shift or a growth in what I personally know about how to go about organising my own life. And that I may be able to pass on to other clients as well. (*Catherine, group B*).

Therapist learning and change was often found to permeate into therapists' wider lives (as reported by seven counsellors and psychotherapists from group A, and nine from group B):

I have learnt that you can never stop being surprised. You know, you think you'll never be surprised by anything you hear again...that's something I've learnt, definitely...it has changed my outlook on life. Its opened my eyes to things I could hardly imagine before, so its certainly done that. (*Claudia, group B*).

I think its affected me as a whole person. Not that I switch that on when I'm with a client or in a group. I think it has had an effect on the rest of my life as well. (*Stephen, group A*).

Similarly, some experiences that affected therapists' private or previous professional lives were found to have impacted on their work (as reported by seven counsellors and psychotherapists from group A, and seven from group B):

Well, I think my work as a social worker has probably helped me in my role as a counsellor in that I would often have pretty awful situations to deal with. I would work with really hardened alcoholics and drug users, paedophiles, and all sorts of people whose way of life and behaviour would be something that I would absolutely deplore, but I think I have the capacity to separate out the behaviour from the person. So I can relate to the person while being opposed to the behaviour. (*Irene, group B*).

I was ordained as a lay Zen Buddhist, six or seven years ago now, so part of my spiritual journey has to do with getting to somewhere beyond duality...and learning humility. The kind of things that become part of my counselling practice, so they seem to nourish each other. I bring my Zen meditation practice into my counselling and my counselling influences will influence or reflect back on my meditation practice. (*Richard, group B*).

In addition, for eleven of the group A therapists, both personal and other professional experiences of HIV had impacted on their work with clients. Three are quoted below:

I think what I have been through, having AIDS and HIV, is almost a lesson in facing certain existential issues with fortitude, with courage. Which are the kinds of things that arise in almost any set of issues, or underlie any set of issues. So there's something at base level about dealing with adversity, being there, which has equipped me as a therapist. (*Fergus, group A*).

I suppose I should say that I've had various links with HIV before I got to the counselling with HIV. A close relative died of HIV...and the other thing was that I have worked as a nurse. In the 80's there were quite a number of patients with HIV and I think I was very shocked by how people were treated. I was very shocked at the level of fear and prejudice that they experienced from staff. The kind of examples that stick in my mind is that people would leave the patients' meals outside their doors. Or someone would be going to make a bed and they would cover themselves up with any number of protective clothing. It was absolutely horrible. And I suppose that would have had an impact on me later on, having been exposed to that, and at some level thinking that I would hope to be better...to do better than that. (*Jill, group A*).

...[HIV antibody] testing was a very big thing for me, I was very scared of testing, and I spoke about it in my therapy for quite a while before I actually tested. That was a big thing for me, that was a challenge which I'm sure affected the way I was in relation to these [HIV positive] clients. I probably wasn't so smug. I don't know if that's the right word, but experiencing that fear, all of those doubts and fears one



goes through, brings you closer to people who have been through that and been diagnosed. (*Carl, group A*).

## **Difficult aspects of counselling and psychotherapy**

The difficult aspects of therapists' work were found to impact on their therapeutic relationships.

### **Training inadequacies**

Some therapists (three from group A, and two from group B) reported that since training is not a complete preparation for client work, they had learnt a great deal after completing their training:

...the college training no way prepares you. I've learnt more, I would say I've learnt about fifty times more in the three years I've been doing this than in the three years I was at college. (*Alice, group B*).

I must say, looking back, I don't think any of the courses had anything about HIV, which is a bit odd when you think about it. People were quite conscious of HIV and AIDS as an issue, so maybe that's quite strange. In that way, I found the courses quite isolating – there wasn't anyone else who was interested. (*Jill, group A*).

### **Intense nature of the work**

Since their work was often intense, a number of participants (four from group A, and four from group B) mentioned that they learnt about the importance of protecting themselves as a therapist both for their own benefit and for the benefit of their clients. Some talked about incorporating a meditation practice into their working lives as a way of grounding and centring themselves before and after counselling sessions. Others, like Tom (group A) said that they had learnt that they should only see a certain number of clients and/or a certain number of clients of a particular type each week:

To be willing to be open with the client means we allow ourselves to be impacted by them. And the impact of having a twenty year old or a succession of twenty year-old people come through your door saying, "I'm positive how am I going to deal with this? I'm in crisis and I can't tell anybody else". The impact of that is enormous. Its very, very, very heart-wrenching. Absolutely heartbreaking...This

was before I discovered that I was positive too, I learnt that there was a limited amount of HIV work I could be doing on a day to day basis... *(Tom, group A)*.

A few therapists also mentioned the importance of keeping themselves generally healthy, of variety, having outside interests and of spending some of their leisure time relaxing:

Well, at the time I was counselling people with HIV and AIDS, one of the most immediate things was that a lot of them were dying or dealing with very difficult conditions. And the pain of losing lots of people...As a human being its painful, and as a therapist too. Needing to have in place sufficient support for one's self to be able to process the losses of lots of clients....I suppose one of the main things I learnt throughout that whole period was that unless I worked to keep myself healthy and sound and supported, I wasn't going to be available to do the necessary work with clients. That's a really important lesson. *(Annie, group A)*.

...the flip side is that I think there is something about having these very intense affective experiences of being with the other that means that sometimes in my private life I'm not that open. If I have had these very intense experiences of being with the other all day, sometimes its like, 'enough already [sighs], you don't want to do *this* right now'. So it impacts on all sorts of levels. *(Nicola, group B)*.

### **No resolution**

Two therapists in group A reported that the fact that HIV positive clients could not be 'completely healed' impacted on their relationships:

I think again, it has similarities with other aspects of counselling, it is one of the things where you are not going to make things totally better. I mean you can imagine doing some counselling with a couple, and by the time they have done 3 months with you or whatever, they are communicating better and they have got through the crisis in their relationship and you've reached a kind of end-point. Whereas, if you counsel someone with HIV, you might meet an end-point in the work that they want to do with you, but the problem is going to continue. *(Jill, group A therapist)*.

...certainly there have been one or two clients I have worked with where the effects of their HIV on them has had a real impact on me. I can think of one particular person who said, "are you ready for a couple of sessions?", this was a guy who was really ill and he had been a model. You could still see elements of his attractiveness, but he'd had full blown AIDS when I saw him, for a couple of years. His body was completely ravaged by the effects of it. He was completely emaciated and he was obviously very distressed when he came to see me.

But there was one point in the session when he was very stressed and very angry and he actually sort of...and he talked about how he used to be a model, and he was going on about changes in his body, and he actually took his shirt off at one point, and he sort of showed me the effects. That really stopped me in my tracks. When you first start doing counselling work, I think there is a sort of naivety about

it. You go into it not really knowing...you have done the course, you have done some of the theoretical stuff, and you have worked in the group. And you start working with other people outside, but there is a certain naivety you go into this work with. And sometimes things like this happen. I think for me, it turned it into something very, very real. Erm, and also there was a sense of really understanding that sometimes I can't help. I think that a lot of people start off counselling with a very optimistic viewpoint, and here was somebody who was basically dying. He was going to be dead in probably about six months. There has been some change in HIV with all the drugs and stuff, but at that time the drugs that were around were experimental and getting HIV was a death sentence for most people that got it. I remember him doing that and me sitting there not knowing what to say. Actually there was nothing to say. (*Tristram, group A*).

## **Therapist Change**

I have placed the categories that arose referring to specific changes that therapists said that they had experienced into three groups. The first, 'personal change', is a group which is comprised of categories that refer to the ways in which the therapists were personally affected by their client experiences (and this change may well have indirectly affected their practices). The second group, 'personal/professional change', includes categories that refer to the ways in which some changes have impacted on therapists both personally and professionally; and the third, 'professional change' group, consists of categories that refer to the ways in which therapists' work practices have changed as a result of their learning experiences with clients.

## **Personal Change**

### ***Inspiration***

Therapists in both groups (eight from group A, and five from group B) reported being inspired by their clients. They were not inspired to do anything, they were simply touched on a very personal level:

And I've been privileged enough to witness some quite, erm, quite remarkable struggles against real odds and pain and difficulties. Absolutely kind of inspirational people, people who've moved me enormously, and whose courage and insight and vision has confirmed something about life for me. So its really powerful. (*Annie, group A*).

...in the long-term work I think clients...are embracing a longer process and they are willing to open up their internal world. They know that they will probably feel more depressed, more anxious, they will feel more envious, they will feel more hatred than perhaps they felt before. When you start to open up and experience these states, they are strong. And I do feel really, really inspired by the choice that

people make to go into those places with the intention of finding a better place. I find that really inspiring, really amazing... (*Nicola, group B*).

### ***Increased self-awareness and self-acceptance***

Additionally, practitioners in both groups reported that their self-awareness (four from group A, and nine from group B) and self-acceptance (two from group A, and four from group B) have increased as a result of their client work:

And I remember a couple I went to see where one guy was basically dying with a younger boyfriend...The partner was in the state where he didn't even have the strength to be emotional about a lot of what was happening to him. He had to spend a lot of time in bed, and all that sort of thing. What I learnt was a lot about the position of the supporter. I had been in that position myself because I had a boyfriend who died of AIDS in 1990. Counselling the carer really helped me to understand and forgive myself as well, for some of the feelings I had been through. (*Fergus, group A*).

And there was one particular client, his name I won't mention, but he was absolutely gifted in the role of therapy, and he kept me entertained for many months. It was so important to challenge him, and as part of that, my learning was to really notice when I'm entertaining people and when I'm not; and I'm going to stop entertaining you and actually tell you something. Riskier, because I'm not going for the response I would if I was entertaining, I'm just showing what I've got. (*Wilma, group B*).

### ***Addressing death***

Only therapists in group A (four in total) reported addressing their own death as a result of their client work. Three are quoted below:

...working with people who were basically dying, young people...in the end you have to develop a comfort with your own death, the concept of your own death, and your own, if you like, lack of infinity, which is very contrary with everything that goes on in this world at the moment, which is very much that death is a dirty word. So you had to become aware of your own finitude in order to work with other's finitude, and be comfortable as possible with it. (*Louise, group A*).

I'm not so scared of it [death] now. I think I was so scared for so many years that its still very, very scary...(*Tristram, group A*).

...its made me less afraid of death, I think. I think... (*Carl, group A*).

Seven group A therapists also noted that they had faced death in general and were more able to be with death in others as a result of their work with clients. In line with these findings, as discussed above, five group A therapists mentioned that the issue of death is

more likely to be relevant to clients who are HIV positive than to most clients who are HIV negative.

## **Personal/professional change**

### ***Confidence and openness***

Several changes were found to have impacted on therapists both personally and professionally. Thirteen counsellors and psychotherapists (seven from group A, and six from group B) reported that, as a result of their work with clients, they had become more confident both in and outside of their counselling roles:

It has seriously boosted my self-esteem professionally and personally. I've only been counselling for [around] 3 years and have felt blocked, deskilled by clients and will continue to do so, as with another client at the moment. But I feel very differently about my competence...I now feel less insecure about my practice – I *feel* qualified. This is what I'm good at, this is what I can offer, and I can apply it to any number of clients (not all). (*Maggie, group A*).

I've always been quite confident and extrovert, but I think it has increased the confidence. And I think that it helps a client to know that I'm confident in what I'm doing and in my approach. (*Rose, group B*).

Some (two from group A, and two from group B) also reported becoming more open:

I would say I have learnt openness. More openness. (*Teresa, group B*).

I learned to be open...to let him take the lead. I learned, as I've said, to be with him wherever he went in the sessions. (*Maggie, group A*).

### ***Acceptance, humility and awareness***

Five therapists from group A and four from group B noted that they had become more accepting as a result of their client experience:

Well, I thought that people who were mentally ill were in mental hospitals at the beginning, in the 1960's. And I thought some people were normal, some people were weird, and most people were stupid. But my opinion about that has very much changed, because I now see people as people. And I don't take any notice

of what the label is of the person I'm seeing – It doesn't mean anything to me. (*Eve, group B*).

...my own views of some sexual practices were challenged. And I had to really think through the implications of that for me as a human being for how I responded, how I continued to make myself available to somebody who was sexually aroused or took sexual pleasure in doing something that previously I might have judged or felt uncomfortable around or something like that. I really had to look at what was going on for me. And I think that has supported me to be more open and accepting generally, I think. (*Annie, group A*).

A few participants in both groups (two from group A, and three from group B) also said that they have become more humble:

The biggest thing I learnt was humility. (*Tristram, group A*).

I guess it has had enormous impact really. I don't know whether I can put my finger...I think its just that I'm much more humble. (*Lauren, group B*).

In addition, many counsellors and psychotherapists (eleven from group A, and ten from group B) reported becoming more aware of others' feelings and experiences:

I think it made me very aware of how vulnerable people with HIV feel. I'm sure it's the same with cancer, but I have not worked with cancer patients, so I don't know. This sense of really being unable to do anything about it. I was working with clients in the earlier days, so it was very much an unknown quantity...I think the other issue which I hadn't considered was the group that were HIV negative and who's friends were HIV positive, and who felt that they were somehow unworthy of being in this community. This was something I hadn't really thought about, so I was made very aware of people who feel excluded by virtue of the fact that they are actually healthy. (*Colmat, group A*).

I'm much more aware of the ways people's behaviour affects the people around them. I see people...behave so badly towards each other. I think its amazing. If only they knew, if only they realised what effect that had on other people, they wouldn't do it. (*Claire, group B*).

Two group A therapists also said that they had become aware of the positive impacts HIV may have on the feelings and experiences of those that are infected with the virus:

To accompany people through a difficult journey that doesn't always lead to something worse and can lead to something better. That has been absolutely fascinating, to work with people who then, because of HIV, make positive changes in their lives, where HIV can become the catalyst for something better. Again very

difficult, this is the kind of stuff that if you talk to the general public about it, they might smack you in the face and say, “What are you talking about? HIV can be something positive?” And I think I would have always felt that its something bad that happens to people. And of course it is something very problematic, and we know about that, but what is interesting is that people can use the problem and have something better through it. (*Soren, group A*).

The most common response from clients who are HIV positive is that “it has given me a kick up the pants”. And we are talking more recently of course, because in the early 80’s it was completely different, it really felt like a death sentence. I am really talking about my more recent experience where people have said “it has made me look at my life”. (*Tom, group A*).

### ***Compassion***

Participants (four from group A, and two from group B) also described the ways in which they have become more compassionate with clients and other people:

Perhaps its changed how I feel towards other people, and perhaps other people in general. It has made me less self-centred and think more about other people. A bit kinder. (*Stephen, group A*).

Well, there’s something about increasingly being able to open my heart to clients...And I think increasingly I have become aware of the need for my heart to be open, and my heart has opened. I would say that Buddhism has assisted me there. The support of Buddhism – the concept of compassion. (*Teresa, group B*).

### ***Trusting feelings, thoughts and images***

Counsellors and psychotherapists in both groups talked about the ‘intuition’ ‘instincts’, ‘gut feelings’, ‘gut reactions’, ‘images’, ‘feelings’ ‘hunches’ or ‘ideas’ they had experienced when working with clients. These were feelings, thoughts or images that can suddenly appear to the therapist. Carl, (group A) explained:

Intuition is...the most in the moment thing. A client is saying something and suddenly something comes into your head. Its not defined, it’s a little bit like a smell, you just think, ‘well, maybe this might be useful’.

He added:

...knowing how to use one’s intuition I think takes years, and I think the best therapists have a lot of experience in that field.

Wilma, (group B) suggested that the images and feelings that suddenly appear to her may be messages from the client:

**Wilma:** ...you can trust the images that you get in the session. Its almost to do with transference and counter-transference, that you sometimes get feeling and sometimes you get images.

**Me:** *It's a communication?*

**Wilma:** I think so, yeh, that's what I think. I would have ignored it, but I have got more...risk taking...experimental....

In contrast, Catherine (group B) argued that intuition is simply the result of experience:

...what people like to call intuition...is just having seen similar things plenty of times and getting a feel for what processes are likely to happen. Which is basically the result of observing and being there and relating experience. Which I think makes a difference to the way we work. To be with someone and just have a very general idea about what is likely to happen, what topics are likely to come up. What's likely to be useful and what's likely to be less useful. Internalising that to a point where I'm actually not even conscious of my thought process about it. And I think it makes a difference.

Whatever their source, participants in both groups (four from group A, and five from group B) reported of their own accord that as a result of their client experience, they have come to trust the feelings, thoughts or images that suddenly appear to them, both in and outside of the counselling room:

And the other thing I learnt was that all through my life, before I was a counsellor, I used to have these really strong gut feelings about people and things and what was going to happen and all the rest of it. I never really took much notice of them, put it down to, "oh don't be so silly", you know, it doesn't mean anything. Since I've been counselling, I've recognised that when I trust in these gut feelings they are always right and they never let me down. So, the more I trust in them, the more usually that I'm proven to be right in the feeling that I'm having, so not only do I trust them in a counselling room, I also trust them in outside life. (*Alice, group B*).

I suppose the learning was that my intuition or gut reaction – whatever you want to call it – was right. You know, a little thing, and I picked it up and it was true. (*Zoe, group A*).



## **Professional Change**

### ***Staying with it***

Nine practitioners (four from group A, and five from group B) reported learning to sometimes 'stay with it'. This means not trying to move the client on, find solutions or try to make things better. Instead, the therapist just stays with the client's and with their own discomfort:

...the examples of one or two clients I can think of who have been quite despairing in the face of their, perhaps not HIV diagnosis *per se*, but for whom this has come at the end of a lifetime of difficulties. And who are coming into counselling not with the view of changing their lives, but just to rehearse their anxiety, depression, sometimes just to be held in that, and erm, who when one does present alternative points of view, when one does challenge their situations and propose the notion of change, close down. It is quite disabling when you are in the presence of someone who really does not want to change. And who is very seriously depressed...To have to sit with the sense that one can't do anything, apart from offer a presence, offer a place to which people can come to explore their anxiety. It makes me realise that its an essential part of the work of therapy, to sit with someone and not have any sense that you can change what is happening for them, but that you are still there none the less. There is something in the presence that without your knowing it maybe is helpful itself. (*Simon, group A*).

In the last three years I have really had a lot of reinforcement that staying with what is in the moment is really sufficient. (*Janet, group B*).

### ***Risk-taking***

Some therapists (one from group A, and three from group B) reported that they had learnt to take more risks in counselling and psychotherapy as a result of their client experiences. These risks sometimes involved acting upon the sudden feelings, images or ideas they had in sessions, as discussed above. Therapists noted that although their actions seemed risky logically, it felt as if they were the right thing to do:

I do use it [self-disclosure] rather more now. I know for certain I'm not going to take up many minutes of their time. I worry about whether I'm gratifying something in me. But on the whole I feel very secure about how and when I use it. I like the idea that it makes the relationship more horizontal...So I've learnt to be a bit more experimental, to take risks. To follow a hunch I have. (*Angela, group B*).

I like to think that because of what I have learnt from my clients I am much more likely to take risks now. Because I have a hunch that it will facilitate the therapy. It can be a short-cut to what would otherwise take much longer. (*Simon, group A*).

I can think of a situation where I really took a risk of lying down, on this floor with the client, just lying there alongside. And there's touch and just stillness. I risked that, just moving, if you like, with the flow. So just something about learning to assess risk. I'm thinking of one client in particular. Now this is a female client...the work, particularly with this person has really moved things on in terms of knowing and appreciating what is something deeply therapeutic. Sitting in our chairs is fine and on the whole completely appropriate. There's abuse in counselling and then it could almost be abusive not to use touch in other ways. I think that's the learning, in long-term work, how to risk using touch in a way that can be deeply healing. So it felt very risky and also it felt right, it was working. (*Lauren, group B*).

### ***Acknowledging and challenging***

Therapists in both groups (one from group A, and three from group B) stated that in some cases they had learnt to simply acknowledge their client's feelings and actions:

**Soren:** I think people with HIV can use the diagnosis to stop them moving forward. I think that needs to be really understood. So for a person who finds it difficult to establish a relationship, if HIV isn't there, you have one less difficulty. So that person finds it difficult to go into a bar and say, 'hey I'm Joe, can I buy you a drink?', because they think about them self, Joe, as not very nice and no-one would want to talk to Joe, so why would I want to...there are all sorts of negative effects. The difference with HIV is that they have a confirmation of being negative inside by being positive.

**Me:** *How did you learn to work with that?*

**Soren:** I think by acknowledging it...Obviously you need to be sensitive to that. If you are working with Joe, you are building Joe's confidence. 'You are really good and what you have inside is good and you can bring that to the world and that's wonderful.' Then how do you work with Joe when actually there's something inside that's not so nice?...I don't think its right to gloss a positive image over it. Some people I work with say, 'You need to embrace it. You need to love your HIV', and I'm not quite so sure that works. (*Soren, group A*).

**Rose:** I must admit, you might have heard other counsellors talk about that a client will perhaps talk a lot in the session, but as they are leaving, and their hand is on the door handle, they will say what they should have said at the outset or part way through. And sometimes it can be something so devastating and alarming or whatever and its like they are just about to go, and handling that....

**Me:** *Have you learnt anything from that?*

**Rose:** Yeh. Just making sure that client is alright before they leave. Obviously not ignoring it, actually acknowledging it. (*Rose, group B*).

In other cases, therapists (two from group A, and two from group B) commented that they had learnt to challenge more:

...the one that springs to mind immediately is a client who spoke with the force of her convictions that she needed to keep one step ahead of the man who had been a wrecker in her past. She was totally convinced that now, in the current day, she would be totally stuck if she didn't manage to keep one step ahead of this man. From my perspective of what she was telling me, that was way out of date, in other words, I didn't see things in anything like the way she saw it. And the way she acted was speaking as if I would naturally, one hundred percent agree with her eye to eye. Because she was so rigidly sure I suppose. And for a while I was kind of making an attempt to understand her position, and it felt like she was challenging me to agree with her on some level where actually there wasn't agreement. And I spoke that discomfort out loud to her, that I don't really agree in a way, and its very hard to make this jump...and that felt quite a dicey thing to do. This was very strong...she was kind of rigidly knowing herself to be in the right, so it was quite hard to disagree with her. Having done that, it was clearly the right thing to have done in that session, because erm, it brought up her desperation to cling on to that need, which wouldn't have necessarily come up. I suppose I was challenging it. And I've noticed that coming again...So I suppose I dare to disagree more, because of the successful disagreeing the first time. (*Janet, group B*).

I am more challenging. I think its only something you can develop from experience...I suppose in a way I have learnt to be not so directive with the challenge, but to make it more of an open question. Or to ask how would it be to look at something from a different perspective. (*Colmat, group A*).

### ***Humour and being human***

A few therapists (one from group group A, and two from group B) learnt about the importance of humour in therapy:

...humour – I introduce it more readily and appropriately than I did in the early days...There is a dance that often goes on in the counselling room. I think when the humour comes in there's a dance...because I'm not afraid to use humour. And a lot of clients thank me for allowing their sense of humour. (*Rose, group B*).

We tend to think of HIV as death, dying and all those sort of things. But you get sessions that are so humorous. And you mustn't forget that. You've got to deal with issues that are very serious. But its about *living* with HIV. Its about building a new life. About humour. Laughter. Even when they are ill, something will happen that will bring that humour into it. Because the person is human. You are dealing with a human being all the time. (*Zoe, group A*).

In addition, through their client work, therapists in both groups (four from group A, and five from group B) reported becoming increasingly aware of and comfortable with the reality that like their clients, they are 'human'. This included learning that it is OK and

sometimes even therapeutic to respond to clients in a ‘human way’ (person-to-person rather than professional-to-client), as well as coming to terms with the fact that they are prone to making mistakes and sometimes failing:

I used to get very worked up when clients made unusual requests, if it was OK to respond or what was the appropriate way to respond. I can remember one time when a client complained about the fact that he could hear a telephone ring outside the room, and I went to my supervisor and said, “What do I do with this?” And he said, “Well can’t you just turn the phone off?” [Laughs]. Its OK to just respond in quite a normal human way, something around that. There was a real experience of working on a very human level. (*Tristram, group A*).

A good many years ago, there was a client that suffered a really awful situation...there had been a murder in the family. She wasn’t an easy person to make an alliance with anyway, and it was a good many years ago, I suspect I might manage that rather better now, but I used a phrase...and the context the phrase was used in was not to do with the tragedy. I’m not going to tell you the phrase because that might identify the event...but it was as if, if someone in the family had committed suicide by jumping off a bridge, it was like me saying, in a different context, “So then you might feel brave enough to take the jump”. It was a bit like that. It was a gaff. I remember that she just stared at me. She was hurt, angry, bruised. She didn’t come back, which wasn’t surprising in the context of how things were going with us anyway. And after that I just thought, “Oh my gosh, how could I have said that?”...it was long enough ago when I wanted all my clients to find me a nice person, that sort of rubbish...and the learning was in tolerating the knowledge that I’d made a really unfortunate intervention and that that does happen in life. It was a sort of gulp, swallow, and stopping myself going to the place of ‘this is unthinkably awful’. It was the learning that I make bad mistakes sometimes, and that doesn’t mean that I’m an all time awful counsellor. I survived making that mistake. (*Angela, group B*).

### ***Usefulness and constraints of theory and models***

Nine counsellors and psychotherapists (three from group A, and six from group B) talked about the usefulness and constraints of counselling theory and models. In terms of constraints, Nkeiru, (group B) who’s training was humanistic and largely person centred, said:

...I can’t be purely person-centred, because I don’t find that approach to be challenging enough. You know, Roger’s core conditions are necessary and sufficient, supposedly. I agree that they are necessary, but I don’t find them to be sufficient quite often. So I challenge quite strongly.

Maggie (group A) learnt about the constraints of theory and technique in working with a client who was HIV positive:

I learned to shed the constraints of a load of therapeutic theory, this technique and that technique.

And Richard (group B) learnt about the limitations of theory through his work with clients:

I think that one of the things my practice as a counsellor has emphasised to me is how difficult people are to know. You can have all the theories in the world, and in lots of ways, they are quite meaningless. Meaningless in the counselling process, because the relationship takes place in some kind of different space, where affect and feeling are somehow far more important than any sort of theoretical understanding. I try to leave all my theoretical baggage at the door when I come in. Most of the time, I think 'let it go', because its not actually helping me to be as fully present with the client as the client needs me to be.

In contrast, Andrew (group A) mentioned that Freudian theory helped him to understand a client who was HIV positive:

Well, the psychodynamic aspects are that...he doesn't seem to have a very good relationship with his father at all. His mother is very assertive and he's not on her wavelength either. He wants to achieve something so that he feels that he has accomplished something in life. He wants to achieve something, I think, so they feel he has accomplished something. That's where the Freudian theory comes in really.

Similarly, Nkeiru (group B) noted that although she does not rely on theory in the counselling room, in understanding her clients' progress stage theory has been useful:

...the theory has to underpin the work. But if you are actually sat with clients, you don't think, 'What was that little piece of theory we learnt six weeks ago when we were learning about Carl Rogers?' Its really not relevant when you are sat in a room with someone, it really is about being yourself. About being straight and honest and trying to be accepting and non-judgemental. But you do have to go away afterwards and try and think what is really going on for that person. One thing that does seem to make sense in practice is stage theory...I mean I don't know whose, but there are recognisable steps in change. So it does help to know that at times, especially at stuck times. You start to think, 'what is happening here'? But its OK. It helps to look back and think, 'Well, 3 months ago she was doing this, 6 months ago she couldn't speak at all, she just cried for an hour'.

And you can recognise that things are moving on. There might be steps backwards and there might be times when nothing is happening at all, that's when you just have to remember that it's a process.

## ***Boundaries***

Participants in both groups (three from group A, five from group B) told me, of their own accord, that they had learnt about the importance of boundaries through their work:

And actually that's something else I've learnt...how different it is to counsel here in my house to counselling in a practice somewhere else, or in a counselling organisation. And how important it is at the beginning to make the boundaries very clear, because if you can't it affects the counselling. That clients keep to the timings, that if they miss a session they have to pay. You know, all that seems very important. So that they can feel secure enough to open up...I've learnt that I have to be very firm, and of course that was quite difficult for me at the beginning. *(Claudia, group B).*

I entered into a game with him [a client who was HIV positive]...its about his partner ringing me, which they didn't ask if they could or not, and she wanted to know if he was with me at a certain time, and I said that I wouldn't reveal that information, but I said I would speak to the client to see what was going on. It basically entered into a game of suddenly I was responsible for the relationship breaking down if I didn't tell her information that I didn't want to give...But what I have done, which might be my learning, is that I will not do that again. I might not even reply to the phone call, they can just leave a voice message. So yeh, I'm thinking that my learning might be that I state that when I enter into a contract with a client, when I say that this is a private agreement between us, I might also say that I will not be speaking to any other third party. Unless its something we specifically agree to. I'm thinking of a doctor or something like that. So that would be my learning. *(John, group A).*

However, in working with very ill and dying people, three group A therapists also stated that they had learnt to be more flexible in their approach:

I think that when somebody is dying, for instance...maybe this again is right across the board, but...I believe in having boundaries very much, but I also believe that its very important to be constantly thinking about them in relation to the client. So there may be times when I may cry, and it may even be therapeutic for the client. So its like a constant thinking process, and analysing and renewing. Working with people close to death is always very intense and some of those boundaries may be tested. When they are broken it may be very therapeutic...Because when you come out of college...you are full of boundaries. And as time goes on, especially working with people close to death, or who have been diagnosed, work becomes very intensive, and boundaries can definitely be tested in all sorts of ways. *(Carl, group A).*

I guess that it [working with a client with AIDS] has been helpful in the sense of making me more flexible in my approach. I think one of the things, when you first become a counsellor, for your own protection and safety, you tend to, well, I certainly tended to stick to quite rigid boundaries. It certainly made an impact on my ability to be more flexible with clients. *(Tristram, group A).*

One of the differences for me would be if I was counselling and doing a home visit and somebody's unwell...for instance, with one guy, who has now died, he was unwell. So I didn't do the counselling. He had chronic diarrhoea. He needed cleaning. So those things will come into it. (*Zoe, group A*).

One group B therapist talked about her use of flexible boundaries in working with a very traumatic situation, also involving death. Lauren tells her story:

...the client was seeing me about other issues and as the issues emerged, her son was very troubled, and so there was a parallel story going on separate from the presenting issues. And then he went missing. This was over a long term counselling relationship, so it was happening lets say over about a year. So he's missing, they're searching here and abroad. And then I get a phone call to say that his body has been found abroad. So there's a phone call late at night. It's a boundaried situation, but the client phones me to say that the police have just called round to say his body has been found. And I say that I will come round and see you tomorrow morning at your home. And I do, and I hold her hand, and she weeps, and I feel weepy with it now. So I was there for about a quarter of an hour and in fact I had to go on because I was working [elsewhere].

I report this to my supervisor, that's right, I phone her up just to tell her the situation, and I'll see her in a few days. When I see her the supervisor says that in the meantime she has seen her supervisor for a supervision and tells me that I have outrageous boundaries, that this is clearly breaking all taboos, and just really questioning whether she can work with me. This is a supervisor I had worked with for about 5 years, with a very good relationship and mutual respect...it transpired that the client's son was a similar age to one of my sons, so this was being challenged too, that I was in a kind of over-identification situation...well, we worked it through my supervisor and I, she owned that she had perhaps over-reacted...in the shock and the distress of a very horrible situation, I'm not going into great details about it because to give further details would be inappropriate, but it was all very shocking. It felt like an over-protectiveness...

My learning there was that there can be elasticity in boundaries whilst maintaining them. I have never been in the client's house again, I have never had a phone call again, we carried on therapy. For me I maintained that strong philosophy that I can be an ordinary human being in the face of trauma and at the same time I owned my own involvement and looked at that and needed to be challenged about that. So that was a major learning thing...It really made me think a lot and it stayed with me very, very deeply. It made me reflect, write a lot, think a lot about the whole danger, I would say about therapy, counselling, taking away our ordinary humanness.

### **Other catalysts of change**

Although the questions I asked participants during the first phase study focused exclusively on the learning and change that they had experienced as a result of their client

work, many therapists in both groups independently, and of their own accord, also mentioned the impacts of training and teaching, their own personal therapy, supervision and supervising, reading and observation of and dialogue with their colleagues on their learning and change.

### **Training and Teaching**

Sixteen therapists (nine group A, seven group B) reported that as well as their work with clients, their initial and ongoing training and teaching experiences have led to learning and change, both personally and professionally:

I did find it hard to stay in the training, in that particular personal-development group. Whether that's because I find it difficult to be in groups or felt so different from the group because I had that particular experience which I share with HIV clients. My personal experience of having HIV and interacting with other people who do, that came out in the personal development part of the group. So its less a case of carrying my experience into training, the training gave me an opportunity to explore that with people who didn't have that experience. Which I think has helped me to integrate that, and come out of that feeling less cut off from other people who don't have that experience. I find it much easier to tell people at work, say, or other people in my life, without it being a traumatic experience for me and for them. (*Stephen, group A*).

...another training I did, fairly recently, on loss. Just realising how multi-faceted any loss is. So if I'm working for a local firm and they close down, I've not only lost my income, but I've lost my colleagues, my identity...I don't know why I'm imagining I'm a bloke, but maybe I've lost my wife's esteem...hundreds and hundreds of losses. And although at one level that's obvious, it sits with me as a clearer awareness in the counselling room now. So if a client talks about any kind of loss, be it a death or a relationship loss or something less big, its almost certainly going to deprive them in lots and lots of different ways, many of which they possibly haven't even quite thought about consciously. (*Angela, group B*).

Susan (group B) felt that she had learnt a lot more from her training than from her client work:

...I probably learnt a lot more on the counselling training than I have done in working with clients. That's probably wrong isn't it? That's the wrong answer! [Laughs].

### **Personal therapy**

Although I did not ask about their own experience of being clients, during the interviews, fourteen participants talked about the positive effects of their personal therapy on their learning and change as therapists. They mentioned working on unresolved issues (three



participants), gaining a greater self-awareness (four participants), learning about the process of therapy (three participants) and learning from their therapist as a model of a therapist at work (four participants).

...I think, I know, I'm enormously informed by the work with my therapist. I carry my therapist within myself in the way that I work. That's because I have had a very, very good therapist. I think this is a common belief that you learn to be a good therapist from your therapist. That's where you learn how to be. I think you learn much more there than with your supervisor...in terms of how to be in that room with people with HIV and AIDS...I think one learns from one's therapist. I know other people have said the same, definitely. (*Carl, group A*).

...I think if I hadn't had a lot of therapy I wouldn't know what therapy is like and what it is. I wouldn't think I would be able to offer it. And whatever happens in my own therapy will shape the way I do therapy because it will just slightly change and widen the experience of what therapy will be. (*Catherine, group B*).

### **Supervision, supervising and reading**

Supervision and supervising (mentioned by thirteen participants: four from group A and nine from group B) and reading (mentioned by three participants: one from group A and two from group B) were also found to lead to learning and change. For some therapists, these activities helped make the learning and change that arose from their client work more conscious and explicit:

**Me:** *So all your real learning was in practice?*

**Wilma:** I think it was. I think it was also in reading a few things that were really good things to read. Which I didn't understand when I read them at the training stage but I did begin to understand them after. (*Wilma, group B*).

**Me:** *Is it in some way a sort of more unconscious learning?*

**Clare:** It is for me, yes. It does help to be made more conscious if you have got good supervision. Or of course if you are reading a book that makes sense to you, you think "ah yes, I know that" or "I've met that" or "that was well put". That's when

I'll remember it. "You put it in a way that I could repeat if I needed to or that I understand". (*Clare, group A*).

I would say that things I would take to supervision would cause me to reflect and that brings about change. Without the reflection, I don't think that the change would happen necessarily. That's just a thought that occurs to me. (*Irene, group B*).

## **Colleagues**

Therapists in both groups (two from group A and two from group B) talked about learning from other therapists:

Another learning experience concerns another therapist. He is not positive, but he is gay. He went all the way through the [training] course, apparently with flying colours, he started working with clients and he just found that...he found the job of a therapist immensely lonely and isolating, he said. He had an experience of erotic counter-transference. A seductive client, very narcissistic. And he was quite damaged by the experience. He was very sure he was going to do that and nothing but that as his full-time occupation. So that was a lesson. Its very important to me to have a lot of breadth in my life. It actually helps. (*Fergus, group A*).

I look at some colleagues who look tired and don't seem to be doing much in terms of professional development and I wonder, could there be a sort of staleness there? (*Lynne, group B*).

And Alice (a group B therapist) pointed out that learning from other therapists was something she would have liked to do as part of her training:

I think what would have been really helpful would have been to have people, like me, in the real counselling world, coming in and chatting to us. We never actually met real counsellors. We just met our tutors, telling us what it was like to be a real counsellor.

## **Other findings**

Five therapists reported that as a result of being interviewed they have been able to reflect on and learn from their work as a whole. They are quoted below:

Its interesting, I've learnt a lot from this, actually. Its useful to reflect back on a client with somebody outside of supervision. (*John, group A*).

I want to say that I really appreciated your warmth, and gentleness and receptiveness. It feels like it has been a gift to me, as well as hopefully to you, talking to you. Its been an opportunity for me to reflect as well as hopefully in the long term to be useful to you. (*Teresa, group B*).

I have come to the conclusion that a by-product of my contact with you will further serve to support my own learning...It is some of the best reflective work (supervision aside) I've done since training. As I suspected, through this, I'm learning. So there's an immediate pay-off for me. (*Maggie, group A*).

Thank you very much. Its very useful...Being interviewed is always useful, isn't it? It makes you think about things that are really helpful to think about, and that often we'd like to talk about, but we don't have time to talk about. (*Susan, group B*).

And thank you, it has been really useful for me to think about it and look back and think, 'what did I learn?' 'How do I learn?' And of course we all learn from the experience not from a book. I have had a lot of experience working with people with HIV, and I'm really thankful for that in a way. So, it would be nice to have more time like this sometimes, to sit down and reflect.

In the financially challenged world of HIV organisations often that doesn't get done. So I think what you are doing is very important, to think about how people learn, because we're always out there and working with other people, but to look inside and look at your own development is very important. So this has been quite useful really. (*Soren, group A therapist*).

## **Summary**

The phase one study findings show that therapists learn and change as a result of their client work in a variety of ways. In terms of personal change, they may be inspired by their client work, and may gain increased self-awareness and self-acceptance through their work. Both personally and professionally, they may become more confident, open, accepting, humble, aware, compassionate and trusting of the feelings, thoughts and images that appear to them.

Professionally, they may learn to sometimes simply stay with their and the client's discomfort, or simply acknowledge their client's feelings and actions. Conversely, they may also learn to challenge their clients more. They might also learn to take more risks in

therapy as a result of their client experience, and they may learn about the importance of humour in therapy, about the usefulness and/or constraints of theory and models in their work, and the value of 'being human' with clients. They might also learn about the importance of boundaries.

The phase one study findings suggest that these changes may occur as a result of learning from or with their clients, and that discussion may consolidate this learning. Counsellors and psychotherapists learn by consciously reflecting on their work, but their learning may also occur outside of their conscious awareness. Re-learning may be an important part of the learning process, and learning from client work may be a gradual process, even if it begins in a very dramatic and disorienting way. In addition, as long as therapists continue to work with clients, their learning is likely to continue.

In terms of the nature of their learning experiences, learning catalysed by one therapeutic relationship may be difficult to untangle from learning catalysed by another relationship or another experience. The effects of learning experiences may be unclear, or they might be seen to impact on a therapist's work with other clients, or on other areas of a their work, such as teaching. Therapists' work experiences may impact on their outside life, and their outside life experiences may, in turn, impact on their work. Difficult aspects of their work, such as its intense nature, might also impact on therapists' learning and change experiences.

As well as from their client experiences, the phase one study findings indicate that counsellors and psychotherapists may learn from and change as a result of their training and teaching experiences, their own personal therapy, supervision and supervising, reading, and observation of their colleagues. Furthermore, they are able to reflect on and learn from their work as a result of being interviewed.

The group A and group B therapists interviewed for the phase one study were found to have encountered similar learning and change experiences in many cases. In line with this finding, most of the group A therapists who were asked about it reported that they had

experienced few differences between working with people who were HIV positive and those that were HIV negative.

However, the phase one study findings suggested that only the group A therapists had addressed their own death as a result of their client work. In addition, it was found that therapists who had learnt about the benefits of using flexible boundaries in their work all did so in cases involving death.

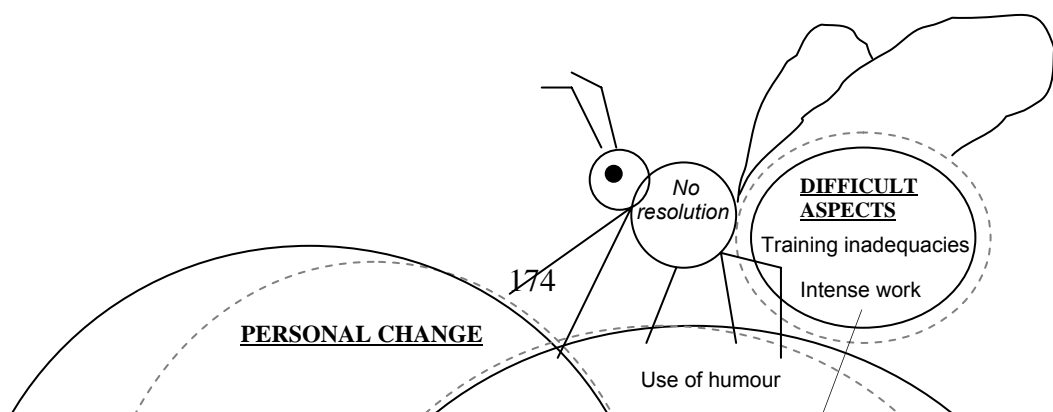
## **Phase 1: The Two Theories that Arose**

Figure 4 (page 175), represents the two theories that arose from the phase one study: A theory of learning and change for counsellors and psychotherapists who have a significant experience of working with one or more HIV positive clients (group A) and a theory of learning and change for therapists who have had no such experience (group B). The theories are represented together in the form of a flower to highlight the study's finding that therapist learning and change is often a lengthy and unnoticed growth process: In the same way that the transformation of a bulb into a flower happens in a gradual way over a relatively long period of time, therapist change is often a slow and steady process. The flower is, however, in full bloom, representing the sudden and spectacular way in which therapist change sometimes begins: Like a flower that opens overnight, therapist change may begin in a very dramatic way, as a result of the relational impact of a single client at one particular time. In addition, like the theories, flowers are temporally limited and sometimes need to be replaced by newer ones!

At the heart of the flower represented in figure 4 is the mutually beneficial relationship that therapists form with their clients. This arose as the core category for both theories of therapist change and links with all other categories. Surrounding this are two categories related to the change processes that this relationship can directly or indirectly catalyse: 'the ways in which therapists learn' and 'effects of learning experiences'. These are detailed in figure 5 (page 177).

The two overlapping petals attached to the centre of the flower are directly linked to the counselling relationship. These represent the personal and professional changes that therapists may experience as a result of the learning that occurs through their relationships

with clients. Some of the difficult aspects of the relationship are represented in the form of an insect, which sits on the petals. Finally, a smaller flower to the right of the main one represents other catalysts of personal and professional change for therapists. These are indirectly linked to the counselling relationship and are therefore shown further away from the centre of the flower.



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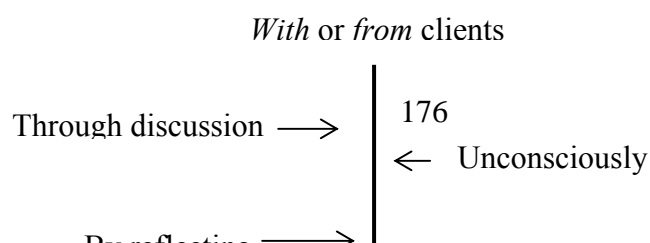
All categories in figure 4 in italics are relevant to the theory of change for therapists who have had one or more significant experience of working with clients with HIV, and these are separated from the categories relevant to all therapists by dashed lines. The category

‘flexible boundaries’ sits on a dashed line to highlight the study’s finding that flexible boundaries are relevant in working with those affected by death.

## The two theories compared

Figure 4 shows that therapists who have significant experiences of working with clients with HIV are more likely to address their own death and, in some circumstances, work within more flexible boundaries than those therapists who do not work with this client group. One difficult aspect of their work is that there is no possible resolution for the problem their clients face – there is currently no cure for an HIV infection. Most of the categories in figure 4, however, are relevant to both therapists who have had one or more significant experience of working with clients with HIV (group A) and to therapists who have had no significant experience of working with this client group (group B).

The categories represented in figure 5, overleaf, are all relevant to group A and group B counsellors and psychotherapists. The top part of this figure indicates that all therapists learn either *from* or *with* clients. They may learn through discussion, unconsciously, or by reflecting. The learning seems to happen gradually and re-learning may be part of the process. In addition, the learning never stops: there is always more to learn. The bottom part of the figure is concerned with the nature of learning experiences that therapists have with their clients. It indicates that the outcomes of learning experiences are sometimes unclear and that learning gained with one client is difficult to untangle from learning gained with another client or in other areas. Furthermore, learning experiences with clients may impact on other areas of therapists’ work, such as training, as well as therapists’ wider lives. Similarly, therapists’ wider life experiences may affect their client work.





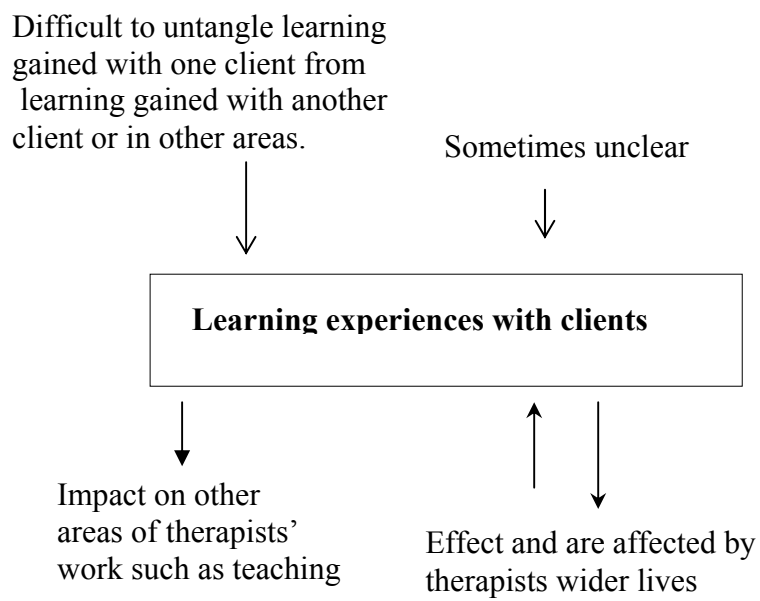


Figure 5: The change process

## **Chapter 3: The Theoretical Sampling Study (Phase 2)**

‘Contact is implicitly incompatible with remaining the same.  
Through contact, though, one does not have to *try* to change;  
change simply occurs’

(Polster and Polster, 1974, p. 101, original emphasis).

### **Background**

Fassinger (2005, p. 162) points out that:

One of the hallmarks of the grounded theory approach is the use of theoretical sampling...the introduction of new data is directed by the gaps, unanswered questions, and underdeveloped ideas in the emerging theory.

The theoretical sampling study carried out as part of my grounded theory study focused on the categories found to be of particular relevance to the group A therapists: The findings of the first phase study indicated that only the group A therapists (who had had a significant experience of working with one or more clients with HIV) had addressed their own death as a result of their client work. In addition, it was found that therapists who had learnt about the benefits of using flexible boundaries in their work all did so in cases involving death.

In carrying out the theoretical sampling study, I aimed to answer the following questions:

- Have counsellors and psychotherapists addressed their own death as a result of working with clients who were not HIV positive? If so, how?
- Have therapists learnt about the benefits of using flexible boundaries in cases that did not involve the issue of death? If so, how?

The sampling was purposive. Four therapists self-selected to take part in the theoretical sampling study by responding to e-mail invitations or an announcement at the 11<sup>th</sup> annual BACP research conference (held in May 2005). These therapists had a range of theoretical orientations and client experience (see appendices E and F).

As detailed in the section on methodology within the preceding chapter, each interview was loosely semi-structured, and lasted for up to an hour. Therapists were asked to talk about their learning from client work in one or both of two specific areas, as appropriate: the use of flexible boundaries and addressing their own death.

As with the phase one study findings, sizable quotations taken from the participants' transcripts have been used to give them a voice (Charmaz, 2000), as well as to illustrate the findings (Glaser and Strauss, 1968). These are shown in a different font from the rest of the text so that they stand out (Speedy, 2005). The quotations were chosen for their relevance to the topic under discussion, and all relevant quotations have been included.

# Findings

## The use of flexible boundaries

### Learning to be flexible

Like four of the phase one study participants, three of the therapists who took part in the theoretical sampling study explicitly stated that they had learnt to make use of flexible boundaries through their client work:

...I was educated by my work in a sense. I found myself learning and reflecting on what was needed by my clients in order for therapy to take place... Well, some orientations would see seating in the room as very, very significant for therapy to take place. I think working with people with chronic pain, in a medical setting, did diminish that in my mind... You know, I had to learn to be pragmatic sometimes. But being quite self-monitoring, I wasn't thinking, 'Oh my therapy is *really* suffering because someone is standing up'. Or 'oh dear, they are in the wrong type of chair'. Some people have to kneel... My point is that I lost any attachment I had to a kind of a need to a specific arrangement for a therapy room. (*Steven*).

At the start I was probably much more nervous about boundaries and what are the right boundaries. And I think I got a lot more worked up when things went wrong. So I think I had more rigid boundaries. And now I think I'm more flexible, because if things go wrong, with your average person, its not going to go that badly wrong. I can always say "look, that's not good". (*Anne*).

In my training I was taught to work with individuals, but its not like that when you work with children... That might mean bringing parents into the session sometimes, or perhaps having a session with the parents. If the child is in care, working with a social worker, erm, with children there is a wider network and sometimes you have to communicate with the school. So all of that has been something that has come out of the work. And it's a work in progress, obviously. (*Clare*).

### Being responsive

Linked to the theme of learning to make use of flexible boundaries through client work, all four participants seemed to conceptualise their use of flexible boundaries in terms of being responsive to the needs of their clients. Steven described this most clearly:

Particularly when I worked in physical health, what I would see as responsive to a client's need, other people might see as very flexible or over-flexible in terms of, erm, length of session, whether or not the client sits or stands - with chronic pain one week we might have only a 15 minute session, because of how they are feeling – that's all they can manage. I'm OK with that. I can work within that. So I

would see that as responsive to someone's need, someone else might see that as flexible boundaries... I suppose I could see it that way, but I have now reframed that in terms of being responsive.

Despite her strict psychoanalytic training, Ruth is responsive to the needs of clients who have to miss a session with her:

Well clearly in the analytic model you do have a very defined structure: Fifty minute sessions. You come on time. If you miss a session you still pay for it. You know, that kind of structure. Some of it I don't agree with, such as I think there's a reality out there, and sometimes people *have* to miss sessions. I'm flexible about that. If people give me enough time, I will give them an alternative session.

Similarly, in spite of her training, Clare is responsive to the needs of her clients, who, when working with children, she sees as 'parent-child relationships'. She explains:

More and more, in the child work, I find myself working with the parents, so I have kind of moved from something that has been fiercely individual, to now seeing the work as being the parent-child relationship as the client rather than the child as the client... In my training I was taught to work with individuals, but its not like that when you work with children. And looking at the relationship as the client, for me has been very useful.

That might mean bringing parents into the session sometimes, or perhaps having a session with the parents. If the child is in care, working with a social worker, erm, with children there is a wider network and sometimes you have to communicate with the school... So boundaries in that work have changed significantly...

In addition, Anne has been responsive to the needs of one client, in terms of payment and length and frequency of sessions:

He's on the dole and I started to see him for ten quid sessions. And then after half a year, I think where we were at was that he had no money, so I was seeing him for free...He also found it really hard to turn up for only one hour, so we had a two hour slot, which meant that he would come a bit late and have time to settle in and time to talk about lots of stuff and actually avoid me in the session, but actually have time with me. And after 6 months we hit quite an existential time, so then we ended up doing two sessions a week, two hours each, with me seeing him for free.

## **Areas in which flexibility occurs**

Between them, the four participants who took part in the theoretical sampling study identified several areas in which boundary flexibility might occur with clients:

### **Payment and Length and frequency of sessions**

Like Anne, Ruth also talked about her use of flexible boundaries in terms of payment and length and frequency of sessions:

I have on occasion seen people less than once a week. My training would not be in agreement with that. But I have found that it has worked out. I have seen someone in that way for about a year, and I have been amazed at what good work we've done. Also, some people's circumstances change in terms of payment. For instance, they'll start therapy stressed as hell in a high powered job, working seventy plus hours a week.

Through the therapy they kind of feel that they don't want to do that any more, and they may decide to go back to university or something like that. I'll then renegotiate a fee, if it feels appropriate... Also once or twice, with one or two people, I have actually done double sessions. I once had a client who was coming from a long distance, so she wanted two sessions back to back. I have consulted my supervisor and I've only done it with a few people, but its worked out OK.

Steven noted that although he usually works to the therapeutic hour, like Anne and Ruth, he is flexible with clients in terms of frequency of sessions:

I think that there is a therapeutic orthodoxy which I suppose I buy into in the kind of therapeutic hour, but in terms of it having to be every week or three times a week or five times a week, I don't go for that so much. Sometimes I'll start by talking about what's on offer, obviously keeping in mind where I'm working at the time. So if its [a particular counselling service], they've got a maximum of ten sessions, so I'll talk about that. And I can't be flexible on any more than that, even if I might want to be. But I'll say that usually I'll work weekly or fortnightly, but sometimes its more helpful for someone to look at other intervals or a combination of intervals. So I would say it's a process of negotiation, but I try to make it an informed negotiation. I don't automatically say its weekly.

### **Negotiating dates and times of sessions**

Linked to frequency of sessions, three of the participant therapists said that they are flexible in terms of negotiating dates and times of sessions with clients.

...we were trained to see people once to four times or five times a week, on a certain day. But clearly there are some people who just can't come every week at the same time. So again, I do use flexibility there. Nurses, for instance. They do shift work, so they bring me their timetable. So I do some fitting in. It's a structure, but bringing in reality all the time. (*Ruth*).

And I think generally I am fairly flexible with boundaries, people swapping times, being a bit late... (*Anne*).

I would say that I *am* flexible in...negotiating the time. So it doesn't have to be that same time, weekly therapy is the thing I do. I suppose I'm person-centred about that... (*Steven*).

### **Intrusions**

Two participants noted that when working at home, pets have intruded on therapy sessions. In both cases, the participants noted that this had been advantageous:

Another thing is, that as you can see, I have two dogs, I have always had dogs. I know that some of my colleagues will lock their dogs away. But this is a family home, so when people ring me I do let them know that I have two dogs, and then they have got a choice as to whether or not they come. I think there has been one man who decided not to come through the years. The dogs don't come into the [therapy] room, although they will come to the door and breathe and what have you. And I have learnt so much from that. There can be sibling rivalry, you know, with one of the dogs, which may relate to a person's upbringing. It is amazing, actually how much people learn through contact with dogs. (*Ruth*).

One of the things I've learnt is that everything is useful. Again you are comparing actual real life client work with training. Erm, you know, you are taught that you have a safe, quiet room, where you are not going to be disturbed, that sort of thing. Whereas, in reality, although you try and provide those kinds of conditions, those kinds of circumstances, the world always intrudes. And those intrusions are really useful. In working in this building, I've got a cat, and my cat is very much like a dog, she wants to be where I am... And I've got a door downstairs that cuts off the other half and this half of the house. But if someone leaves that door open, and she hears my voice, she'll come and scratch at the door, and meow. And I don't want that when I'm with a client. But occasionally she's been here [at the therapy room door].

There was one time when my client [was doing artwork]...The outcome was that the cat scratching on the door and meowing had a profound effect for the good – there was a big shift in the client's perception of [their issue]. It was a very powerful moment. (*Clare*).

### **Conducting therapy with another person or an animal present in the room**

Three participants mentioned that they had been flexible in terms of allowing others in the therapy room with a client:

Although, strictly speaking, my training would say that I shouldn't have dogs in the room, I did let one in on one occasion, at the client's request. A young man, who was usually quite schizoid, with few feelings or caring, saw the dog in the corridor. It was Bonfire Night and the dog was terrified. He asked me to let the dog come into the room and the dog lay quietly at the young man's feet throughout the session. The dog never stayed in the room again, but from that evening the young man seemed to 'let me in' and started to get much more in touch with his feelings. *(Ruth)*.

Working with a third person in the room – interpreters. Done that. With a carer in the room, with someone who had a head injury. In order to help me interpret certain sounds that were made by the person who had a real speech difficulty. And that was carefully negotiated, but again, in some areas of counselling, that might be seen as moving the boundaries quite flexibly to allow this other person into the space. *(Steven)*.

I had a client, a little boy, and what he was desperate for was his father to listen to him. So in order to facilitate that, I got Dad in the room to try to facilitate a conversation between a little boy and his father. *(Clare)*.

### **The use of touch**

In the phase one study, one therapist mentioned her use of touch in therapy, in the context of learning to take risks with clients. Similarly, as part of the theoretical sampling study, two participants talked about their flexibility with regard to the use of touch in client work.

Erm, touch is another boundary... I certainly never initiate touch...Touch with someone who was completely blind. My first encounter with her was in a waiting area of a [counselling] service. And the first thing I did, other than say "hello I'm so and so" was to touch her. Because she wanted to be, in order to be guided where to go. That added a different dimension for me, but probably not for her. Because its her normal way of being... I let her touch me, too, so she could 'see' my face as it were. It wasn't a problem then, because it was new, and it certainly wouldn't be again. *(Steven)*.

...there were two young men and one woman. There was some transference stuff going on, but they were in absolute agony. And they held out their hand, and I did take it. For me it has to feel right, with no contra-counter-transference feelings. There are loads of papers, you know, Casement's paper, for instance, about why he didn't touch a client. But as therapists I think we are human beings, first and foremost. I would usually analyse if people want to be held, and all that. But for these three, they held out their hand and I took it. And it would have felt wrong not to. *(Ruth)*.



### **Therapy not conducted in a therapy room**

Steven told me that he has seen clients outside of a specially designated therapy room:

I've only done this once, and I talked about it in supervision. This was years ago. I visited someone in hospital. They had to go in for a procedure, and it was in the middle of therapy. She asked if I would visit her on the same afternoon I would normally see her. It was in the same hospital [as I worked]. I actually thought, well if I don't, I wonder what that's about. I was clear in my mind, and she was clear in her mind, that I wasn't visiting her as a pseudo-friend. In a sense it was part of the work...And I worked briefly in a hospice as well, and some of it was by the bedside, because they were too ill to get to a therapy room. You know. Some would say that you can't do that kind of work in that way. Well...you know...

In addition, Clare noted that she had considered being flexible in this way with one client:

I was thinking about the person I worked with who was terminally ill, because in working with her, I was already thinking about boundaries, because as she became less able, she wasn't going to be able to physically manage the sessions. And I was thinking about, first of all, where else in the building we could meet... We didn't actually get this far, because the therapy finished, but I was thinking, you know, there is going to be a point where she won't want to come to the building again.

### **Other areas of boundary flexibility**

Several other areas of flexibility were mentioned by individual participants. These included allowing clients to contact the therapist outside of therapy sessions (Anne), giving clients wedding gifts (Ruth), doing coaching instead of counselling (Clare) and seating arrangements (Steven):

To some people I will be available via e-mail and phonecall. And I guess its making that distinction about what I can handle, what I want to give. And making it very clear for some people that I'm not always there. (*Anne*).

On occasion, I have given someone a wedding present. I took it to supervision. The person comes, a lonely isolated person, and during the therapy they meet someone. It has felt appropriate, anyway, and almost stingy not to. It has been well received, but I know to look out for bad effects as well, because it may be a bit frightening for something like that to happen. With any of these boundary breaks, as long as it is brought into the work, then you can deal with it. (*Ruth*).

I was thinking of a recent case, where I haven't actually seen the child, but I have seen the Mum. And I've seen the Mum once, as a one off. And she came with all these symptoms that the child had been exhibiting. And at the moment I'm very busy. I'm not in a position where I can take on clients. And I said that to her on

the phone. But she sounded desperate. And I had a cancellation, I said, "I can see you as a one off. What I can do is I can refer you to somebody". And that was in my mind. But it seemed, if I read it right, and I'll find out because she's going to get back to me, that the best way forward was that there are things that she could do. So it was not like a therapy session, it was more like a coaching session. And that's something I haven't done before. And that's not what I do, you know, I'm a therapist, and I work within my therapeutic paradigm. But this is education, or coaching, really. And I don't know what will happen. She's going to go and do all these things, and she's going to come back in six weeks, and let me know how its going. And either I'll take the child on after Christmas, or it'll be sorted. Or I know I'll refer her on. So yeh, that was a definite boundary incursion there. *(Clare)*.

Some counsellors and therapists would use the same seats, at the same height, all the rest. Having worked with people who use wheelchairs, or have chronic back problems, I have been quite flexible about seating arrangements. Sometimes people have to stand. If they are in wheelchairs, clearly I'm not in one... So working in a physical health setting, I would say I was appropriately flexible in that. ...So sometimes we'd stand if someone couldn't sit for a period of time. Not that its easy to do that. Mostly in our work I think we sit, so to stand and do therapy is quite interesting, or to sit while someone else is standing. Or if they are walking around because they can't stand still, or sit still. Or indeed if someone is lying on the floor. I did not join them [in] lying on the floor, I have to say! *(Steven)*.

## **Links to other areas of learning**

I found that participants' use of flexible boundaries could be linked to three areas of learning identified in the phase one grounded theory study: Taking risks, 'being human' and trusting feelings, thoughts and images.

### **A link to taking risks**

Four therapists reported that they had learnt to take more risks in counselling and psychotherapy as a result of their client experiences, during the phase one study. Anne linked the use of flexible boundaries to taking risks:

Well, I would probably see myself as quite a risk taker when it comes to psychotherapy. I would want to say, 'lets try something out, because it might work and it might be good and it might feel right, even if its not what it usually done'. And I think I do my best work on that level. So I think as I've learnt I've tended to give more leeway, and then feel the impact...And, er, I still like taking risks... I mean there's many people who will challenge my boundaries.

### **A link to 'being human'**

Through their client work, nine of the therapists who took part in the phase one study reported becoming increasingly aware of and comfortable with the reality that like their clients, they are 'human'. This included learning that it is alright and sometimes even therapeutic to respond to clients in a 'human way' (person-to-person rather than professional-to-client), as well as coming to terms with the fact that they are prone to making mistakes and sometimes failing. Three of the theoretical sampling study participants linked the use of flexible boundaries to 'being human', and one of these (Ruth) noted that making mistakes can have a positive effect on client work:

The most embarrassing thing that has ever happened to me is that my husband uses a wardrobe in this [therapy] room, and he uses it when we are not seeing clients. And once he left a pair of silk boxer shorts out. A client came early, so she came into the room before me and saw the shorts. That could have been absolutely disastrous! But it was incredible, how in fact, it was so positive. The client saw that I was just an ordinary human being. And I think it was the way that I managed to not be overwhelmed by the mistake that helped. But I think it was the most embarrassing thing that has happened! But it actually shifted the therapy. She was actually training to be a therapist herself. And she saw that if you make a mistake, that the client can learn from it. She became much less anxious with her own clients from then on. (*Ruth*).

I mean the other thing that I have learnt in practice is that the most important thing is being human, I think, being real. And of course there is a theoretical imperative, people talk about being congruent or being authentic. But there's something about simply being human. And clients have given me feedback that significant moments for them have been...there have been two occasions of moments outside of sessions, as they were coming in, so that's been interesting. I've got hanging baskets outside, and a little bird had made its nest in a hanging basket one spring. And I commented on that as we were walking in. For that person, that was a significant moment in realising that I was just an ordinary human being, like everybody else. And not just this professional person that worked with feelings. (*Clare*).

Its in the space between us that I can be a bit flexible. And I think it makes it more human, in a way...Erm, I think its more of an acknowledgement there are just two people involved, and you don't have to be that damn formal. It doesn't mean its not good therapy or its not professional if we're not rigid.

Giving people the sense that there is a 'right way to do it' is something I definitely want to challenge in the process or in terms of the content of the therapy, and if I try and impose that as a framework that's not that good. (*Anne*).

### **A link to trusting feelings, thoughts and images**

Nine phase one study participants reported that as a result of their client experience, they have come to trust the feelings, thoughts or images that can suddenly appear to them, both

in and outside of the counselling room. Some of these therapists used the word ‘intuition’ to describe these thoughts, feelings and images, and Wilma linked her increased use of images and feelings to becoming more risk taking. Similarly, during the theoretical sampling study, Anne made links between the use of flexible boundaries and both risk taking and intuition:

And I've learned a lot... That its OK to take risks and work it out as you go along. And I don't have to get scared about doing it right or doing it one way or another. That its really OK to be patient and just wait. To trust my own intuition.

In addition, Ruth noted that she trusts her feelings in working with flexible boundaries:

But anything I do in terms of boundary flexibility has got to feel right. I could have been colluding with the client's terrible need for attention, so if I feel I might be colluding I will share that with the person, and we have got to, you know, work it out, if it begins not to feel right.

## **The effects of using flexible boundaries in client work**

### **Positive Effects**

Two participants talked explicitly about the positive effects that using flexible boundaries can have on client work. Anne talked about the effects of her use of flexible boundaries (in terms of payment and length and frequency of sessions) on one client, while Ruth talked more generally:

..three years down the line, its amazing to see him. He's still drinking, that's still true. But he's so much more relaxed, and he's starting to re-engage with the world, he's getting in touch with his process, and there's a level of trust there that I don't think he would have ever thought was possible. So that was really worthwhile for me. And its like there's real space between us now. He doesn't have to keep me out any more at all. He can let me in, he can let me talk. He can let me have some power and know that I'm not going to attack him. (*Anne*).

I never put any breaking of boundaries under the carpet. The impact of breaking a boundary and the discussion afterwards can lead to fantastic effects I think. You can really have breakthroughs with some flexibility. (*Ruth*).

### **Negative Effects**

During her interview, Anne also talked about a client with whom she now feels that she was too flexible. She has asked me not to disclose any details here, but notes that:

...that was the only time up to now where I have had an experience of things getting much worse rather than getting better or staying the same. And it was quite a shock to my system.... And now I have a sense of clinically what I could have done better and what was the underlying process that I didn't pick up. I think I'd be much better equipped in handling this again.

## **Addressing death**

It was found that none of the four theoretical sampling study participants felt that they had faced their own death as a result of their client work. However, Clare and Steven both addressed their own deaths before starting to train as therapists, through personal experiences:

...the whole thing that has propelled me on this journey, the trajectory that my life has taken, was the premature death of my mother. That's had a *huge* impact on me. Nothing in my life prepared me for that. I fell apart, really. And that caused me to think about my own mortality... I also think that because my mother died as a relatively young woman, I'm about to outlive her, she died when she was my age now. I've thought about that a lot. So its not been a direct result of my client work, its more from my personal experience. (*Clare*).

The thing is, just before I started therapy training, I faced my own [death]...so it kind of works that way round. I think that an accident that happened to me - and I'd already decided to train as a therapist, by the way, it didn't make me do it - shaped some of my thinking around living and dying, around the meaning of life... But I think my own near death experience, *and* my partner - twice I've thought she's died right in front of my eyes... It does focus one's attention on these kinds of issues. (*Steven*).

Although they did not address their *own* deaths as a result of their client work, like seven of the group A participants who took part in the phase one study, both Clare and Steven have addressed death *in general* as a result of their client work.

And I think that when you do work with somebody who is dying, or as I am currently with people who are around people who are dying, it does raise mortality as an issue. But it doesn't feel to me to be that my own death is uppermost. (*Clare*).

Also, I think, clients facing death often made me think about, both politically and philosophically about what it is to die. How we die in the UK, how we choose to and how we are made to. (*Steven*).

Ruth, however, noted that her clients have led to her appreciation of life:

I'm not sure if my clients made me look at my own death, but they have certainly made me appreciate life... And because I appreciate life, and because I've had a good life, I think, I hope, it would make death a bit easier. (*Ruth*).

### **Other areas of learning and change**

Participants also mentioned other areas of learning. Like fourteen of the phase one study participants, Ruth noted that she had learnt from her personal therapy:

...if you've had psychotherapy yourself, you learn that mistakes and breaking the boundaries on occasion can have very positive consequences.

Like five of the therapists who took part in the phase one study, Steven noted that "Humility is something I've also learnt." In accordance with the phase one findings, he also briefly mentioned that he had learnt from both training and reading. Furthermore, like thirteen phase one study participants, Steven also mentioned that he had become more self-aware through his work:

...So the learning was about myself in terms of how to be really responsive to [a client], whatever my relative judgement of their experience was... I suppose it was teaching me about my own limits.

### **Summary**

The theoretical sampling study findings indicate that, as a result of their client work, therapists have learnt about the benefits of using flexible boundaries in cases that did not involve death. The study participants seemed to conceptualise their use of flexible boundaries in terms of being responsive to the needs of their clients, and several areas in which boundary flexibility might occur were identified: Payment, length of sessions, frequency of sessions, the date and times of each session, intrusions in the therapy,

conducting the therapy with another sentient being in the room, the use of touch, conducting therapy outside of a therapy room, allowing clients to contact the therapist outside of therapy sessions, giving clients wedding gifts, doing coaching instead of counselling, and seating arrangements. Additionally, the use of flexible boundaries was found to be able to give rise to both positive and negative effects in terms of client work.

None of the study participants felt that they had addressed their own death as a result of their client work, although two reported that they had addressed death in general. Since only four therapists took part in the study, no firm conclusions were made with regard to the research question, 'Have counsellors and psychotherapists addressed their own death as a result or working with clients who were not HIV positive?', at this stage.

## **Literature Review**

### **Parameters of the literature search**

The literature review below forms part of the deductive, theory testing phase of my grounded theory study, and it has therefore been placed after a description of my phase one findings within this thesis. A literature review on the topic of therapists' learning and change could potentially include thousands of journal articles and books. This review was at first therefore restricted to the outcomes of an electronic journal search, a manual search through available copies of four journals that were accessed at the University of Exeter, and ten books I thought to be most relevant from an online search. Further books and journal articles, referenced in those originally selected, subsequently recommended by others, or discovered by myself were later obtained and included within the review if they were thought to be relevant to the topic of my study. Material taken from conference papers and keynote speeches that I have attended has also been used.

The computerised journal search I carried out made use of the EBSCO journal service, which was accessed via the University of Exeter website. Searches were carried out using the following key words and phrases and variants of them (alone or in combination with others in the list, as appropriate), which were obtained from or relevant to the phase one study findings represented in figure 4: 'Counselling', 'Psychotherapy' 'Self-development', 'personal-development', 'professional development', 'death', 'inspiration', self-awareness', 'self-understanding', 'self-acceptance', 'confidence', 'acceptance',

‘awareness’, ‘humility’, ‘compassion’, ‘openness’, ‘intuition’, ‘gut feelings’, ‘gut reactions’, ‘humour’, ‘being human’, ‘risk-taking’, ‘acknowledging’, ‘theory’ ‘models’, ‘boundaries’, ‘challenge’, ‘staying with it’, ‘personal therapy’, ‘training’, ‘reading’, ‘supervision’, and ‘colleagues’.

The manual journal search was carried out using copies of the ‘British Journal of Guidance and Counselling’ (1973-1991 and 2001-2005), the ‘Journal of Counselling and Development’ (1984-2005), the ‘Journal of Counselling Psychology’ (1966-2005) and ‘Counselling Psychology Quarterly’ (1990-2005). Ultimately, a total of one hundred and five publications were selected for the review: thirty-one books, twenty book chapters, one booklett and fifty-three journal articles. In addition, five conference papers and speeches and one website are referenced.

I can not claim that what follows is a complete review of all the relevant literature on the topic of the learning and change that counsellors and psychotherapists’ experience as a result of their client work. However, it indicates the ways in which some of the most relevant literature is related to the findings of my phase one and two studies. To echo Clarkson (2003, p. xxiii, original emphasis):

I did not mean to set myself a completely impossible task, such as surveying all of [counselling], counselling psychology, psychotherapy and psychoanalysis fairly...I have gathered learning and quotations from a variety of sources, in the knowledge that *space and time are the compromises we make with perfection.*

## **Ongoing learning and change**

The findings of the phase one study detailed in this thesis suggest that learning and change occurs in training and continues throughout the career of a therapist. As Sugarman (2004, p. 28) points out, for counsellors and psychotherapists, ‘both personal and professional development do not end with the attainment of a diploma, or even with accreditation by a respected professional body...’. Kottler (2005, p. 10) adds, ‘I think every client changes me, and every therapy relationship impacts on me almost as much as it does my clients’.



Skovholt and Ronnestad (1992 and 1995) have developed a model of therapist development from data obtained from interviews with counsellors and psychotherapists with a variety of client experience. This model suggests that practitioners continue to develop professionally throughout their careers, becoming ever more authentic and individualised in their practices.

Schon's (1991) concepts of 'knowing-in-action' and 'reflecting-in-practice' may also be applicable here. Schon (1991, p. 50) notes that 'there is nothing strange about the idea that a kind of knowing is inherent in intelligent action'. It may therefore be argued that therapists' know-how about therapy lies in and is made known through the counselling and psychotherapy that they do. In addition, therapists' know-how is tested and altered as they reflect on their work *as they do it*. As one therapist (Steven) who took part in the theoretical sampling study said,

I suppose [what you are asking me about involves] separating out learning from doing in a way, and I haven't done that really. I have been doing stuff and thinking about it at the time and shortly afterwards and integrating it as I've gone along, without doing a chunk of stuff, reflecting on it and [then asking myself] 'what have I learnt from it?'

As long as they continue to engage in client work, counsellors and psychotherapists will have the opportunity to continue to reflect whilst they practice, and therefore to continue to learn and change while they work. Furthermore, as a result of this 'reflecting-in-practice' more experienced practitioners are likely to rely on 'experience-based generalisations' rather than theory (Skovholt and Ronnestad, 1992, p. 510).

Rogers (1961, p. 10) was one such practitioner: 'We had to live with our failures as well as our successes, so that we were forced to learn...I found I began increasingly to formulate my own views out of my everyday working experience.'

Therapist learning and change may occur as a result of the impact of wider life experiences as well as client experience. During training, the theoretical orientation being learnt by the trainee counsellor or psychotherapist impacts on and affects his wider life (Sugarman, 2004). The therapist may begin working towards integrating his personal philosophy with

the core model at this stage (Fear and Woolfe, 1999). After training, however, his life experiences can impact on and change the way the therapist works (Sugarman, 2004).

In line with Owen's (1993) ideas, the findings of my first phase study suggest that client experience can also impact on the personal as well as the professional life of the therapist. As West puts it, (2004, p. 77) 'My own experience as a full-time therapist...included feeling [that]...my own development fast tracked...'

Whether it leads to personal or professional development, the learning and change that therapists experience as a result of their work with clients never stops, according to fifteen of the 39 therapists interviewed as part of my first phase study. Several highly experienced therapists also seem to be aware that there is always more to learn: Mahoney (1989, p. 17) acknowledges that 'the process [of becoming a psychotherapist] has taught me much – most importantly how much more I have yet to learn'. Bloomfield (1989, p. 45) writes, 'My formal training had finished a long time [ago]...but informal training and learning have never stopped'. And Heppner (1989, p. 80) adds 'I see myself continuing to evolve and learn as a therapist; there is not an end to the learning in sight.'

In agreement, Skovholt and Ronnestad, (1992, p. 512, emphasis added) note that 'Clients are a *continuous* major source of influence and serve as primary teachers'. Yet this is only one aspect of the mutually beneficial relationships that therapists form with their clients.

### **The mutually beneficial relationship**

'Relationship' is defined in the dictionary as an 'emotional association between two people' (Elliott *et al.*, 2001, p. 636). Clarkson (2003, p. 4), however, provides a richer definition:

Relationship...circumscribes two or more individuals and creates a bond in the space between them, which is more than the sum of the parts. It is so obvious that it is frequently taken for granted and so mysterious that many of the world's greatest psychologists, novelists and philosophers have made it a focal point of a lifetime's passion.

What is more, relationship is inextricably linked to being human:

Even when we are physically alone and experiencing loneliness we are still essentially with others; indeed, the very fact that we can feel lonely indicates that participation is a basic structural element of our being (Batchelor, 1983, p. 72).

Relationship, then, is part of our personal existence. But it is also used professionally: Five of the thirty nine therapists who were interviewed during the first phase study explicitly stressed the importance of the counselling relationship in their work. Relationship is significant in many healing professions (Clarkson, 2003), including nursing (Jackson, 2004) but as many research studies have suggested, it is of particular importance in counselling and psychotherapy (Cooper, 2004).

Laing (1965, p.26) notes that:

Psychotherapy is an activity in which that aspect of the patient's being, his relatedness to others, is used for therapeutic ends. The therapist acts on the principle that since relatedness is potentially present in everyone, then he may not be wasting his time sitting for hours with a silent catatonic who gives every evidence that he does not recognise his existence.

The quality of the therapeutic relationship, as perceived by the client, is an indicator of therapeutic outcome (Watson and Geller, 2005). Lammers (2005) distinguishes between two qualitatively different forms of relationship: 'power-over' and 'power-with'. In the former, one person controls the relationship, while in the latter there is equality.

In counselling and psychotherapy, the therapist might work towards developing the 'power-with' aspect of the relationship with the client, but at the same time maintain 'power-over' the client to contain and maintain the professional nature of the relationship. As Buber (1958, p. 99) points out, real healing in a therapeutic relationship 'can only be attained [by the therapist] in the person-to-person attitude of a partner [of the client], not by the consideration and examination of [the client as] an object'. However, any relationship where one person is working for the benefit of another 'persists in virtue of a mutuality which is forbidden to the full' (*ibid.*).

Clarkson (2003) details five types of client-therapist relationship in her book *The Therapeutic Relationship*: the working alliance, the transference/countertransference

relationship, the developmentally needed or reparative relationship, the person-to-person relationship and the transpersonal relationship. Clarkson claims to have identified these relationship types through her own ‘*academically validated [doctoral studies] research*’ (*op. cit.*, p. xxviii, original emphasis) which she details in the final chapter of her book. Her study made use of her own ‘personal and professional experience as a client, teacher and supervisor of psychotherapists’ (*op.cit.*, p. 333), as well as an extensive literature review and discussion with colleagues. However, precisely how her own experience and discussions with others were recorded is not detailed.

I have some concerns with the way in which Clarkson claims to have tested her ‘five-relationship model’. She claims that her pilot study was tested by ‘peer review and acceptance by a premier journal’ (Clarkson, 2003, p. 339) and a training course based on her five-relationship model tested it ‘*by application*’ (*op. cit.*, p. 342, original emphasis). The fact that several students were ‘awarded merits or distinctions by an external examining board based on their casework presentations and dissertations’ (*op. cit.*, p. 342) seems to have been taken as proof that the five-relationship model works. However, it may be argued that publication is not an indicator of validity, since findings that are published may later be invalidated. Furthermore, students passing a counselling course does not validate the model on which the course is based any more than students passing a course on extra-terrestrial life-forms validates the existence of such creatures.

It is interesting to note that Clarkson’s findings are not necessarily supported by my own. She claims that only the person-to-person relationship type is mutually beneficial for both the therapist and the client:

Emotional involvement in the relationship between psychotherapist and patient is that between person and person in the existential dilemma where *both stand in mutuality to each other*...It involves mutual participation in the process and recognition that *each is changed by the other*. (Clarkson, 2003, p. 16-17, emphasis added)

Although the other four relationship types might not be equal in the way that the person-to-person relationship is, the phase one study findings detailed in this thesis suggests that engaging in *any* relationship with a client may be potentially beneficial for the therapist in that she might learn, be healed or be affirmed through it. In line with this, Rogers (1961, p.

19) points out that he is able to learn from clients who may not be capable of forming a person-to-person relationship with him:

I find when I am working with clients in distress, that to understand the bizarre world of a psychotic individual, or to understand and sense the attitudes of a person who feels that life is too tragic to bear, or to understand a man who feels that he is a worthless and inferior individual – each of these understandings somehow enriches me. I learn from these experiences in ways that change me, that make me a different, and I think, a more responsive person.

Although only four participants in the phase one study talked explicitly about the mutually beneficial relationships they had formed with their clients, the study's findings indicate that, in terms of learning and change, many of the therapists interviewed had benefited from the relationships they formed with their clients.

Kottler and Carlson (2005, p. 2001) write, 'mutually rewarding relationships...are possible between client and therapist'. In agreement with this, Norcross and Guy (1989) have found that in completing a questionnaire, ten well-known counsellors and psychotherapists rated self-knowledge and self-growth as important sources of satisfaction in their work.

Interestingly, in writing about their careers, only two of these therapists overtly stated that they had personally benefited from the relationships that they had formed with clients. Jocelyn Chaplain (1989, p. 169) admits that 'helping to heal other people's souls is intimately connected with the healing and development of my own'. Similarly, Brian Thorne (1989, p. 66) confesses:

It will now be clear that for me the practice of psychotherapy is serving my own needs and desires in fundamental ways. It allows me to love and to be loved... Emotionally and spiritually I am challenged every day.

Kopp (1979, p. 16-17) is another of the few therapists willing to reveal in writing that, 'Every hour treating a particular patient is an hour of my life as well...being a

psychotherapist is...a bit like remaining in treatment all your life...I operate not to help the patient but to help myself’.

Therapists’ general unwillingness to disclose that they benefit from their work with clients may indicate that this could be viewed as unprofessional. Wosket (1999), for example, admits that she sometimes gains personally from her work with clients, but is quick to point out that this does not mean that she isn’t doing her job well:

I am not saying here that my clinical work does not meet my own needs – at times it most certainly does...What I am suggesting is that what I receive in return from my client as a by-product of my own investment in the relationship is not something that I *require* of the client in order to satisfy some need in myself. (pp. 41-42, original emphasis).

However, far from being unprofessional, it may be argued that a mutually beneficial relationship is actually an indicator that the counsellor or psychotherapist is doing a good job and the therapy is going well: ‘Good counselling alters the counsellor’s outlook as much as the client’s, and until this process of mutual impact and reverberation has begun, the work remains superficial and glib’ (van Deurzen-Smith, 1992, p. 43).

A more detailed discussion of the ways in which therapists learn and change as a result of the mutually beneficial relationships they form with their clients is presented below. Following this, I consider what a counsellor or psychotherapist may gain, either personally or professionally, from this learning and change.

### **How learning and change occurs**

The findings of the first phase study indicate that in their work with clients, counsellors and psychotherapists learn in a variety of ways: They learn both consciously and unconsciously, through experience (both *from* and *with* clients), through discussion, and through reflecting. They often learn gradually, although learning experiences may start in a very striking way, and re-learning may be important in their development. Furthermore,

learning through their client work can impact on other aspects of therapists' work as well as their wider lives, and wider life experiences can influence their work with clients. To a large degree, these findings are mirrored by anecdotal evidence in the literature.

### **Learning from and with clients**

Therapists interviewed during the first phase study differentiated between learning *from* and learning *with* their clients. The literature also provides examples of each of these modes of learning, although no author seems to have explicitly made a distinction between the two.

Kopp, (1979, p. 33) describes what he learnt *from* one female client:

My work with Willow has been a rewarding opportunity to join and guide an unhappy young woman along the way of her pilgrimage toward freedom, self-respect and appreciation of her personal worth. We have helped each other, and she has taught me to understand something of the nature of a woman's ordeal in the struggle to become who she might be.

Similarly, Yalom (1991, p. 139) recalls what he learnt *from* a client: 'I, too, had profited from our relationship. I had wanted to learn about bereavement, and Penny had, in only twelve hours, taken me, layer by layer, to the very nucleus of grief'.

Heppner (1989, p. 80) tries to learn *from* every client he works with: "I have...an attitude of approaching each client in terms of learning from them, either about life or about the complex processes of human beings'.

However, Heron (1998) argues that an experience is never simply *of* something or someone outside of that experience, it is 'always an experience *with* someone or something. It is participative, shared. (Heron, 1998, p. 12). In line with this, West, (2004, p. 90, emphasis added) writes about what he learnt in working *with* a client: 'I learnt a lot about working with my clients' spirituality *through* working with Matthew. I also learnt a lot about my own spirituality.' In addition, in her book chapter on the value of failure for therapists, Wosket (1999, p. 132) notes that the failures she describes have led to learning for the therapists involved that could only have happened through their work *with* clients:

What is striking about the powerful learning recorded in these responses is that it is situated within unique encounters with clients. This is learning that could not take place in a lecture hall, the skills training room, in discussion with a supervisor or through reading the research and teaching of others. It is learning about using the self that comes about when counsellors are able to experience themselves as fallible in the presence of their clients.

### **Gradual Change**

Mearns (1990) notes that in counselling and psychotherapy, client change is often a gradual process: ‘The client may not be aware of this gradual change until he realises that he is different’ (*op. cit.*, p. 103). Nine of the participants who took part in the first phase study indicated that learning from and with their clients was also a gradual process. Similarly, Norcross and Guy (1989, p. 228) write, ‘It hardly seems possible to become a sophisticated therapist in less than ten years...therapists’ odysseys poignantly attest to the gradual process of professional maturation’. As van Deurzen-Smith (1992, p. 26) puts it:

Only time will allow you to genuinely reap the benefits of new insights and to implement them into your work. People can take many years to assimilate new ideas, and counsellors are no exception to the rule.

This was certainly true for Bloomfield (1989, p. 40): ‘It has been a very long, slow, and often very painful task to develop the characteristics which I believe to be important for a good therapist’.

### **Learning through discussion, reflection and unconscious processes**

Three of the participants involved in the first phase study talked about the importance of discussion in their learning. Discussion is often referred to in the literature in relation to the role of colleagues in the development of counsellors and psychotherapists. Walker (1992, p. 135), for example, writes: ‘I find dialogue with other therapists and counsellors stimulating and exciting. I value enormously the contribution of others to my own development and knowledge.’ In addition, Bloomfield, 1989 (p. 45) says: ‘...informal training and learning have never stopped. They continue in exchanges with colleagues...’



Four therapists who took part in the first phase study mentioned that their learning seemed to be outside of their conscious awareness, while seven reported that they learn by reflecting. With regard to reflection, van Deurzen-Smith (1992, p. 26) writes: ‘The key to learning...remains the same in all situations: that of candid reappraisal.’ I was not able to find any mention of the unconscious learning in the counselling and psychotherapy literature.

### **Effects of wider life on therapeutic work**

Much anecdotal evidence in the literature suggests that therapists’ wider life experiences impact on their work with clients. As Karp (1989, p. 95) points out, ‘my informal training comes from life experience. Negative learning as well as positive gains have been instructive’. Mahoney (1989) writes about the effect of his marital experiences on his career. He notes that his third wife, Teresa ‘has also had a significant impact on my thinking and practice as a clinician’ (*op. cit*, p. 28). In addition, Heppner (1989, p. 79) notes that his experiences of living abroad have affected his work: ‘After having lived in two other countries, I have a deeper sensitivity to cross-cultural issues and individual differences in general and within counseling in particular’.

Fourteen therapists interviewed for the first phase study reported that their private or previous professional lives had impacted on their client work. In agreement, Wosket (1999) notes that feeling misunderstood as a child has led to her efforts to communicate understanding to her clients. And Weinstein (2005) has found that therapists’ and trainees’ experiences of a significant bereavement impacted on their client work in positive ways: They described themselves as more understanding and empathic as a result of suffering this type of loss.

Wider life experiences also often influence a person’s decision to become a therapist, as several counselors and psychotherapists interviewed as part of the first phase study revealed. A counsellor who decided not to take part in the first phase study for personal reasons sent me an article he had written about his experience of finding out that his boyfriend at the time had deliberately infected himself with HIV. This experience, he notes, influenced his decision to become a therapist:

I don't think I'd be a therapist now without the catalytic experience of knowing him. In the oddest of ways, in seeing the extent to which I could be wounded, I learned how much I could heal, too. And I'm grateful for that.' (Moore, 2003, p. 2).

### **Effects of therapeutic work on wider life**

As well as the effects of wider life experiences on therapists' work, the literature also provides examples of the ways in which therapists' work affects their lives in general. Bloomfield (1989, p. 48), for example, writes:

In so far as my behaviour and ways of relating to other people – as well as my sense of what matters in life – have undergone marked changes since I began to work with patients, doing therapy has certainly been therapeutic for me.

Sixteen counsellors and psychotherapists who took part in the first phase study reported that the learning and change they had experienced permeated into their outside lives. In line with this, Karp (1989, p. 96) describes how her work as a psychotherapist helped her to deal with the death of her neighbours' son and to listen to his parents talk about him shortly after the death:

In those few hours I felt that my life as a psychotherapist was deeply rooted in me as a person. There was a fusion between my ability to cope with grief professionally and the ability to meet a personal crisis. The work was transferable.

### **Re-learning**

Three of the practitioners interviewed as part of the first phase study talked about the importance of re-learning in their development. Re-learning is also occasionally referred to in the literature, and it is mentioned by four of the ten therapists who contributed to the book *Hard-Earned Lessons in Counselling in Action* (Dryden, 1992a). Clarkson (1992, p. 12) for example, points out that 'Very often a lesson will be re-presented to us many times over in different guises until we finally learn its meaning'.

In writing about a hard-earned lesson he learnt through his work with clients, Dryden (1992b, p. 50) says, ‘In fact, I had to learn the lesson several times before I grasped its true message’. He later adds:

One of the most painful lessons I have had to learn as a counsellor is that sometimes I just don’t seem to learn – that I seem to make the same mistakes over and over again...The point I want to stress here is that as counsellors we don’t learn once and for all. (Dryden, 1992b, pp. 54-55).

### **Difficult aspects**

Several participants talked about the difficult aspects of counselling and psychotherapy in my first phase study. Five counsellors and psychotherapists noted that training is not a complete preparation for client work. Similarly, Wosket (1999, p. 31) argues that ‘...the completion of training constitutes a point of departure more than a point of arrival’. Thorne (1989, p. 62) echoes this idea in writing about his first job after training:

The first day I entered my counsellor’s consulting room I felt fraudulent and sad...I felt almost trapped by the one-to-one relationship and frightened by the unpredictability of what the client might bring. I felt hopelessly ill-equipped and what a few weeks previously had passed for a sound and creative training experience now seemed in retrospect to be inadequate and superficial.

Therapists I interviewed also talked about the intense nature of their work. Similarly, Thorne (*op.cit.*, pp. 63-64) writes:

I have never attempted to deny to myself or to others the arduous nature of a therapist’s work. The intense concentration required in therapeutic relationships, the anxiety generated by close involvement with those who are often highly self-destructive...It is gruelling and demanding work and the therapist who denies this is mendacious, deluded or incompetent.

As a result of the inadequate preparation for client work that they receive from training, combined with the intensity of this work, eight of my phase one study participants mentioned that they had learnt about the importance of protecting themselves through their work. The idea of therapists protecting themselves is also documented in the literature.

Like Chaplin (1989, p. 179), some participants in the phase one study used meditation: ‘as the years go by I learn to protect myself better; for example, by visualising golden light around me in sessions, to create a psychic boundary between my client and myself’. Other counsellors and psychotherapists that I interviewed protected themselves by limiting the number of clients they work with at any one time and by engaging in a variety of activities. Heppner (1989, p. 82) also uses these methods:

I have learned from my experience as a therapist that I can not work with very many clients at any one time...other people tend to tire me rather than rejuvenate me...In addition, I have found that other professional activities are absolutely essential to my well-being, such as research, teaching and supervision.

Rowan (1989, pp. 162-163) also mentions the importance of variety:

I would need much more sustaining if I were to become the kind of psychotherapist who sees client after client all day every day. But I don’t need much sustaining because my practice is very varied in all sorts of ways.

The specific importance of leisure activities were not discussed by any of therapists whom I interviewed as part of my phase one study. Research carried out by Grafanaki *et al.* (2005), however, shows that leisure time helps counsellors and psychologists to cope at work and it also improves their performance. Although their study is based on interviews with only ten therapists, the findings are in agreement with anecdotal evidence in the literature. Chaplin, (1989, p. 187), for example, notes that ‘Painting...helps to sustain me...Holidays are also vital’. In addition, Milner (1992, p. 85) urges counsellors to ‘take care of themselves through exercise, relaxation, treats, holidays or breaks...’

## **The benefits of learning and change**

### **Self-awareness, self-acceptance and confidence**

Rogers (1961) points out that a good relationship between a teacher and pupil, or a parent and child will enable the pupil or child to become more self-aware, confident and

authentic. Daloz, (1987, p. 234) argues that through their relationship, a mentor can also help a student to become more self-aware:

One of the more important aspects of the special mirror that mentors hold up to their students is its capacity to extend the students self-awareness. To see oneself in new ways, from a range of different vantage points, is the chief way that we distil what we are learning from the challenges and supports of our world. In an expanded view of the self, one might almost say, lies the definition of development itself.

In the same way, through a counselling relationship, clients can gain a better understanding of themselves and become more self-confident (Jinks, 1999). The findings of my first phase study also indicate that, at the same time, the counsellor may also gain self-awareness, self-acceptance and confidence. With regard to confidence, Fransella (1989, p. 127) says: 'I am much 'braver' than I was fifteen years ago'. Chaplin (1989, p. 182) adds: 'Over the years my confidence increased...'. Wosket (1999) suggests that the therapeutic environment provides therapists with opportunities to learn more about themselves. Etherington (2004d, p. 109) concurs:

As counsellors and psychotherapists we usually accept that we are changed by the encounters that we have with our clients: we are impacted upon in their process of change and our relationship with them can open us up to parts of ourselves hitherto unknown or only dimly known.

Dalton (1992, p. 13) writes more personally: 'During the past ten years I have learned many lessons about the intricacies of the counselling process, about the complexities of clients, and, perhaps most of all, about myself'.

Camilleri (2001, p. 81) notes that self-awareness adds 'depth and quality' to the work of therapists. In addition, Chamberlain and Haaga's (2001) research, in which 107 men and women between the ages of 19 and 81 were asked to fill out a series of questionnaires, suggests that people who are highly self-accepting tend to be more happy and less anxious.

Although questionnaire answers may not necessarily reflect actual lived experience (Cohen *et al.*, 2003), Chamberlain and Haaga's (*ibid.*) study proposes an important link between an individual's level of self-acceptance and her emotional responses.

### **'Being human' and inspiration**

Zoe, a group A practitioner interviewed as part the first phase study pointed out that, '...the person [client] is human. You are dealing with a human being all the time'. An article in a charity newsletter for young people with HIV echoes this idea:

The teenagers here...are...trying to live up to expectations and pressures from all around and yet often inside they can feel chaos, insecurity and a feeling of just wanting to be accepted. When I see them...breaking from these expectations, being vulnerable, being who they want to be, it is with great admiration. I once read, "The main thing in life is not to be afraid to be human", but I guess this is often one of the hardest things to do (Emma, 2005, p. 2).

The phase one study findings indicated that, as a result of their client work, nine of the therapists I interviewed had become more aware of and comfortable with the reality that like their clients, they are human. As Rogers (1961, p. 17, original emphasis) puts it:

I feel I have become more adequate in letting myself *be* what I *am*. It becomes easier to accept myself as a decidedly imperfect person, who by no means functions at all times in the way which I would like to function.

Jung (1958) notes that 'A human relationship is not based on...perfection...it is based, rather, on imperfection...'. For the therapists who were interviewed for my phase one study, 'being human' included coming to terms with the fact that they are prone to making mistakes and sometimes failing. Yet Wosket (1999, p. 103) points out that this is not necessarily a bad thing: 'It is from my experience with Rachael [a client] that I have come to ask myself whether mistakes and errors are to be welcomed, rather than regarded as something to be avoided.' She writes, 'I now look out for the therapeutic opportunity revealed in mistakes, errors and gaffs I make' (*op. cit.*, p. 104). Wosket (1999, p. 109) concludes that 'When we are fallible we are at our most human and when we are most human we are in touch with our greatest potential for helping others'.

Yalom (1980) argues that although it may be commonly practiced, ‘being human’ in a therapeutic relationship is rarely taught to trainees. In line with this, therapists who took part in the first phase study learnt that it is sometimes therapeutic to respond to clients in a ‘human way’ (person-to-person rather than professional-to-client) not through their training, but through their work with clients. Rogers (1961, p. 33) also learnt this through his work: ‘I have found that the more I can be genuine in the relationship, the more helpful it will be’.

Many references to ‘being human’ can be found in the literature. In contrast, although thirteen counsellors and psychotherapists interviewed during the first phase study reported that they had been inspired by clients, I was only able to find one reference to therapist inspiration. Chaplin, (1989, p. 185) writes: “it is often quite awe-inspiring to be a psychotherapist. I often marvel at people’s resilience in the face of dreadful life experiences, at the strength of the human spirit.’

### **Humility and acknowledging**

Five of the therapists who took part in my first phase study reported becoming more humble as a result of their work, and four stated that in some cases they had learnt to simply acknowledge their client’s feelings and actions. Several authors have written about humility. Clarkson (1992, p. 6), for example, writes about the ‘powerful and humbling lesson’ she learnt with one client. In addition, van Deurzen-Smith (1992, p. 45) says that:

Writing up some of my own mistakes and lessons learnt has shown me once more just how hard it is to have...humility publicly... Yet there is a curious satisfaction in mentioning the failures and letting go of the professional bulwark of pride and dignity. Openly admitting how biased and limited one is, how faltering and bumbling one’s attempts at understanding life is, to say the least, humbling.

Few references are made in the literature about learning to simply acknowledge. However, in her discussion about ways of working with clients who are newly diagnosed with sight loss, Southwell (2005, p. 36, emphasis added) says:

I have learnt not to talk of acceptance, but to acknowledge that an ongoing loss can eventually be managed by adaptation. Clients appreciate this way of framing the task, as it *acknowledges their deep feelings of not wanting to accept sight loss*, whilst indicating the possibility of working to find how they can find a viable way of living with their impairment.

### **Awareness, acceptance, and openness**

Rogers (1961, p. 115) notes that through therapy a client may become more open and aware:

...in a safe relationship of the sort I have described, this defensiveness or rigidity tends to be replaced by an increasing openness to experience. The individual becomes more openly aware of his own feelings and attitudes...He also becomes more aware of reality as it exists outside of himself, instead of perceiving it in preconceived categories.

He later mentions acceptance: ‘Closely related to this openness to inner and outer experience in general is an openness to and an acceptance of other individuals’ (*op. cit.*, p. 174).

The findings of the first phase study indicate that like their clients, some therapists also become more aware, accepting and open through their work with clients. I was not able to find any referneces in the literature to support this finding, although it is evident that these qualities are viewed in a positive light. Wheeler (2000), for example, has found that counsellor trainers felt that openness and awareness are qualities present in ‘good’ counselling trainees. In addition, Gray (1979) argues that openness enables personal growth.

### **Compassion**

Compassion is referred to in only a few counselling and psychotherapy texts (such as Brazier, 1995 and Gilbert, 2005). Brazier (1995, p. 194) claims that compassion ‘means to value others’ and Leathy (2005, p. 195, original emphasis) defines it as feeling ‘*with* and



*for* another person and [to] care about the suffering of that person'. Carr (1999, p. 411) adds that compassion is an altruistic emotion, 'directed at the needs of others'. Six of the therapists who were interviewed for the phase one study reported becoming more compassionate as a result of their client work: They thought more about others and had opened their hearts to others.

I was not able to find any references to learning about compassion in the counselling and psychotherapy literature. However, some authors (such as Clarkson, 1992, West, 2004 and Wosket, 1999) mention 'love'. Wosket (1999, p. 41) writes, 'By love in the counselling relationship I mean the ability to care deeply enough about the other person to commit myself fully and unconditionally to their process of change and development...'

Clarkson (1995, p. 275) has learnt about the need to love:

From the authenticity of the joy with which people have told me that they loved me, I have in more recent years just how important, genuine and unfulfilled is the need to love...From my own life, and experience in psychotherapy of being a client, I have also learned this – that my gift of healing needs to be accepted and valued, and that my need to love is greater than my need to be loved.

Like compassion, love is only mentioned by a few authors. Possibly, as Wosket (1999, p. 44) claims, this is because 'the majority of counsellors have become frightened of the concept of love. Perhaps to them it smacks of unprofessionalism...'

### **Trusting feelings, thoughts and images**

West (2004) describes how he once suddenly saw the image of a beaten, chained dog in a session in which a client was particularly inhibited. West shared the image with the client who was then able to talk about his experiences of being abused. He later wrote:

It does seem as if the most useful developments in the work with a particular client come out of the seemingly absurd – passing images and words, fleeting bodily sensations and so on. Ignore these at your clients and your own peril (West, 2004, p. 148).

In line with this, nine of the counsellors and therapists who were interviewed for the first phase study reported that as a result of their work with clients, they have come to trust the feelings, thoughts or images that suddenly appear to them, both in and outside of the counselling room. Wosket (1999, p. 53) describes these in more detail:

These may be thoughts, feelings, images, fantasies, echoes or resonances, bodily sensations, lapses or increases in energy that can normally be trusted as having some relevance and significance because they arise from the meeting between us [herself and her client] and not from something I choose to bring into the meeting.

These feelings, thoughts and images may be referred to as ‘gut feelings’ or ‘intuition’. Intuition is defined in the *Oxford Dictionary and Thesaurus III* as ‘immediate apprehension by mind without reasoning’ (Elliott *et al.*, 2001, p. 400). Although Charles (2004) gives no single definition in her book *Intuition in Psychotherapy and Counselling*, she notes that the literature suggests that intuition, ‘is not a rational process’ (*op. cit.*, p. 28), instead ‘it is a process that happens largely out of awareness’ (*op. cit.*, p. 8). Furthermore, it ‘arrives in consciousness as a complete construct in one of a variety of forms’ (*op. cit.*, p. 38) including ‘a feeling, thought or bodily sensation...an impression, a joke or a visual image’ (*op. cit.*, p. 32).

Charles’ (2004) own research findings add to this list: Her participants have reported that intuitions may also arise as a sudden perception, a feeling of certainty, an empathic response, a sense of urgency or danger, a feeling of disbelief or the making of connections. Her findings also show that therapists may respond to their intuitions by verbally communicating with clients or acting in some way, and they may also avoid responding. Furthermore, clients may respond to a therapist’s intuition positively, negatively, with a mixed reaction or with no apparent reaction (*ibid.*). Charles (2004, p. 171) notes that ‘it seems therefore that intuitions need to be applied with care and perhaps sometimes not at all’.

Charles (2004) admits that as her research findings were based on the analysis of only a single focus group meeting and the journal records of only six therapists (including herself) and may therefore, in some ways, be biased. However, she does not seem to be aware that although she claims to make use of the grounded theory methodology, in opposition to

Glaser and Strauss' (1968) suggestion, she appears to have started her research with a literature review. Her reading may have therefore influenced her naming of categories during the data analysis stage. Despite this, and although further research is needed, Charles' work provides an interesting insight into intuition as it is used in counselling and psychotherapy.

Intuition is also used in other professions, including nursing (King and Appleton, 1997; McCutcheon and Pincombe, 2001) and teaching (Johansson and Kroksmark, 2004), as well as in qualitative (Janesick, 2001) and even scientific research (Bowler, 2000). However, there is perhaps most anecdotal evidence of the use of intuition or gut feelings in counselling and psychotherapy in the literature. Rogers (1961, p. 22), for example, admits:

I have come to have more respect for those vague thoughts which occur in me from time to time, which *feel* as though they were significant. I am inclined to think that these unclear thoughts or hunches will lead to important areas.

In agreement, Wrenn (1990, p. 586) says, 'In decision making, listen to your inward voice, your so-called gut feelings'.

One therapist who took part in the first phase study suggested that intuition is simply the result of experience. In agreement, Dryden (1988, p.8) claims that 'Intuition refers to sensitive judgements that have become internalised and appear, in highly skilled and experienced hands, effortless'. Moustakas (1990, p. 23) says, 'The more that intuition is exercised and tested, the more likely one will develop an advanced perceptiveness...'. Furthermore, Easen and Wilcockson (1996, p. 667) write:

Intuitive thinking has certain essential features and involves the use of a sound, rational, relevant knowledge base in situations that, through experience, are so familiar that the person has learned how to recognise and act on appropriate patterns.

## **Humour**

Humour is a universal phenomenon (Kruger, 1996) that can build self-esteem and confidence (Johnson, 2005), establish good relationships (Olsson *et al.*, 2002) and promote good health (Boyle and Reid, 2004).

It is used in nursing (Astedt-Kurki *et al.*, 2001, Astedt-Kurki and Liukkonen, 1994; Beck, 1996), including children's nursing (Sheldon, 1996) and community psychiatric nursing (Struthers, 1999); as well as in factories (Holmes and Marra, 2002), government departments (Holmes, 2000) and banks (Thomas and Al-Maskati, 1997). Although it may also be used successfully as a therapeutic tool (Goldin and Bordan, 1999; Murgatroyd, 1987), Wosket (1999, p. 198) points out that humour '...is excluded from accounts of therapy to the extent that one might almost assume that it never happens – or if it does, that it has crept in uninvited, as a breach of therapeutic etiquette'.

Despite this, Lapworth, Sills and Fish, 2001, list humour as one of the necessary elements of therapeutic engagement. They note that:

Handled with care, humour can be a vehicle for insight, an affirmation of the working alliance, a true moment of meeting in the person-to person relationship or a gentle means of confrontation...humour has a place in psychotherapy when the intent is clearly of therapeutic value and insight for the client and part of a secure and developed working alliance (Lapworth, Sills and Fish, 2001, p. 24-25).

One therapist who was interviewed as part of the first phase study noted that humour could be used even when clients were discussing very serious concerns, such as HIV. In agreement, Wosket (1999, p. 199) argues that 'There is a place for the life-giving breadth of humour in even the most harrowing of therapeutic encounters...'

Three of the participants who took part in the first phase study said that they had learnt about the importance of humour in therapy. However, none of these therapists talked about the potential danger of using humour. In contrast, Lapworth, Sills and Fish (2001, p. 24) warn that 'Handled clumsily, it can be humiliating, shaming, reinforcing of negative beliefs (as in 'gallows' laughter) confusing or patronizing.'

### **Risk-taking**

Four of the practitioners who were interviewed during the phase one study reported that they had learnt to take more risks in counselling as a result of their client experiences. In

addition, one of the theoretical sampling study participants linked the use of flexible boundaries to taking risks. Wosket (1999, p. 160) writes about a counsellor who has also learnt to take more risks in his work: ‘In terms of his own learning he records that he has learnt ‘to take more risks; to be more creative, to be more fluid...’

Fontaine and Hammond (1994, p. 223) urge all novice counsellors to ‘Take the risk of trying something new’ and Jacobs (1992, p. 61) adds that risk-taking can lead to breakthroughs in therapy:

The hard lesson is to give up waiting for the client to take the lead. Instead, provide the opening; voice what seems inappropriate, ‘out of the blue’. We may fear losing the client, but there is often a breakthrough.

In line with this, Rowan (1992) describes taking a risk in which he and his client shouted at a spider which represented the client’s mother. This helped to shift the client’s perception of her relationship with her mother.

Pearce’s (2005) research on therapeutic risk-taking was based on interviews with eight counsellors. Only person-centred or integrative therapists were interviewed, and as a result, the findings may not be relevant to therapists of all theoretical orientations. However, in line with Jacobs’ (1992) ideas and Rowan’s (1992) experience, Pearce’s (2005) research shows that taking risks can lead to breakthroughs in therapy. A few of the therapists who took part in the first phase study also found this to be true.

### **‘Staying with it’ and use of challenge**

Nine out of the therapists who took part in the first phase study said that they had learnt to sometimes simply ‘stay with it’: Not try to find solutions, move the client on or make things better, just stay with the client’s and with their own discomfort. Similarly, West (2004) notes that he is sometimes drawn to be with his clients without doing anything. And Jacobs (2001, pp. 282-283) writes:

Time and time again I have noticed that when I try to argue against, convince or otherwise, however gently, move patients into a different perspective, they become more committed to their current perspective, more rigid and defensive. But if I can welcome their perspective, open myself to it even when it is full of anguish, then the forward-moving processes of life take over.

As well as providing support by staying with it, therapists might also challenge their clients. Four of the participants who took part in the first phase study reported learning to challenge more through their work with clients. Dryden (1992, p. 51) also learnt about the importance of challenge through his work with one female client:

...my client and I struggled for weeks until I broke ranks and, taking a leaf out of Albert Ellis' book, I successfully helped the client by strongly attacking her rigidly held belief that she needed approval in order to be happy.

### **Theory and models**

Nine counsellors and therapists talked about the usefulness and constraints of theories and models during the phase one study. One of these therapists (Nkeiru) has found that the person-centred approach in which she was trained in seems to be incomplete.

Similarly, in the book *How Therapists Change*, Goldfried (2001) gives voice to sixteen experienced and well-known therapists, including himself, who have found that the theory they originally trained in was in some way limited. As a result, they have become more integrative.

Goldfried (2001) claims that '...it is not at all atypical for practicing clinicians to encounter instances in which they find their theoretical approach to be lacking, where they decide to borrow methods from other orientations' (*op. cit*, p.4). In agreement, West (2004, p. 56) writes: 'I find that trying to fit my ongoing sense of myself as a therapeutic practitioner within some kind of therapeutic frame as a highly challenging process'. Rogers (1961, p. 32) goes one step further, suggesting that all theory and models may be unhelpful in practice:

It has gradually been driven home to me that I cannot be of help to this troubled person by means of any intellectual or training procedure. No approach which

relies upon knowledge, upon training, upon the acceptance of something that is *taught*, is of any use.

Heron (1996) describes four ways of knowing: propositional (knowing intellectually, in words and concepts), practical (knowing how to do something), experiential (knowing through engaging with someone or something), and presentational (knowing aesthetically, pattern recognition). If a professional's knowledge lies in the work that they do, as Schon (1991) suggests, then for therapists, this knowledge may be practical and/or experiential and/or presentational. Theories and models, however, represent propositional knowledge, which may well get in the way of the other forms of knowledge possessed by therapists. In line with this, Wosket (1999, p. 3) says:

My belief is that many counsellors could become more effective if they sometimes directed their attention away from the models and processes originally taught to them and more towards acknowledging their own unique helping attributes.

Wosket's (1999) book, *The Therapeutic Use of Self* focuses on the limitations of theory and the usefulness of using 'self' for the therapist. Clarkson (2003, p. 22, original emphasis) adds that theory and models are not useful in the transpersonal relationship: '*Implied is a letting go of skills, of knowledge...*'

### **Boundaries**

Boundaries help clients to feel safe, represent emotional containment and prevent abuse by therapists (Collins, 2005; Symons and Wheeler, 2005). It is not surprising then, that eight therapists who took part in the first phase study reported that they had learnt about the importance of boundaries through their work with clients. In line with this, Clarkson (2003, p. 52) writes:

I would like to state empathically that I agree with, support and teach the importance of maintaining, preserving and reconstituting the boundaries of time, place, role, task and relationship under most conditions, at most times and in most places...

Similarly, Wosket (1999, p. 38) stresses:

There is a precision to the therapeutic relationship... There is certainty and therefore some safety in the knowledge that it will run its course, will end and start again with clearly defined boundaries.

Although several therapists reported that they had learnt about the importance of boundaries through working with clients, during the first phase study, some therapists also mentioned that they had learnt to be more flexible: Four of the participants, three of whom had had one or more significant experiences of working with a client with HIV, noted that they had learnt about the importance of flexibility through their client work.

All four participants discussed cases involving death. The findings of the theoretical sampling study, however, showed that other counsellors and psychotherapists have learnt to be flexible in their use of boundaries in cases which did not involve death. One therapist (Steven) conceptualised this as 'being responsive to the needs of the client'. In line with this finding, Atkins and Loewenthal's (2004) heuristic study of the experience of psychotherapists working with older clients showed that 'most participants experienced a need to be more flexible when working with older people (Atkins and Loewenthal, 2004, p. 498). This included visiting clients at home and in nursing homes or hospital and encouraging clients to end the sessions early if they felt very tired.

Anecdotal evidence of the use of flexible boundaries is also present in the literature. Clarkson (2003) mentions that she has told clients who suffer from panic attacks that they can call her anytime of the day or night, and Wosket (1999) admits that she is flexible with the timing of sessions with clients who have suffered from abuse. Gale (1999) adds that he has conducted therapy in a café, a bar, a hotel room and whilst walking. He once also made an omelette for a client. He says, 'she told me, after finishing therapy that it was the most helpful thing I had ever done for her' (Gale, 1999, p. 129).

Wosket (1999) distinguishes between 'boundary crossing' and 'boundary violation'. While the latter places the client at risk, the former may benefit the client. As Clarkson (1992, p. 2) points out 'Rules can prevent harm, but taken as true in themselves, they can prevent healing.' In support, Mearns (1990) suggests that boundary flexibility often leads to success in counselling.



Boundary crossing may be especially important in working with learning disabled adults, for example, who may not be able to concentrate for long periods of time and may wish to be counselled in unconventional locations (Dowling, 2005 and Read, 2005). In writing about one counsellor's work with a disabled client, which involved a great deal of boundary crossing, Wosket (1999, p. 161) argues that 'This counsellor's experience immediately raises an important question about whether clients with different or special needs may sometimes require unusual or innovative responses from counsellors'.

Some clients with HIV may be regarded as having 'different or special needs' and this may explain why three of the group A therapists interviewed for the phase one study learnt to use flexible boundaries in their work with such clients. Yet, as Mountford (2005) notes, in reality, all clients' needs vary. In working flexibly with time, he has found that 'few clients favour the standard counselling hour' (Mountford, 2005, p. 44). Mountford (2005) points out that the fifty or sixty minute hour only came into being because Freud found that this suited his schedule, yet most training programmes now imply that it is not professional or appropriate to work beyond an hour and most counsellors work within this limit. Despite this, Mountford, (*op. cit.*, p. 45) finds 'longer sessions a more satisfying way to work' and thinks that overall counselling time is reduced when crossing the boundary of the standard counselling hour.

It may be argued that although he claims the therapy was successful, Thorne's work with a client called Sally involved a number of boundary violations rather than crossings (Thorne, 1991). Sally saw Thorne because she had been suffering from long-term sexual difficulties. In describing his work with Sally, Thorne (1991, p. 90) writes:

I found myself allowing my body to express its acceptance and understanding for Sally's. I gently massaged her stomach and stroked her back. Her tears flowed and from time to time she moaned. I felt sexually excited...

He continues:

I discovered, with her help, that my principal task was to massage with great gentleness her stomach, her shoulders and sometimes her buttocks. It was also important for her to be held, sometimes for long periods (Thorne, 1991, p. 94).

In addition, during some of their final sessions, Thorne (1991, p. 96) was literally naked with his client: ‘...it was possible for us both to be naked and vulnerable before each other...Sally allowed herself to be held closely and tenderly...’

Wosket (1999, p. 140) stresses that no touch should occur ‘between the waist line and knees of any client nor anywhere on the chest of female clients’. Yet Thorne massaged his client’s stomach and buttocks. As Page (1999, p. 27) points out, ‘a significant number of clients experience themselves to be hurt or damaged through sexual contact with their counsellor or therapist’. Wosket (1999, p. 134) adds, ‘I wish to state that I do not condone the use of erotic touch or sexual contact with clients under any circumstances and I agree with those authors...who view this as a serious abuse of power...’ However, Thorne admits to feeling sexually aroused by his client.

Lapworth, Sills and Fish (2001, p. 52) write:

...unless specifically trained in bodywork approaches, we do not consider it ethical, professional practice for therapists to employ hands-on bodywork techniques with their clients as such skills are outside the competency of the practitioner.

Thorne (1991) admits to having no such training.

Although she argues against the use of erotic touch in therapy, Wosket (1999) notes that non-erotic touch, which the client has given permission for, may be a much needed human response. Similarly, Etherington (1998, p. 361) suggests that ‘touch is a primary source of communication of which many clients, as children, were deprived’. Avoiding appropriate touch, she says, can be damaging to the client. Similarly, Lauren, one of the therapists who took part in the phase one study said, ‘There’s abuse in counselling and then it could almost be abusive not to use touch in other ways’. Palmer (2002), however, suggests that therapists should question their motives before working in this way and should also address the issue in supervision.

## **Addressing death**

In the first phase study, only therapists in group A (four in total) reported addressing their own death as a result of their work with clients with HIV. In line with this finding, Dworkin and Pincu, (1993, p. 275 and 280) point out that:

When working with an HIV-infected population, there are themes that the counsellor must be ready to address within herself or himself and with clients. ...The disease forces us to confront our beliefs and attitudes about...health, sickness, quality of life, and death and dying.

Yet Sugarman, (2004, p. 50) argues that counsellors and psychotherapists working with elderly clients are also likely to think about death: ‘Clients in late adulthood bring with them the reminder *memento mori* – remember you will die – thereby forcing counsellors to face their own aging.’ Atkins and Loewenthal’s (2004) findings concur with this idea: Their study of counsellors who have worked with older clients showed that this experience ‘raises questions and fears of their own decline and mortality’ (*op. cit*, p. 503). Similarly, Henderson (2005, p. 30) notes that clients working on issues associated with bereavement may remind therapists of their own mortality: ‘As soon as there is bereavement in the room, death is also there, reminding us that we all must die’.

Barnett (2006) admits that she needs to remind herself of her own mortality in order to fully engage with clients who have spent time in intensive care. Furthermore, in her book about her work with a client who was diagnosed with cancer part way through his therapy, Schaverien (2002, p. 11) proposes that ‘The psychotherapist who truly engages with [a terminally ill client]...is obliged to confront the inevitability of their own death’.

Addressing one’s own death may be beneficial. Clarkson, (2003, p. 171) argues that, ‘The existential reality is that endings are part of life... We live in the presence of our mortality and the avoidance of death detracts from the vitality of our lives’. In agreement, Yalom (1980, p. 33) writes:

The integration of the *idea* of death saves us as, rather than sentence us to the existences of terror or black pessimism, it acts as a catalyst to plunge us into more authentic life modes, and it enhances our pleasure in the living of life.

However, Mander (2005) argues that however much experience a counsellor or psychotherapist gains in working with clients who talk about death, the therapist will not stop fearing her own death: 'I do not believe that anyone is ever without anxieties about dying nor that daily exposure to stories of death and dying can inure one entirely to the natural fear of death' (*op. cit.*, p. 45).

## **Other learning**

Therapists may also learn about honesty from their client work. This was not mentioned by the phase one study participants, although it is detailed in the literature. Rogers (1961, pp. 16-17, original emphasis) says:

*...I have found that it does not help, in the long run, to act as though I were something I am not. It does not help to act calm and pleasant when I am angry and critical. It does not help to act as though I know all the answers when I do not...to act in one way on the surface when I am experiencing something quite different underneath.*

Similarly, Wosket (1999, pp. 51-52) writes:

My client will perceive things about me that I am not consciously choosing to disclose (for instance, if I am scared or embarrassed by what they are telling me...I have learnt that it is best to 'come clean' even when this leaves me feeling vulnerable and exposed.

It could be argued, however, that honesty may be part of the 'being human' category or the 'openness' category that arose from my phase one study. And it may also be linked to other categories because, although they are presented separately in this thesis, it is unlikely that the experiences that these categories refer to were separate. As Batchelor, (1983, p. 90-91) notes, 'In actual life our diverse experiences are not classified into clearly defined types, sets or categories; they impinge upon, merge into, and fluidly penetrate one another'.

## **Other catalysts of change**

Although they were only asked to talk about the learning and change experiences they had had as a result of their client work, therapists who took part in the first phase study also mentioned other catalysts of change: Training, colleagues, supervision, their own therapy, reading and teaching. These are also referred to in the literature.

### **Colleagues**

Skovholt and Ronnestad's (1995) research indicates that for therapists, after their clients, colleagues are most influential on their development. In support of this finding, Goldfried (2001, p. 324) notes that nearly all of the sixteen contributors to his book, *How Therapists Change*, 'indicated that their interactions with colleagues of a different orientation had an important effect on their clinical work'. Four of the therapists who took part in the first phase study mentioned that they had learnt from other therapists.

### **Personal therapy**

Many more participants (fourteen in total) talked about the positive effects of their own therapy on their learning and change as therapists. In line with this, a survey of UK chartered counselling psychologists showed that most of the 192 professionals who took part viewed their personal therapy as a constructive experience (Williams *et al.*, 1999). As Goldfried (2001, p. 324) says, 'being in personal therapy with an experienced therapist...was a profound personal and professional experience for me'.

Rowan (1989, p. 165) adds, 'It seems crystal-clear to me that the most important influence on any therapist is the personal therapy they have experienced themselves on themselves, and for themselves'. However, Grimmer (2005) notes that most of the research on the personal therapy that therapists have engaged in has been quantitative and not all has relied on therapists' own evaluations. In addition, much of this research is methodologically problematic and has focused on psychodynamic therapy only (*ibid.*). The fact, then, that this research has not been able to reliably demonstrate that personal therapy leads to improved mental health for the therapists, or better outcomes for their clients, need not, I suggest, concern both trainee and qualified therapists who feel that they have developed as a therapist as a result of their own personal therapy.

Murphy (2005, p. 27) has carried out a 'qualitative study into the experience of mandatory personal therapy during training'. He claims to have used 'a form of grounded theory called the constant comparative method...for data analysis' (*op. cit.*, p. 29). However, constant comparison is not a form of grounded theory, it is the first step of the process of doing grounded theory (Glaser and Strauss, 1968). In addition, Murphy seems to have based his 'grounded theory' study on a single group interview with five trainees who self-selected from one MA counselling course (see Turner, 2005c; appendix M). McLeod (2001) suggests that grounded theory research should be carried out with between eight and twenty participants. Fewer than eight, he says, results in something similar to a case study.

Taken as a case study, the analysis of which was based on some of the principles of grounded theory, Murphy's (2005) study supports the findings of Williams *et al.* (1999), and is in line with Goldfried's (2001) and Rowan's (1989) views: 'The key findings suggest that personal therapy for trainees can be a positive experience and can enhance the process of becoming a professional counsellor' (Murphy, 2005, p. 27).

My own findings support and extend those of Murphy (2005). The qualified and practicing therapists who talked about their own therapy during my first phase study mentioned four things that they had gained from this: An opportunity to work on unresolved issues, increased self-awareness, an opportunity to learn about the process of therapy from the client's perspective and an opportunity to learn from their therapist as a model of a therapist at work. Grimmer and Tribe (2001), add that therapists may also use personal therapy as a form of protection and support in coping with their intense and demanding jobs. In addition, Wosket (1999) suggests that personal therapy is an opportunity for practitioners to develop an integrative practice through the understanding of the practitioners' own problems and healing processes.

My research findings with regard to personal therapy, together with the literature on this topic, may be of interest to trainee therapists who engage in compulsory personal therapy

only in order to fulfil course or accreditation requirements. Many counselling and psychotherapy courses currently insist that trainees undertake personal therapy. For some, though, fulfilling these requirements may be extremely costly and may seem relatively unrewarding. Mearns and Thorne (2000) point out that, for example, the person-centred model requires that a client in person-centred therapy must be in a state of incongruence. Yet a trainee may not be in such a state. There is therefore a disparity between compulsory therapy and the person-centred approach. As my phase one study findings suggests, though, therapists may learn a great deal from personal therapy, even if they are not in a state of incongruence.

In spite of this, at the beginning of 2005, the BACP dropped their individual accreditation requirement of a minimum of forty hours of personal therapy (BACP 2005a). However, they still insist that those who apply for accreditation must have engaged in ‘an experience or activity which contributes to your self-awareness’ (BACP, 2005b, p. 2). Interestingly, though, according to my phase one study findings, working as a therapist would fulfil this BACP accreditation requirement, since client work may give rise to an increased self-awareness.

However, the BACP’s *Ethical Framework for Good Practice in Counselling and Psychotherapy* (BACP, 2002, p. 4) states that ‘The principle of self-respect encourages active engagement in life-enhancing activities and relationships that are independent of relationships in counselling or psychotherapy’. Perhaps, then, the BACP accreditation requirement relating to engaging in self-awareness raising activities and experiences should read ‘Can describe an experience or activity, *other than client work*, which contributes to your self-awareness’.

### **Reading**

Goldfried (2001, p. 325) points out that ‘many of the contributors [to his book] indicate that reading the works of others expanded their therapeutic horizons’. In addition, Wosket (1999, p. 60) says:

Whenever I pause to review what seem to have been the important influences on my development as a counsellor...I think of the wisdom of experienced practitioners that I have heard about from their books and writings...

Reading as a catalyst of change was mentioned by three people who were interviewed for the first phase study. Although none of the first phase study participants mentioned that they had learnt through writing, Mahoney (1989, p.17) notes that this is also possible: ‘...my early writings were as much for me as for anyone else. They were my meditations, my musings, and often my private medium of self-teaching and self-therapy’.

### **Supervision**

‘Longer experience with counselling has shown me the importance of supervision’, says Dalton (1992, p. 25). Supervision of client work is always integral to counsellor training, and it is often seen as an important part of the trainee counsellor’s learning (Wheeler and King, 2000).

The grounded theory study findings detailed within this thesis show that supervision and supervising may also catalyse learning for qualified therapists. Thirteen out of the thirty-nine participants of the first phase study said that they had learnt and changed as a result of supervision and supervising. In line with this, Milner, (1992, p. 85) writes: ‘Supervision is a reward – it supports us in learning about ourselves, our clients and our work in the company of someone who cares about us.’

Other research studies have also shown that supervision may lead to learning and change. Vallance (2005), for example, used open-ended questionnaires and semi-structured interviews to gain data on nineteen counsellors’ perceptions of supervision. Her findings show that supervision gave her research participants ‘a greater understanding of client patterns and helped to raise awareness of their own feelings and responses’ (Vallance, 2005, p. 108). However, Valance’s (2005) study is limited in that all of her respondents



were integrative practitioners whose work was underpinned by person-centred theory. Furthermore, all participants were known to her, and only one was male. Valance (2005) does not acknowledge that these limitations may affect the confirmability and transferability of her findings, although she does suggest that her study could be extended with further participants.

McMahon and Patton (2000) have studied fifty one school counsellors perceptions of supervision using focus groups. Their findings show that supervision may promote skill development and increase self-awareness. However, this study was carried out in Queensland, Australia, and the authors do not discuss the possibility that their findings may be transferable to British settings.

As well as giving rise to a greater understanding of their clients' patterns, greater awareness of themselves and improved skills (Vallance, 2005; McMahon and Patton, 2000), supervision also encourages a counsellor or psychotherapist to reflect on his work. With regard to her work with a client who was diagnosed with cancer during his therapy, Schaverien (2002, p. 196) notes that supervision gave her space to think about the 'extension of the analytic boundaries' that she made. Wheeler and King (2000, p. 288) note that 'ideally, the supervisor will encourage the development of the internal reflection process in the counsellor'. This reflection process may be one of the mechanisms by which learning and change occurs as a result of supervision.

### **Training and teaching**

Sixteen of the therapists who took part in the first phase study reported that their initial and ongoing training and teaching experiences have led to learning and change, both personally and professionally. The development that occurs as a result of studying on a counselling or psychotherapy course is a well documented and often an expected outcome of training (Wheeler, 2002). In contrast, I was only able to find anecdotal evidence to support the idea that teaching counselling and psychotherapy can catalyse learning and change experiences. Heppner, (1989, p. 79) says, 'Being in the role of teaching, advising and supervising graduate students in counselling psychology has also been a critical developmental process for me as a therapist'. Chaplin (1989, p. 181) adds: 'My own students have taught me a lot through their openness to ideas and willingness to share their responses'.

## **Research can foster reflection for participants**

Grant and Boersma (2005, p. 217) note that their hermeneutic-phenomenological study on obesity ‘created an opportunity for processing and self-reflection’ for participants. Similarly, five of the therapists who were interviewed for the first phase study reported that as a result of being interviewed they have been able to reflect on and learn from their work.

## **Summary**

The findings of my first phase study are, to a large degree, also supported by the literature, much of which exists in the form of anecdotal evidence. Like the therapists who took part in the phase one study, counsellors and psychotherapists who have described their experiences in writing reveal that even when highly experienced they do not stop learning from their work with clients. A few have also admitted that the relationships they form with their clients are mutually beneficial. They have described learning *from* as well as *with* clients, through discussion, and through reflecting. They say that they learn gradually, and sometimes need to re-learn. In addition, they note that learning through their client work can impact on other aspects of their lives, and wider life experiences can influence their work with clients.

Within the literature, I have found references to therapists who have learnt about the importance of humour in therapy, learnt to take risks in their work, and learnt about the limitations of theory and models in working with clients. In addition, they have learnt about the importance of boundaries, to sometimes stay with it (not try to find solutions, move the client on or make things better, just stay with the client’s and with their own discomfort), and to challenge more.

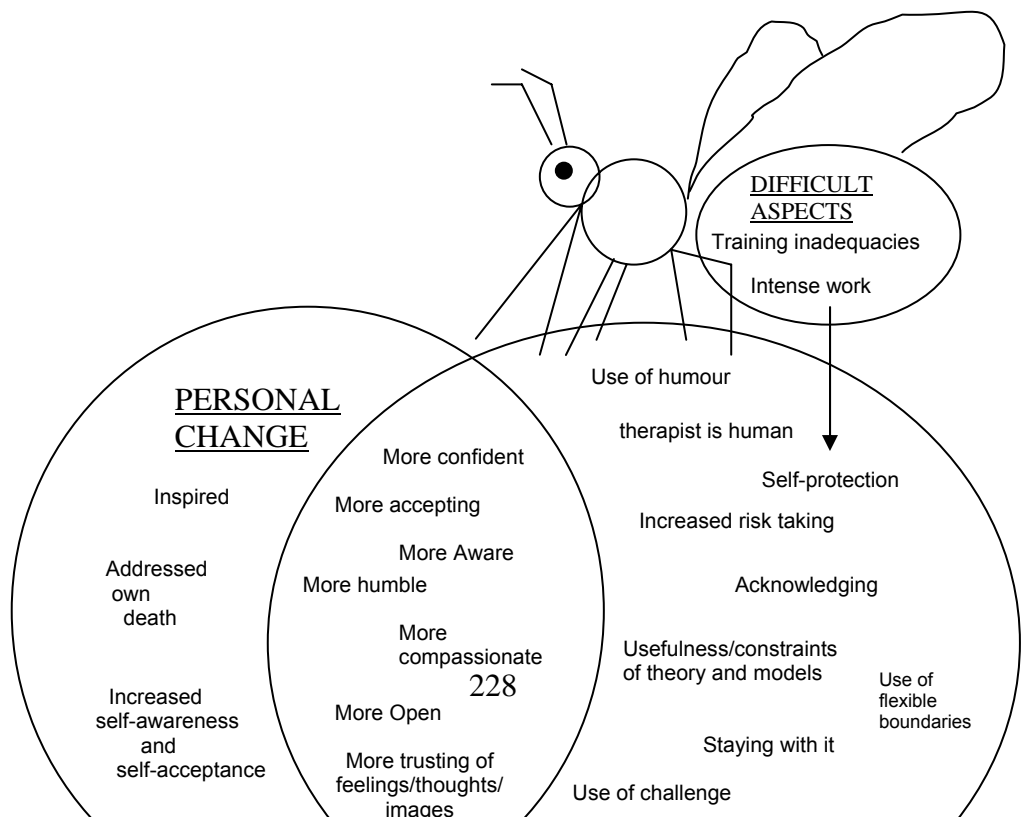
The literature also mentions that therapists may be inspired by clients, and gaining confidence, self-awareness and self-acceptance, and becoming more humble as a result of work with clients. In addition, protecting oneself as a practitioner, the importance of ‘being human’ whilst working a therapist, learning to acknowledge and learning to trust the thoughts, feelings and images that suddenly appear are also discussed in the literature.

Although the use of flexible boundaries was linked to clients facing death in the first phase study, in line with the findings of the theoretical sampling study, the literature gives several examples of therapists who have crossed boundaries with a variety of clients. In addition, the literature suggests that therapists might address death as a result of working with clients who are not HIV positive, even though addressing death was only referred to by therapists in the context of their work with clients with HIV in the first phase study.

Some reports of learning that were found to be present in the literature were absent from the phase one study findings, and the reverse also seems to be true. Unlike the first phase study findings, the literature review revealed that some therapists had learnt about the potential dangers of using humour, as well as the potential benefits. In addition, some therapists quoted in the literature review talked about the specific importance of leisure time in protecting themselves, about learning to be honest with their clients and about the possibility of learning and change through writing as well as reading. Learning and changes included in the first phase study findings but which I was not able to find mention of in the literature included therapists becoming more aware, accepting, open and compassionate as a result of their work with clients. Furthermore, unconscious learning was not explicitly mentioned in the literature.

## **The Adapted Model**

Extending the findings of the first phase study, the theoretical sampling study findings, supported and extended by a literature review, show that therapists working with elderly clients and those with cancer might address their own death, while practitioners may learn about the benefits of using flexible boundaries from working with a variety of client types and issues. In the light of the phase two findings, the ‘two theories of therapist change’ presented as a flower model in figure 4 (page 175) has been updated. An adapted model is shown in figure 6, overleaf.



## **Chapter 4: The Co-operative Self-Search Inquiry (Phase 3)**

‘We are all personalities that grow and develop  
as a result of all our experiences,  
relationships, thoughts, and emotions.  
We are the sum total of all the parts that go into the making of a life’  
  
(Axline, 1990. p. 194).

## **Rationale**

The findings of the grounded theory study detailed in this thesis shed light on the learning and change that counsellors and psychotherapists experience as a result of their client work. In an attempt to gain a more in-depth and longitudinal understanding of this learning and change, I undertook a phase three study, focusing on my experience of the therapeutic relationship from the perspective of a voluntary counsellor, and a co-researcher’s experience of the therapeutic relationship from the perspective of a paid therapist. For the purposes of this study, I chose to work for a bereavement charity and a hospice. However, in order to avoid burnout through working in only one area (Mander, 2005), I also worked for a charity which provides counselling to children in schools. My co-researcher was employed as a part-time higher education student counsellor and also had a small private practice.

In contrast to many other PhD students within the counselling and psychotherapy arena, at the start of my doctoral studies, I had no client experience. Yet Maslow (1966, pp. 45-46) stresses that:

...there is no substitute for experience, none at all. All other paraphernalia of communication and of knowledge – words, labels, concepts, symbols, theories, formulas, sciences – all are useful only because people already knew them experientially.

In addition, Heron (1996, p. 20) points out that, ‘Propositions about human experience...are of questionable validity if they are not grounded in the researchers’ experience’. And Jung (1953, p. 71) says:

The man who would learn the human mind will gain almost nothing from experimental psychology. Far better for him to put away his academic gown, to say goodbye to his study, and to wander with human heart through the world.

Rogers (1961, pp. 23-24, original emphasis) adds:

*Experience is, for me, the highest authority.* The touchstone of validity is my own experience. No other person’s ideas, and none of my own ideas, are as authoritative as my experience. It is to experience that I must return again and again, to discover a closer approximation to truth as it is in the process of becoming in me. Neither the Bible nor the prophets – neither Freud nor research...can take precedence over my own direct experience.

In addition to gaining a more in-depth and longitudinal perspective of therapist learning and change through carrying out a study on my own and a co-researcher’s learning and change experiences over a period of time, by focusing on my own experiences, I also intended to gain an experiential understanding to complement and perhaps add to my grounded theory study findings. As Fassinger (2005, p. 157) points out, ‘no one data collection method is perfect...triangulation might result in discovery of additional information’.

## Methodological Issues

### Heuristic inquiry

In line with Maslow (1966), Heron (1996), Jung (1953) and Rogers (1961), Moustakas (1990, p. 90) also stresses the importance of studying personal experience:

There is no substitute for direct, comprehensive, accurate first-person accounts of experience, for the importance of self-inquiry and self-dialogue in discovering the nature and meaning of one's own experience and that of others.

Clark Moustakas developed the heuristic research methodology whilst carrying out a study on the loneliness he felt when he was asked to decide whether or not his daughter should undergo major heart surgery that could improve her health or lead to her death (Moustakas, 1961). More recently published examples of heuristic research include Telles's (2000) study of teachers' critical awareness of language, a study of life stages by Mitchell-Williams *et al.* (2004), Atkins and Loewenthal's (2004) study of psychotherapists' experiences of working with older clients, Antoniou's (2002) study of her experience of her own body; and Cadavan's (1998) study of his experience of spiritual death.

The word 'heuristic' is derived from a Greek word, 'heuriskein', which means to find or to discover, and it refers to the discovery of the meaning of experience. The phenomenological approach also focuses on experience (McLeod, 2001). However, Douglas and Moustakas (1985) suggest that heuristic inquiry is different from phenomenology in that phenomenology encourages the researcher to be detached from the topic of study, whereas heuristic inquiry relies on the researcher's engagement.

Conversely, Lavery (2003, p. 3) argues that 'phenomenology and hermeneutic phenomenology are often referred to interchangeably, without questioning any distinction between them'. She goes on to note that one of the differences between these two methodologies is that in carrying out a phenomenological inquiry, a researcher aims to bracket out her own ideas, biases and assumptions, whilst in a study carried out from a hermeneutic phenomenological perspective, the researcher's background, assumptions and ideas are acknowledged and made use of as part of the interpretive process. Van Manen (1997) adds that hermeneutic phenomenologists recognise that the meaning of experience



is communicated through language, and this is inextricably linked to assumptions and ideas.

Like heuristic inquiry and hermeneutic phenomenology, other methodologies rely on the researcher's personal engagement with, and immersion in, the topic of study. Moustakas (1994) points out that the researcher's first-hand experiences, as well as her thoughts and feelings are important pieces of data within an ethnographic inquiry. Within a grounded theory methodology, the concept of the researcher's theoretical sensitivity points to the importance of her relevant wider reading of and previous experiences within the field of study (Glaser and Strauss, 1968). In addition, the researcher is required to be personally engaged with the topic of study in a co-operative inquiry (Heron, 1996). However, heuristic inquiry is unique in that the *primary* focus of any study that is carried out is the *experiencing self* of the researcher.

### **A focus on the 'self'**

According to Moustakas (1990, p. 11), heuristic inquiry involves 'self-search, self-dialogue and self-discovery'. He notes that in heuristic research, 'The self of the researcher is present throughout the [research] process' (*op. cit.*, p. 9). However, Moustakas (1990) makes no attempt to define the word 'self'.

The *Oxford Dictionary and Thesaurus III*, however, gives four definitions: '1 individuality, essence. 2 object of introspection or reflexive action. 3 one's own interests or pleasure. 4 concentration on these' (Elliott *et al.*, 2001, p. 688). Reason and Heron's (1995, p. 123) definition of 'a person' is congruent with the first two of these dictionary definitions of 'self': '...a person is a fundamental spiritual entity, a distinct presence in the world, who has the potential to be the cause of her own actions.'

However, these definitions emphasise a separateness of the 'self', distinct from the rest of the world. In contrast, other definitions highlight the relationship between the 'self' and

the outside world, perhaps also noting that the ‘self’ changes in response to external conditions. Singer and Salovey (1993), for example, suggest that the stories that people tell about their lives (stories that are linked to memories of intense emotional experiences) are in some way self-defining. My co-researcher, Neil, defines self as ‘an experiential intersubjective field’. Soth (2005, p. 11) notes that modern psychoanalysts and body psychotherapists see ‘the self as contextual, fluid and open-ended’. Putting these two definitions together, I suggest that self is ‘an experiential intersubjective field that is contextual, fluid and open-ended’.

In whatever way that ‘self’ is defined by the researcher, in heuristic research, from the start, the focus is on the researcher’s ‘self’: He begins by deciding on a topic for the research, choosing something from his life experience that is currently not well understood. The researcher then immerses himself in the experience of the topic in order to try to understand it better by uncovering the tacit knowledge he has about it (Moustakas, 1990).

### **Uncovering tacit knowledge**

Tacit knowledge, as Polanyi (1969, p. 133) defines it, is the ‘capacity of ours to know more than we can tell’. It is knowledge that we have access to, but that we are unaware of. In line with Moustakas (1990), Polanyi (1966) argues that it is necessary to immerse oneself in an experience in order to uncover the related tacit knowledge. He says, ‘it is not by looking at things, but by dwelling in them, that we understand their...meaning’ (Polanyi, 1966, p. 18). More specifically, according to Moustakas (1990) tacit knowledge reveals itself through intuitive insights when an experience is focused on for a long enough time period. Sources of data for heuristic research therefore include ‘visions, images, and dreams’ (*op. cit*, p. 11), and it is important for the researcher to record her emotional reactions and fleeting awarenesses. However, rational thoughts may also be useful sources. Moustakas (1990, p. 10) notes that ‘Whatever presents itself in the consciousness of the investigator as perception, sense, intuition, or knowledge represents an invitation for further elucidation’.

### **Recording methods**

The recording methods used in heuristic research depend on the needs and preferences of the researcher, so that ‘each research process unfolds in its own way’ (Moustakas 1990, p. 43). Some methods of recording experiences (including thoughts, feelings, visions, images and dreams) that may arise during a heuristic inquiry are decided upon at the outset, while others may be added later.

Heron (1992) distinguishes between four types of knowledge: experiential, presentational, propositional and practical. Experiential knowledge is gained through direct encounters with people, places or things, while presentational knowledge is created through the ordering of our tacit experiential knowledge into patterns or images, which may be symbolized in stories, sounds, colours, shapes and/or poetry, amongst other things. It is not surprising, then, that Moustakas (1990) recommends the use of diary extracts, poems, stream of consciousness writing, narratives, metaphors, analogies and artwork in recording and exploring personal experiences during a heuristic inquiry study.

Reason and Heron (1995, p. 124) point out that ‘The development of presentational knowledge is an important, and often neglected, bridge between experiential and propositional [intellectual] knowledge’. However, as they engage in the six phases of his heuristic research process, Moustakas seems to encourage researchers to work with presentational knowledge, so that the gap between experiential understandings and propositional knowledge may be bridged.

### **Six phases**

The heuristic research process is divided into six phases (Moustakas, 1990). After the ‘initial engagement phase’ in which the researcher finds an area of interest to be studied and defines any important terms to be used, the ‘immersion’ phase begins. The researcher totally immerses herself in the topic of study, allowing it to impact on all areas of her life, and in this way, she becomes as intimate as possible with the topic of study, so that experiential knowledge (recorded in either presentational or propositional formats by the

researcher) may be gained (Heron, 1992). West (1998a) points out that the heuristic researcher should fully live the research during the immersion phase, even while asleep, and notes how he ‘dreamt several times that I received supervision on my research’ (*op. cit.*, p. 62).

Following immersion, the researcher does something entirely different, in what is known as the ‘incubation’ stage. West (2001, p. 129) advises that ‘It is important to put the research aside and get on with other tasks in one’s life. Physical activities can be a great help, such as gardening, walking or cycling’. In reality, though, this may be difficult. Atkins and Loewenthal (2004, p. 497) note that during their three week incubation ‘it was difficult to switch off completely from the topic’. When the research topic is not focused on, though, unconscious processing takes place, so that further insights can occur. Moustakas (1990) uses the analogy of a key that cannot be found when one is looking for it, but which suddenly appears when one decides to stop looking, in order to explain what happens during this time.

As soon as a new insight comes into awareness regarding the research topic, the ‘illumination’ phase begins. This new insight might lead to a new understanding of the topic of research, alter an old understanding or allow the researcher to integrate fragmented knowledge to form a more coherent whole. In order for illumination to happen, Moustakas (1990) notes, the researcher must be open and receptive without striving for a possible insight. Patience and trust are required (West, 1998b).

Moustakas (1990) notes that after illumination, the ‘explication’ phase takes place. At this time, a full examination of the data gathered and understandings reached so far takes place and new understandings may arise. This leads to a full (propositional) description of the research topic. Finally, during the ‘creative synthesis’ phase, a narrative depiction, story, poem, drawing, painting or other creative form is used to presentationally communicate what has been learnt experientially through the research process.

Although the six phases are presented in a linear fashion by Moustakas (1990), Atkins and Loewenthal (2004, p. 497) point out that illumination and explication actually occur

together and ‘have a more circular nature’, so that the data is returned to each time new understandings emerge. In agreement, West (1998a, p. 63) stresses that in practice, ‘there is movement between [all] the different stages, backwards and forwards towards the final synthesis’. If this is the case, then the researcher may also move, forwards and backwards, between Heron’s (1992) four different types of knowledge until the final synthesis is created.

### **The research question**

Moustakas (1990) notes that the heuristic research question must engage the whole self of the researcher and lead to active participation in the research process: ‘the question itself is infused in the researcher’s being’ (*op. cit.*, p. 43). In addition, the question should not seek to find causal relationships or quantitative information, and instead should lead to a depiction of the meaning of a particular experience.

### **The use of co-researchers**

Moustakas (1990, pp. 46-47) writes:

Although in theory it is possible to conduct heuristic research with only one participant, a study will achieve richer, deeper, more profound, and more varied meanings when it includes depictions of the experience of others...

If co-researchers are to be used, Moustakas (1990) suggests that phases two to five of the six phase process should be carried out on each participant’s material in turn, so that ‘individual depictions’ (*op. cit.*, p. 51) of the experience studied can be created after each explication phase. Individual portraits should then be created from these, by including biographical details (Moustakas, 1994). After all the individual portraits have been made they should be viewed together so that a ‘composite depiction’ (Moustakas, 1990, p. 52), representing the main points emphasised by the co-researchers, can be created, before a creative synthesis is developed.

Although Moustakas (1990) encourages the use of co-researchers in heuristic research, Hiles (2001, p. 3) points out that ‘...although heuristic inquiry can certainly involve the

exploration of the experiences of co-researchers, it is an approach to research that very much focuses on the experience...of the researcher'. In agreement, Lowenthal (2003, p. 369) writes, '...heuristic research...puts the researcher centre stage and the researched are used to convince the reader of the legitimacy of the researcher's experience'.

Sela-Smith (2002), however, argues that the inclusion of co-researchers in heuristic inquiry may create a distraction from the researcher's internal process, so that the focus is on the experience rather than the self who is experiencing. She proposes a research methodology which she calls 'heuristic self-search inquiry', based on Moustakas' (1990) methodology, but which is firmly focused on the internal experiences and feelings of the researcher: 'It is in this surrender into feeling-the-feelings and experiencing-the-experience that allows the self-as-researcher to enter heuristic self-search inquiry' (Sela-Smith, 2002, p. 84).

### **Co-operative inquiry**

John Heron's co-operative inquiry model was created in the late 1960's. Heron (1996, p. 1) notes that:

Co-operative inquiry involves two or more people researching a topic through their own experience of it, using a series of cycles in which they move between this experience and reflecting together on it.

The inquiry begins with a reflection phase, in which the focus of the research is agreed upon, and a plan of action for the first action phase and a method of recording experiences are decided. This is then followed by the first action phase, in which each co-researcher immerses herself in a relevant experience and keeps records of the experiential data generated. After an agreed length of time, the second reflection phase begins. The co-researchers then share the data they have generated and choose a plan of action for the next action phase in the light of the data so far gathered. The topic of inquiry and method of data collection may also be modified at this time (Heron, 1996).

According to Reason and Heron (1995), the reflection phases primarily involve propositional knowledge, while the action phases occur in the modes of practical knowledge and experiential knowledge (which may be recorded presentationally or propositionally). Each co-operative inquiry, Heron (1996) suggests, should involve

between five and eight reflection-action cycles. At the end, a longer reflection phase is planned, so that research outcomes can be clarified and a method of report writing can be agreed upon.

In co-operative inquiry, everyone taking part is usually involved in both the research decisions that are made during the reflection stages and the data gathering that occurs during the action phases (*ibid.*). As Reason and Heron (1995, p. 123) point out that:

If the behaviour of those being researched is directed and determined by the researcher, then they are not being present as persons...One can only do research with persons in the true and fullest sense if what they do and what they experience as part of the research is to some significant degree directed by them.

However, the authors (*op. cit.*, p. 125) admit that ‘It may of course take time, skill and hard work to establish full, authentic reciprocity...’.

### **My use of the heuristic and co-operative inquiry methodologies**

The methodology used during the phase three study presented within this thesis makes use of the heuristic methodology (Moustakas, 1999) to which some of the principles of the co-operative inquiry methodology (Heron, 1996) have been added. I have called this methodology ‘co-operative self-search inquiry’ (CSSI) because dialogue between co-researchers is combined with periods of individual data collection on the experiencing self of the researcher.

I have made use of the CSSI methodology in order to examine and gain an in-depth understanding of my own and my co-researcher Neil’s learning and change experiences which have occurred as a result of being in the role of a counsellor. Throughout the study, I was guided by the following research questions: ‘In what ways will I, a novice counsellor, learn and change as a result of engaging in voluntary counselling work?’ and ‘In what ways will Neil, a more experienced therapist, learn and change as a result of engaging in paid counselling work for the first time?’

Hiles (2001, p. 3) notes that:

There is a very striking similarity between the methods of heuristic inquiry and the practice of counselling and psychotherapy, particularly with respect to the use of “self”. It is therefore a method of research that particularly resonates with inquiry into counselling and therapy related issues.

In addition, West (1998a) points out that counsellors are familiar with using ‘the self’ in their work and that heuristic inquiry is therefore congruent with counselling. Whether counsellors and psychotherapists question what ‘self’ they are using at any one time, though, is unclear. And if the self is ‘contextual, fluid and open-ended’ as some psychotherapists suggest, (Soth, 2005, p. 11) a therapist’s self may change as it is being used. Similarly, heuristic researchers’ selves might change, whilst they are being studied, as Neil and I experienced.

In line with Moustakas’ (1990) suggestion, a co-researcher was included in my study so that richer, deeper and more varied data could be collected. Following the findings of my grounded theory study, which showed that discussion supports learning from client work, communication with Neil was built into the study at several stages.

However, Sela-Smith’s (2002) warning that inclusion of co-researchers in heuristic inquiry may create a distraction from a researcher’s internal process was taken into account, and in order to avoid distraction during data collection periods, no contact was made between myself and Neil, with regard to our learning experiences.

The CSSI that took place involved an initial engagement phase, an immersion phase, an incubation phase, an illumination phase, an explication phase and a creative synthesis phase, as outlined by Moustakas (1990). In addition, in order to encourage unconscious learning to enter into conscious awareness throughout the immersion phase, several cycles of reflection and action were incorporated (Heron, 1996). Although I made the initial research decisions and decided upon the focus of the research, Neil thereafter became an equal in the decision making processes that took place throughout the research.

Moustakas (1990) highlights the value of the heuristic inquiry methodology in uncovering the researcher’s tacit knowledge of a particular area. However, as our study focused on all the learning and change experiences that arose from our client work, Neil and I were concerned with recording our explicit learning as well as uncovering the tacit knowledge that resulted from our implicit learning. Moustakas (1990, p. 14) also notes that ‘The



heuristic process is not one that can be hurried or timed by the clock or the calendar'. He later adds that 'The inquiry is complete only when the individual has had an opportunity to tell her story to a point of natural closing' (*op. cit*, p. 46). However, within the constraints of a PhD study, I believe that it is necessary to apply a time limit to each research phase carried out. A flexible time frame of 'about a year' was therefore agreed upon for the immersion, incubation and illumination stages of the study.

Neil and I achieved immersion by carrying out regular part-time counselling work, by reflecting on our practice both inside and outside of supervision and training, and by recording our learning experiences. Engaging with relevant reading material and attending personal therapy, in which personal issues brought to light through our client work were worked on, also supported our immersion.

### **Ethical considerations**

Many of the ethical issues that are relevant to my CSSI are outlined in an earlier section on this topic, in chapter 2. Therefore, only those ethical considerations that are of particular relevance to my CSSI are discussed here.

### **Being a practitioner-researcher**

Bell and Nutt (2002, p. 70, emphasis added) define practitioner-researchers as 'those who have responsibilities as health/social care practitioners (*including trainee practitioners*) and who are also conducting research.' During our engagement in therapeutic work with clients, as we recording our learning experiences for the purposes of research, Neil and I both became practitioner-researchers.

Ethical dilemmas are especially likely to occur for practitioner-researchers who have multiple roles and responsibilities (Bell and Nutt, 2002). In carrying out this research, I was both a trainee counsellor and a trainee researcher. I perceived myself to be ethically responsible towards my clients, the counselling agencies I worked for, and my co-researcher, Neil. I also felt responsible towards my academic and clinical supervisors and responsible for meeting academic requirements for both my diploma in counselling course (which provided a framework in which my client work could most safely take place), and

my doctorate. At the outset, though, it was decided that my ethical responsibility towards my clients would take precedence above all else. During the data collection period of the CSSI, my role as a practitioner was therefore stressed and my role as a researcher was de-emphasised. This was also true for Neil.

Bond (2004b) discusses the importance of researcher reflexivity in considering ethical issues in research. Similarly, Bell and Nutt (2002) note that reflexive professional practice is of importance for the practitioner-researcher, and they suggest that this type of reflexivity connects with researcher reflexivity. Whilst avoiding breaking the contracts of confidentiality that we had made with our clients, throughout our CSSI Neil and I therefore engaged in reflexive discussions with our clinical supervisors and each other, as well as recording our learning experiences reflexively in our journals. The outcomes of our discussions are detailed in a later section of this chapter.

### **Informed consent, confidentiality and anonymity**

West and Byrne (2006, p. 9, original emphasis) write:

We find that informed consent remains highly problematic. How people can give *informed* consent to something they have never previously experienced is beyond us...the researcher themselves may have only a vague idea of which way the research is going.

In agreement, Elliston (2002, p. 18) points out that, ‘researchers themselves may not be fully aware of the direction of the research, nor of the outcomes, and this needs to be communicated to the participants’. West and Byrne (2006) therefore suggest gaining consent from participants at the start, throughout the study and at the end, regularly reminding them that they are free to withdraw from the study at any time.

Consent was sought and gained from Neil at the outset, as well as at regular intervals throughout the research, and he was informed about the methodology that we would use, and told that our research process could not be fixed at the outset. He was given the option to refuse to take part in the research and was aware that he could withdraw at any time. He was also aware that he could have chosen, at any time up until publication or thesis submission, to alter his chosen pseudonym in research reports.

Gaining consent from our clients was not appropriate, as it was the researchers' learning and change that was focused on, rather than any client material. Gaining consent from clients may actually have been unethical, as this may have shifted the focus of the therapeutic work, in their eyes, from their agenda, to that of the researchers. Client anonymity was guaranteed by ensuring that any records of researcher learning and change produced throughout the study were free of client names and distinguishing details. A third party (an academic supervisor) was also asked to read the first draft of all research reports produced in confidence, to ensure that no distinguishing client details were present. One of my diploma course trainers also later read and approved a draft of the findings.

### **Avoidance of harm, detriment and unreasonable stress**

In order to avoid harm, detriment or unreasonable stress to our clients Neil and I focused primarily on providing an ethical, sound and adequately supervised therapeutic service for our clients and only secondarily on recording the learning and change outcomes that resulted from providing such a service. Our learning and change outcomes would have been of no worth, in fact, if our clients were used for the purpose of the research only, without being provided with an adequate therapeutic service. Moreover, we felt that the reflective practice that the CSSI catalysed may well have been of benefit in our client work.

### **Other issues**

With the intention of ensuring that I had attempted to address all overtly important ethical issues associated with my CSSI before starting it, I discussed my ideas with my academic supervisors. I also submitted an ethical approval form to the Exeter University School of Education and Lifelong learning Ethics Committee, which focused on this particular phase of my research. Approval was given (see appendix O).

One of the ethical principles of counselling and psychotherapy is self-respect (BACP, 2002). It is noted that, 'The principle of self-respect...includes seeking counselling or

therapy and other opportunities for personal development as required' (*op. cit*, p. 4). In line with this, Neil and I remained in personal therapy and/or group therapy throughout our study. This also enabled us to reduce the risk of using our client work to resolve our own personal issues, which concurs with the BACP's ethical principle of non-maleficence (BACP, 2002). Additionally, we were both members of the BACP throughout the study, and our work was guided by their *Ethical Framework for Good Practice* (*ibid.*) throughout.

Before the inquiry was carried out, Neil and I had been trained at Master's level in counselling, and, during the study, we were engaged in diploma level training courses, which provided us with further skills training, tutor and peer support and feedback as well as self-development opportunities which were relevant to ourselves as evolving, ethically minded practitioners.

In addition, as well as gaining further generic counselling training, in preparation for my client work, I also undertook specialised training which was provided by the voluntary organisations I worked for.

Finally, Bell and Nutt (2002) note that even if one begins research with a clear set of ethical guidelines in mind, qualitative practitioner research cannot be totally managed and controlled. Further ethical issues may arise throughout the research process. Neil and I therefore remained open and responsive to any further ethical concerns which might have arisen during our study and we discussed these in a safe and confidential environment, and acted on them as they arose.

### **The ethical issues that arose during the study**

At each of our reflection phase meetings, consent was regained, and Neil was reminded that he was free to withdraw at any time. However, during our phase 6 meeting, Neil responded by admitting that he was taking part in order to help me with my research, so he did not feel that it would be appropriate to withdraw. With regard to writing the journal entries, he also noted that he worried about 'getting it right' for my sake, as he didn't want to let me down. Although he was assured that it was entirely acceptable for him to withdraw from the study if he wished to do so, Neil continued to give his consent and take part in the research in order to avoid letting me down.

After the phase 6 meeting, I therefore decided that I would end the research myself if I ever felt that it was having a negative effect on him or his clients. However, this never became necessary, and at the end of the research, Neil commented that taking part in the study had actually been a useful experience for him.

### **The quality of the research**

Hiles (2001) argues that although Moustakas (1990) only outlines six phases in heuristic research, he actually indicates a seventh phase: a validity check. Heuristic research is a rigorous process which demands careful data collection and thorough analysis, and although it is a subjective methodology, it 'is clearly a disciplined subjectivity' (West, 2001, p. 128). Moustakas (1990, p. 32) therefore asks the researcher to answer the following question:

Does the ultimate depiction of the experience derived from one's own rigorous, exhaustive self-searching and from the explications of others present comprehensively, vividly, and accurately the meanings and essences of the experience?

In order to gain a valid depiction of the experience being researched, Moustakas (1990) suggests that the researcher should continually return to the data to check whether it portrays the experience as accurately as possible. If co-researchers have been included in the investigation, the researcher should also ask them to assess the accuracy and comprehensiveness of any reports written. In contrast, though, Sela-Smith (2002, p. 81) argues that validity is established by 'surrendering to the process...then noticing results in expansion of self-awareness..'

In line with both Moustakas (1990) and Sela-Smith (2002) Neil and I returned to our data each time we met, to check whether our experiences had been portrayed accurately and, if necessary, to decide on ways in which our data recording methods should be altered so that more accurate portrayals could be gained. During data collection periods, though, we attempted to ‘surrender to the process’ as fully as possible. Neil not only assessed the correctness and completeness of all reports written on our findings, he also took part in the writing of his individual depiction and he was fully involved in the production of the creative synthesis.

Reason and Heron (1995) outline seven different procedures for enhancing validity in co-operative inquiry: They suggest that all co-researchers should develop discriminating awareness (the ability to accurately notice what is happening, which can be cultivated through meditation, martial arts and other practices), engage in research cycling (taking ideas round the cycles of reflection and action several times), and authentic collaboration (in which each co-researcher is able to voice their own ideas and make personal contributions to the decision making). They also encourage the practice of falsification (in which the ideas of one co-researcher are critically challenged by others), and suggest that unaware projections (distress and psychological defences which might distort the inquiry) should be managed, perhaps through personal therapy or co-counselling (in which co-researchers take it in turn to be a counsellor for each other). Furthermore, Reason and Heron (1995) note that periods of action and reflection within the study should be balanced and that all co-researchers should be prepared for chaos (feeling confused and lost during the inquiry) and should allow this to occur, so that new understandings can emerge out of it.

Many of these procedures for enhancing validity have been addressed within the co-operative self-study inquiry presented within this thesis: With regard to developing discriminating awarenesses, I spent some time learning and practicing meditation before and during the inquiry. Neil and I also took part in counselling or psychotherapy training

throughout the inquiry, and we had both previously undertaken counselling training. During these courses of study, we developed discriminating awarenesses through feedback received on our skills practice and personal development work. Furthermore, I believe that our personal therapy (undertaken both before and during the inquiry) aided our developing discriminating awarenesses.

Research cycling occurred as we re-learned and added to our learning during the inquiry, and, to the greatest extent possible, authentic collaboration and falsification took place, since Neil and I entered the study with a very honest, open and supportive relationship. Unaware projections were addressed through both the personal therapy that we engaged in, and our supervision and training. What is more, I was prepared for and allowed chaos to occur. Towards the end of the study, I wrote in my research journal:

I will soon write the last journal entry for my co-operative self-search inquiry study...I'm looking forward to completing the study because it feels as if I haven't done anything productive, academically, in a long time. And I haven't been able to see the findings take shape as I did with the grounded theory study. I wonder if anything much will come out of this study, and it is uncomfortable to wonder this. Is this the chaos that Reason and Heron (1995) refer to? It feels more 'foggy' than 'chaotic' (Turner, research journal, 2004-2007, entry 67).

Guba and Lincoln's (1989) authenticity criteria have been considered. Both my own and Neil's material is represented in the report of our findings ('fairness') and our understandings of our own and each other's experiences have been increased as a result of the study ('ontological authenticity' and 'educative authenticity' respectively).

With regard to Lincoln and Guba's (1985) parallel trustworthiness criteria of credibility a member check was carried out: As described above, Neil took part in the report writing and also verified the accuracy of any material that made use of the data that he had generated. Triangulation occurred through the inclusion of a co-researcher who added a different set of experiences and learning to my own set, and as both Neil and I spent a total of nine months collecting our data, prolonged engagement was achieved.

As regards dependability and confirmability, an 'audit trail' for the CSSI can be seen to be included within this thesis: An account of the way in which the research was carried out

has been given, and a detailed account of the way in which Neil and I experienced the research process is also included within this chapter. In addition, samples of raw data have been included in the findings section, and data analysis and reduction products, in the form of individual portraits, composite depictions and a creative synthesis are shown.

Some might suggest that confirmability could have been dealt with through the use of bracketing. The German philosopher Husserl developed the concept of bracketing, suggesting that it is necessary to bracket out the outer world as well as personal biases in order to make contact with the essences of things. This involves becoming aware of your biases, beliefs and ideas in order to suspend them or bracket them off, so that an object of study can be seen clearly (Laverty, 2003). Unlike Neil, I knew of the findings of my grounded theory study at the start of the CSSI. This knowledge may therefore have impacted on the way in which I recorded my learning experiences.

However, in agreement with Heidegger, I believe that pre-understanding is not something than can simply be put aside. 'Heidegger went as far as to claim that nothing can be encountered without reference to a person's background understanding' (Laverty, 2003, p. 8).

In order to attempt to prevent my knowledge of my grounded theory findings affecting my CSSI, I intended to simply focus on recording the immediacy of my lived experience. At first, however, this proved to be more difficult than expected: as Neil pointed out in our first meeting, my writing seemed to be overly cognitive. This, it was suggested, was my way of controlling and defending myself from staying in touch with the raw emotion that accompanied my learning experiences. With the support of my co-researcher, however, who was also recording his experiences at an equally intimate level, I became able to stay in touch with and record my lived learning experiences at a deeper level.

With regard to transferability, the CSSI is based on the unique personal experiences of only two participant-researchers. However, the findings may be transferable and of interest to others. Atkins and Loewenthal (2004, p. 508) note of an outcome of their research: 'While this is a very personal outcome, reflection of the meanings and insights presented here may be helpful to other practitioners.' I suggest that although our study findings are personal to Neil and me, reading what we have written about them may be useful for other trainees.



As Rogers (1961, p.26) writes:

I have almost invariably found that the very feeling which has seemed to me most private, most personal, and hence, most incomprehensible to others, has turned out to be an expression for which there is a resonance in many other people.

## **Our experience of the study**

### **Immersion: Phase 1**

Neil and I began our study by agreeing upon a recording method and time frame for our first phase of action within the immersion stage of our project. It was decided that we would write journal entries, recording the following, each time a learning experience arose:

a) What was learnt, b) what form the learning arose in (for example, a sudden insight, a gradual awareness etc.), c) what context the learning arose in (for example, during a session with a client, in supervision, whilst engaged in an activity unrelated to therapy etc.), and d) how the learning experience affected us. We intended to pay particular attention to our bodily and emotional reactions, our dreams, intuitive insights, images that arose and fleeting awarenesses, in an attempt to uncover implicit learning as it happened (Moustakas, 1990).

### **Immersion: Phase 2**

After the first action phase (a period of approximately 2 1/2 months) Neil and I met in order to read each other's journal entries, discuss whether the data we had generated portrayed our experiences as accurately as possible, reflect on our findings and to plan the next phase of action. I noted that it was interesting that Neil's journal entries focused almost exclusively on learning about himself, and it transpired that he thought that the journal entries were confined to this type of learning. I then explained that we were to record all learning in our journals.

Neil then pointed out that the recording method we had agreed on at the outset was restrictive to his flow in writing the journal entries. We therefore decided that subsequent entries would be written as one continuous whole and then summarised in terms of the four

headings we had agreed upon. Furthermore, we would add two more summary headings: e) what, if anything, has come up in the writing of the entry, and f) what, if any links can be made to learning in other professional areas (ie. has this learning arisen previously in training, supervision, personal therapy etc?)

#### **Immersion: Phases 3 and 4**

Our second action phase lasted approximately four months. During the meeting that followed, in reading Neil's journal entries, I became aware that he had recorded learning experiences that had happened in his outside life and may have impacted on his client work. I pointed out that our study focused on the learning that had occurred as a result of our client work, rather than outside life experiences, but noted that his phase 3 journal entries could possibly be usefully included in our study, anyway.

We agreed that Neil may have forgotten our focus because at the time he wrote his journal entries, he needed an outlet through which he could express some important thoughts and feelings. He agreed to focus on recoding the learning that arose from his client work during phase 5.

After reading my phase 3 journal entries, Neil noted that it was interesting to him that in one entry I had written, 'Writing this down and reading it back makes it seem less clear and more confusing...': For Neil, recording his learning experiences in writing had always helped him to clarify his thoughts. He and I discussed alternative ways of recording and expressing my learning experiences, and I noted that I had made several ceramic sculptures in order to explore my own experiences of working with one client. We agreed that if necessary, I should use clay and other art materials in order to express my learning experiences in the future.

In another entry, I noted that I seem to disclose more about myself to child clients than adult clients. I added that it had felt important to self-disclose in response to children's personal questions in order to help them to feel safe with me. Neil suggested that I might also feel safer to self-disclose with children than with adults, and I agreed that this may well be true.

### **Immersion: Phases 5 and 6**

The third action phase - phase 5 – lasted for a month. At the start of the meeting that followed, Neil and I reflected that we had learnt that client work is very different from skills training: clients may expect us to do all the work and/or be very difficult to engage with.

In one journal entry, I had reflected that I had re-learnt that I am nervous about meeting new people through my work with clients. Neil pointed out that actually I seem to be more nervous about meeting new adults than new children. This is true. After reading one of Neil's journal entries, in which he wrote about learning the importance of timing and learning not to interpret too quickly, I pointed out that he had written about these issues in an earlier journal entry as well.

### **Immersion: Phases 7 and 8**

The final action phase lasted for just under two months. Neil and I then met for the last time before we began the incubation stage of our study. After reading each other's latest journal entries, we commented on the themes that seemed to arise: According to Neil, my entries were all about relationships and endings, whilst it seemed to me that his were all about power and professionalism. Neil also noted that my entries seem more 'human' and 'emotional' than earlier entries. Perhaps my client work had led to this change, he wondered.

Finally, we both agreed that since we couldn't remember a lot of what we had written in our journals, we wanted to re-read them before we began incubating. We agreed to spend no more than two months incubating, and were happy to jump to the explication phase if no illumination arose.

### **Illumination**

Neil did not experience an illumination. In contrast, towards the end of the two month incubation period we had agreed upon, whilst on holiday in Brazil, I had a sudden realisation. I wrote the following notes in order to capture the experience:

Its early morning. I was woken up about an hour ago by a woman crying out a sentence over and over again in the corridor next to the room I'm staying in. I didn't understand what she was saying.

I couldn't get back to sleep, so I lay awake, thinking. My thoughts clambered over or melted into each other as they often do when I lie awake at night, thinking. I started thinking about my PhD, my viva, life after my doctoral studies... Then I thought about some ways in which I could be critical of my research, as Christine [one of my supervisors] had asked me to do.

A comment someone had made about my grounded theory study findings at a conference floated into my head: All the changes that my participants had reported seemed to be 'positive'. Her own research, on counsellors who had experienced vicarious traumatisation from their client work painted a different picture of the impact of clients on their therapists [Crowley, 2005]. I thought about my own client work and the learning that has arisen. Although the learning outcomes may be positive, the process has been both difficult and painful. Then suddenly the illumination came: I had focused so much on learning and change *outcomes* that my participants had told me about in my grounded theory study that I hadn't really heard how difficult and painful the learning *process* could be.

### **Explication and creative synthesis**

Neil and I met once again at the start of the explication stage of our study, to re-immers ourselves in the data that we had gathered. Between us, we had produced a total of 47 journal entries, many of which were one A4 page or more, in length. Using these entries, I wrote my individual portrait, as well as a composite depiction, and Neil wrote his own individual portrait and made an equal contribution to the creative synthesis. He was given the opportunity to read the composite depiction and suggest alterations, but decided not to make any.

Neil noted that he had particularly enjoyed working on our creative synthesis. I experienced the process of writing my individual portrait and the composite depiction as time-consuming, sometimes difficult and sometimes tedious. However, engaging in this writing was also a creative and rewarding. Making the creative synthesis felt quite joyful, and very creative.

## **Findings**

Moustakas (1990, p. 54) suggests that 'verbatim examples illustrating the collection of data' should be used in writing up the findings of a heuristic study. Many quotations taken directly from our learning journals were therefore included within the individual depictions, and these are presented in italics so that they stand out to the reader. (Some

of the quotations taken from my journals have been altered slightly, so that they are in the past, rather than present tense).

The depictions are also presented in a different font from the rest of the text, to indicate that they represent the voices of the research participants. However, no dates are shown so that the flow of the text is not interrupted.

## **The individual portraits**

### **My individual portrait: Sarah**

I am a trainee integrative counsellor, studying and working (voluntarily) in the South East of England. I work with both adult and child clients. I am female, age 29 at the time of writing, and I have backgrounds in both biology and education.

*I am aware that I have learnt a great deal from my client work, although I needed to record it, as it happens, in order to be able to remember most of it. Often I found it really difficult to motivate myself to write...or think about what I had learnt....I really had to force myself to think about and write about my learning...because...few sudden and exciting realisations occurred.*

*Sometimes my thoughts were clarified as I wrote them down. However, some experiences have been quite difficult to put into words...and writing my learning down and reading it back made it seem less clear and more confusing, whilst just simply feeling the learning had made it seem so obvious.* In these cases, I found it more useful to express myself through artwork.

From my client work so far, I have learnt more about my lack of confidence in some therapeutic encounters, and I have become more confident in my abilities as a counsellor. I have learnt more about therapy in general, about clients and about myself. I have also learnt that the process of counselling and the process of learning from it can be difficult, emotional and painful, but also very rewarding.

## **Confidence**

In the nine months that I have worked as a voluntary counsellor so far, I have consciously battled with a lack of confidence in my ability to be a good therapist.

*When I started, I couldn't help feeling as if there was something wrong with me. I didn't feel as if I came across as very confident during my first four sessions as a therapist.*

*I was nervous.*

*I questioned my abilities*

*and even whether my personal characteristics were suited to counselling.*

*I would judge my own counselling*

*according to the mood of the client:*

*if they seemed happier, then I had done well;*

*if they were not happier, I had not done well.*

*And when a client decided not to continue after only a few sessions, I felt awful – that it was my fault and that I was not good enough.*

As I continued to practice as a counsellor, through *gradual insights, sudden insights, quickly clearing hazy thoughts, thoughts, reflections, feelings, bodily sensations, and images*, I became more aware of and learnt more about this lack of confidence. I learnt by *talking to others, through writing, or by thinking to myself*; and this learning happened both *during and after counselling sessions, whilst riding my bike home, at home, and in supervision.*

*I have gained a greater understanding of the roots*

*of my lack of confidence in my abilities.*

And through my client work I have also learnt *to have faith in my own abilities.*

Working with one child client in particular

*Has given me a great deal of confidence in play therapy as well as in my abilities as a therapist.*

At this stage though, my newfound confidence is still very vulnerable.

*It still takes a while for me to form a solid relationship with a client perhaps because it takes a while for me to feel comfortable with them. But if and when I do feel that I have formed a good relationship, the experience boosts my confidence.*

## **Therapy**

I have learnt more about therapy in general from my client work:

*Whilst riding my bike one day,  
during a period of reflection on my work,  
I became aware that the standard time boundary of an hour  
protects both the client and counsellor from exhaustion.  
However, longer sessions may be useful.*

*On another occasion,  
after a client had missed an appointment,  
at home,  
and with associated feelings, bodily sensations and thoughts,  
I realised...how a regular session day and time is beneficial to clients.*

*After a session with a client,  
reflecting on the session whilst riding my bike home,  
I became aware that it is important to trust the client's process.*

*Yet in thinking about a first session,  
as I sat on a train,  
and thinking about a second session,  
after it had ended,  
whilst walking away,  
I realised that it may also sometimes be useful to be directive with clients.  
I later concluded that it is best to respond to the needs of each individual.*

*As a thought...which seemed to become clear gradually,  
both in a session and afterwards,  
I learnt about the value of self-development for counsellors.*

*And on two different occasions,  
I learnt to 'trust the process' in counselling.  
It seemed to just 'happen' with an adult client...  
and I'm amazed at the way in which children I have worked with  
just seem to do what they need to do.  
This learning arose as a thought which seemed to come gradually,  
as I wrote my notes after seeing a client,  
and as thoughts combined with memories,  
during a time when I sat and forced myself to think and write about my learning.*

*And as I sat and forced myself to think and write about my learning,  
I realised that for me, it feels important to be genuine...and open with clients.  
I have been able to become more genuine with clients  
as I have gained more confidence in what I am doing.*

### ***Myself***

*I have learnt more about myself through my work with clients.*

*One learning about myself arose as a sudden thought.  
I realised, as I was riding my bike,  
that I am willing to self-disclose a lot more with children than I am with adults.  
As Neil has pointed out, this may be because I feel safer  
with children than with adults.*

Another learning  
*About my counter-transference  
and its power  
arose in a session...as an awareness of my thoughts and feelings,  
and in thinking about it afterwards in supervision.*

### ***Challenging and gratifying aspects of counselling***

Both in and outside of sessions with clients, through a combination of *bodily sensations, thoughts, awareness of my feelings, and memories*, I have learnt that both counselling and learning from it can be difficult, emotional and painful. When experiencing and learning more about my lack of confidence in my abilities, for example, *I feel very uncomfortable...I also feel quite embarrassed.*

I have learnt that *working with clients can be hard work. And intense feelings can stay with the therapist long after the session has ended:*

*When I spent an hour with a client who has suffered several huge losses.  
It felt like a huge weight in the session, almost unbearable.  
Very painful.  
Overwhelming, numbing....  
Long after the session, I still felt a heavy tightness in my chest and throat  
...as well as a weighty sadness.  
And after making a mistake in a session,  
I felt really, really crap about what I had done.  
Overwhelmingly awful.  
And crap for the rest of the day and the next one.  
When my work with this client came to an end,  
After our last session, I cried a few tears on my way home.  
And later, at home, I felt quite sad.  
My chest felt heavy and my head hurt a little.*

*I have noticed that I seem to have 'taken on' more than I thought I would. Work with clients has stirred up a great deal of emotion in me:*

*I felt gutted about the client who had had to end our work together  
...hours after the final session had ended.  
And I felt really depressed...  
on a day I didn't see any clients,  
for no known reason;  
although a client I was seeing at the time  
had talked about feeling really low  
and unable to do anything.  
And a few days after working with someone expressing anger...  
I felt really angry and frustrated...*



*Although I have learnt that it can be incredibly difficult, it can also be very rewarding to do this work. It can feel really warm to be part of a relationship with a client, especially, I have found, with children... I feel really privileged to be a therapist.*

**My co-researcher's individual portrait: Neil**

I am currently practicing in the North East of England as a paid counsellor and also training in Existential psychotherapy. I am male, and 27 [at the time of writing].

Although I have learnt most from my work with clients during sessions, learning related to my client work has also arisen through the processes of writing session notes, writing in my learning journal, reading, personal therapy, and relaxing at home. This learning has emerged in the form of thoughts or awareness, often coupled with emotion and/or bodily reactions. It has sometimes arisen suddenly, and at other times it has appeared more gradually.

I have learnt that I cannot separate myself from the client's process. I am embedded in the work; in my experience of them and in their experience of them. About myself, I have learnt that I experience a form of 'time anxiety', and I realised this whilst writing journal entries after sessions with clients. I have learnt that my own experience of time may affect the client's progress if it is permeated with anxiety. I have also learnt that being 'right' or 'wrong' is a core concern for me and therefore a concern in my client work. This learning has arisen as a gradual awareness, again aided by the journal writing. It has helped to remind me of the ambiguity of things – as long as I practice ethically, there is really no 'right' and 'wrong' in therapy. Linked to this are my feelings of competence and confidence which change considerably depending on the client and the moment in therapy. Yet I have learnt that overall, mistakes in practice are not necessarily 'wrong', they can be opportunities for further awareness for both the practitioner and the client.

***Anxiety of Time/Time Anxiety***

For me, there is a feeling of time being something that encroaches on the therapeutic encounter. It makes itself known either during or after a session with a client. There is urgency in the work;

*...I brought her back to it continuously...frustrated at her unwillingness.*

Through the process of writing, I realised that

*My worry is that I'm impatient with patients...In pushing the client too soon, I pushed him away.*

*On a personal level I know I must slow down. I'm obsessed with time...*

And I now know that my anxiety of time impacts on my work under the guise of my being frustrated with the client's rejection of me:

*I...have been pissed off with this client because he was effectively rejecting my efforts to help.*

All of my experiences of time anxiety have become known to me during my writing, not during sessions with clients. Yet my practice has changed as a result of this knowledge, though not without relapse.

*I now focus more on the client's position...not to make quick analyses.*

### **Being Right**

In making mistakes with clients, I have learnt that I have held a conception that there is a way to 'do' counselling that does not involve mistakes, or at least that it is possible not to make mistakes. As a result of this conception, I have struggled with being genuine

*...it is impossible to live or work authentically as a person in a world...*

I also seemed to believe that there is a general truth or right place for clients to get to

*...my own desire to help the client see the truth.*

*Sometimes I'm quick to show clients that 'mirror of truth'...*

I realise now, as I write this piece, what I did not even seem to realise when writing the journal entries: Although I tend to feel anxious in the face of 'right' or 'wrong' in my client

work, mistakes are not 'wrong'; instead, they are opportunities that both my client and I can make use of.

### **Competence and Confidence**

In the beginning, I struggled to feel confident about my capacities as a therapist, and this affected my practice. While this relates to my anxiety of being right or wrong, it is more specifically linked to the way I am with clients, or the way I am seen by them.

*Was I qualified to handle this case? The client himself seemed to have doubts. Would I be compared to his previous therapist? How would I compare? Would I be good enough?*

*I feel pressurised by myself to produce results. I've become a problem-solver...in the face of failure...So, to narrow this down, I'm frightened of failing my patients/clients.*

In conjunction with this, I seem to have a confidence in my abilities.

*Thinking about my work, I'm conscious about how capable I've become...I'm rather amazed how I've acclimatised so quickly to the job.*

So there is a desultory feel to this, an obvious oscillating between feelings of competence/incompetence and confidence/doubt, which may be linked to experience:

*With one client I saw, perhaps a more experienced counsellor would have known to tread more cautiously...*

### **The composite depiction**

I have written the composite depiction, as a participant in the research, on behalf of Neil and myself, which is why it is presented in another font. It has been written for other trainee therapists, as I envisage that our peers will gain most from reading about the findings of our research.

As therapists, we cannot separate ourselves from the client's process. We are embedded in the therapeutic work; in our experience of our clients and in *their* experience of themselves. And so we learn as we practice.

As trainee therapists, we can perhaps learn as much from being with our clients as they can learn from being with us. We might learn from our work during sessions, whilst writing our case notes or whilst discussing our work in supervision. But the learning might also arise whilst we are engaged in other activities like relaxing at home or riding a bicycle.

As a result of talking to others, writing, or thinking, learning arises for us in the form of gradual insights, sudden insights, quickly clearing hazy thoughts, thoughts, reflections, feelings, bodily sensations, and/or images. If it is not recorded, though, our learning could disappear from our conscious awareness. And motivating ourselves to record it might be difficult.

Those that do decide to record their learning, perhaps by writing about it in a journal, might find that the process of writing helps to clarify their thoughts and deepen their learning. But writing about her/his learning could also make a trainee feel more muddled, and s/he may prefer to express learning experiences in the form of artwork instead.

From our client work we might learn more about therapy, about other people and about ourselves. One trainee therapist might, for example, learn more about the roots of her lack of confidence in her work, and as she continues to practice, her fragile confidence may blossom. Another trainee might learn about his tendency to feel anxious in the face of 'right' or 'wrong' in his client work. On reflection, though, he may realise that mistakes are not 'wrong'; instead, they are opportunities that both the client and therapist can make use of.

Both working as a therapist and learning from this work can be difficult and painful. A great deal of emotion can be stirred up. It can be hard work, and intense feelings can stay with the therapist long after a session has ended. But it can also be very rewarding to work with clients and worthwhile to learn from this work.

## **The creative synthesis**

The creative synthesis, which Neil and I produced together, is shown overleaf (figure 7). The synthesis contains many words and several images, representing various aspects of the learning that arose for us during the study. The tree, interconnected swirls and larger web symbolize the interrelated, multifaceted and complex nature of our learning, while the dangling spider and screaming face embody the difficulties and challenges that trainee therapists face as they learn. Neil added an image of part of a clock inside a web and a whirlwind to represent his time anxiety. Some of the words used have been written more than once, indicating that therapists may learn the same thing over and over again from their client work. Finally, the word 'process' (large and in capitals), appears twice because it represents both the therapeutic process and therapist's learning process.



Figure 7: Creative Synthesis

## **Chapter 5: Connections and Conclusions**

Education is therapeutic.  
Counselling is educational.  
Both, at best, touch us deeply  
and draw from us powers,  
skills and insights  
we never knew we had.

(Howard, 1996, p. 31).

## **Contributions**

### **My contribution to research methodology**

The studies presented in this thesis make use of research methodologies that have been adapted to suit a particular purpose. I have based the grounded theory study on Charmaz's (2000) constructivist grounded theory methodology, whilst also making use of some of the ideas of Glaser and Strauss (1968), Glaser (1978), Strauss (1987), Strauss and Corbin (1998) and Speedy (2005). I have also included an extra layer of comparison, in comparing two different groups of counsellors and psychotherapists. This has allowed me to identify similarities between the two groups, as well as potential differences. The differences found were then explored during the theoretical sampling study and within the literature review. This comparative grounded theory methodology may be used by other researchers who wish to find out more about the similarities and possible differences between two cohorts of participants.

I based my co-operative self-search inquiry (CSSI) on the heuristic methodology (Moustakas, 1990), but also made use of some of the principles of the co-operative inquiry methodology (Heron, 1996). Sela-Smith's (2002) warning that inclusion of co-researchers in heuristic inquiry may create a distraction from the researcher's internal process was also

taken into account, so that dialogue between myself and my co-researcher was combined with periods of individual data collection, during which time we were not in contact.

West (1998a) points out that counsellors are familiar with using ‘the self’ in their work and that heuristic inquiry is therefore congruent with counselling. I suggest that counsellors are also familiar with working co-operatively with their clients, and a research methodology like CSSI, which is based on both the heuristic and co-operative inquiry methodologies, may be of particular interest to practitioner-researchers.

### **My contribution to the literature**

In writing about what she has learnt from Kottler and Carlson’s (2005) book, in which twenty four therapists describe the ways in which they have changed as a result of their work with clients, Halunka (2005, p. 213) notes that ‘Every theory of psychotherapy includes a theory of how change takes place in the client’. She adds, ‘I have yet to read about the changes that a therapist may experience’ (*ibid.*). This may be because relatively few books and papers have focused on therapist learning and change. (Some that have include, Kottler and Blau, 1989; Dryden, 1992a; Seibold and Avants 1999; Goldfried, 2001 and Kottler and Carlson, 2005). Yet as McLeod, (1990, p. 79) points out, ‘compared with much research which is...published in journals, research into counsellor experience may well be more accessible, applicable and relevant to practitioners...[and] useful for supervisors and trainers...’

The findings of my grounded theory study fulfil one of the aims of my research by providing an insight into the ways in which counsellors and psychotherapists might learn and change as a result their client work: They could become more confident, open, accepting, humble, aware, and compassionate, as well as more trusting of the feelings, thoughts and images that appear to them. They may be inspired, and might gain increased self-awareness and self-acceptance through their work. In terms of professional development, they may learn to sometimes simply stay with their and the client’s



discomfort, or simply acknowledge their client's feelings and actions. Conversely, they could also learn to challenge their clients more or to take more risks. In addition, they might learn about the importance of humour in therapy, about the usefulness and/or constraints of theory and models in their work, and the value of 'being human' with clients.

As well as finding out about the ways in which counsellors and psychotherapists learn and change as a result of their work with clients, at the start of my doctoral studies, I also aimed to find out if working with clients infected with HIV impacts on therapists in any unique way. I am now able to conclude that it seems as if working with these clients does not affect practitioners in any unique way.

The findings of my first phase study suggested that therapists who have significant experiences of working with clients with HIV may be more likely to address their own death and, in some circumstances, work within more flexible boundaries than those therapists who do not work with this client group. The literature review, however, indicated that therapists may address their own death when working with elderly clients, bereaved clients, clients with cancer and those who have spent time in intensive care. In line with the literature review, the findings of the theoretical sampling study also showed that flexible boundaries are used in a variety of circumstances, and with a variety of clients.

Webb (1997, p. 185) suggests that 'there is an urgent need for research into the nature of boundary dynamics and violations...'. The findings of my theoretical sampling study indicate that although therapists might view their use of flexible boundaries in terms of being responsive to the needs of their clients, their use of flexible boundaries can give rise to both positive and negative effects in terms of client work. Counsellors and psychotherapists might be flexible in terms of payment, length of sessions, frequency of sessions, the date and times of each session, intrusions in the therapy, conducting the therapy with another sentient being in the room, the use of touch, conducting therapy outside of a therapy room, allowing clients to contact the therapist outside of therapy

sessions, giving clients wedding gifts, doing coaching instead of counselling, and seating arrangements.

In answer to my research question concerning the factors that therapists perceive are involved in the learning and change processes that they experience, the findings of the grounded theory study suggest that therapists can learn *with*, as well as *from* their clients, by consciously reflecting on their work, or as part of a process that occurs outside of their conscious awareness. Perhaps as a result of the unconscious learning processes that might take place, the learning catalysed by one therapeutic relationship may be difficult to untangle from learning catalysed by another relationship or another experience altogether, and the effects of learning experiences may be unclear to a therapist.

However, discussion with colleagues can consolidate the learning that arises for counsellors and psychotherapists as a consequence of their client work, and re-learning may be an important part of the process. Learning from client work may be a gradual process, even if it begins in a very dramatic and disorienting way, and as long as therapists continue to work with clients, their learning is likely to continue. This learning might lead to changes in therapists' work with other clients, and it could also impact on other areas of their work, such as teaching, or on their outside life. (Therapists' outside life experiences may, in turn, impact on their work.) Difficult aspects of their work, such as its intense nature, might also impact on therapists' learning and change experiences.

My grounded theory study findings also indicate that counsellors and psychotherapists are able to reflect on and learn from their work as a result of being interviewed. In addition, they may learn from and change as a result of their training and teaching experiences, their own personal therapy, supervision and supervising, reading, and observation of and discussions with their colleagues, as well as from their client work.

The findings of my co-operative self-study inquiry gives a more in depth account of processes involved in the learning that therapists experience as a result of their client work: The forms in which learning may arise include thoughts (which may at first be hazy),

gradual or sudden insights, reflections, feelings, bodily sensations, and images. In terms of the contexts in which this learning can arise, therapists might learn during sessions with clients, whilst writing case notes, whilst discussing their work with a supervisor, or whilst engaged in activities not related to their work, such as relaxing at home or riding a bicycle.

In line with the grounded theory study findings, it was found that learning linked to client work can arise as a result of talking to others. It may also occur whilst thinking or writing. Writing down what has been learnt can prevent it from disappearing from conscious awareness and can help clarify and deepen the learning. However, some therapists may find it more helpful to express their learning in other ways, such as through artwork.

As detailed above, the grounded theory study findings suggest that trained counsellors and psychotherapists could become more confident as they continue to work with clients. In agreement, my co-operative self-study inquiry findings indicate that trainee therapists may also become more confident as a result of their work with clients.

Trainees may also learn more about themselves, other people and therapy in general (including, for example, about ‘right’ and ‘wrong’ in therapy) through their work with clients. And they might learn that this work can be both difficult and painful, and rewarding and worthwhile.

## **Links to the Literature**

### **Links to some of the literature on education and learning**

While teachers create environments in which learners may experience and learn from their experience, the teacher may also learn in this environment (Boud, Cohen and Walker, 1993). As Andresen (1993, p. 63) writes, ‘When I cease learning more each time I teach, I am in danger of tiring of teaching itself’. The findings of the studies presented in this thesis indicate that the same may be true of therapy: Both the therapist and client can learn and change as a result of their work. What is more, the experience of their work as difficult and painful, yet rewarding and worthwhile may be part of the learning process, as well as an outcome, for counsellors and psychotherapists. As Boud, Cohen and Walker (1993, p. 13) point out, ‘all learning involves feelings and emotions’.

McConnell-Imbriotis (2004, p. 1) suggests that ‘...adult learning happens everywhere’. As the findings of the studies presented in this thesis show, it arises for therapists, as a result of their client work, in a variety of contexts. This learning may be positioned at the informal end of the learning continuum, as it occurs outside a classroom context and may take place with or without the conscious awareness of the learner (Jeffs and Smilt, 1996; Knapper and Cropley, 1991). I suggest that it may be implicit, since it can arise without any conscious attempts to learn (Reber, 1995), or reactive, because although the learner may be aware that learning is occurring, this learning is unplanned. (Eraut, 2000).

Therapists’ learning could be described as practical (therapists can learn about alternative ways of working, such as being more ‘human’ with clients), presentational (therapists can learn as a result of sudden insights and images), or propositional (therapists learn more about themselves and others) (Heron, 1992). It may also be described as experiential (*ibid.*), since it occurs for therapists as a result of their experience of working with clients.

As detailed above, this learning may lead to an increase in confidence. Yet a certain amount of confidence may be required at the start: Boud, Cohen and Walker (1993, pp. 15-16) argue that ‘Developing confidence and building self-esteem both flow from, and are necessary for, learning from experience’.

Polyani (1966) conceptualises learning in terms of making use of knowledge, and this idea can be applied to the learning that counsellors and psychotherapists experience as a result of their client work: This learning might lead to changes in the therapists’ work with other clients, and it could also impact on other areas of their work, such as teaching, or on their outside life.

However, the learning described within this thesis does not fit neatly into Cranton’s (1994) three-part typology of adult learning, which includes ‘subject-oriented adult learning’, ‘consumer-oriented adult learning’ and ‘emancipatory learning’. The pace of the learning is likely to be determined by the therapist, as with ‘consumer-oriented adult learning’, yet the learning requirement is not determined by the therapist at the outset. It is similar to ‘emancipatory learning’ in that it may occur independently of a formal educator, and may be a difficult experience for the learner, but unlike ‘emancipatory learning’ the outcome is

not necessarily freedom ‘from forces that limit our options and our control over our lives’ (Cranton, 1994, p. 16).

Illeris’s (2004) definition of adult learning is perhaps more fitting. He suggests that adult learning is the way in which adults make permanent changes in their emotional, social, rational and bodily capacities, with or without formal adult education. My findings suggest that learning from client work might lead to changes in the emotional capacities of therapists (for example, they may learn to sometimes simply stay with their and the client’s discomfort). Changes in therapists’ social capacities (in terms of increases in humility and compassion, for example), rational capacities (for example, they may gain an increase in self-awareness) and bodily capacities (through perhaps learning to trust the thoughts, feelings and images that appear to them) may also occur.

As my grounded theory study findings show, therapist learning may occur outside of their conscious awareness and the effects of learning experiences may be unclear to a therapist. Counsellors and psychotherapists therefore ‘know more than..[they] can tell’ (Polanyi, 1969, p. 133). As well as using this tacit knowledge in their work, Schon (1995) suggests that therapists may reflect-in-practice (think about what they do as they do it), which results in new ways of working. This may be the one of the ways in which therapist learning gives rise to change.

### **Links to some of the literature on transformative learning**

At the outset of my PhD, I aimed to discover whether the theory of transformative learning can be usefully applied to the learning and change experiences that counsellors and psychotherapists gain as a consequence of their client work. Since this theory is still ‘in the process of development’ (Mezirow 2004, p. 70), and there is little agreement about what it actually is, I am not able to come to any final conclusions here. However, my research findings may usefully add to the debate about transformative learning.

In linking my research findings to the literature on transformative learning, I have also made reference to the terms ‘personal development’, ‘self-development’ and ‘personal growth’, as these terms are most commonly used to describe change within the fields of counselling and psychotherapy.

Taylor (1997, p. 53) argues that:

It is through relationships that learners develop the necessary openness and confidence to deal with learning on an affective level, which is essential for managing the threatening and emotionally charged nature of a transformative learning experience. Without the medium of relationships, critical reflection is impotent and hollow, lacking the genuine discourse necessary for thoughtful and in-depth reflection.

More succinctly, Daloz (2000, p. 115) writes, ‘we develop through relationships’. In educational contexts, learners may change through their relationships with their teachers (Cranton, 1994), and in therapy, clients change as a result of their relationships with their counsellors and psychotherapists (Clarkson, 2003).

Cranton (1994) argues that if they wish to encourage it in their pupils, adult educators should work towards their own transformative learning; and in a chapter devoted to the subject of transformative learning in educators, she describes how this can be achieved. Similarly, continued personal and professional development is encouraged for therapists: if they wish to help clients to change, they must experience change themselves. However, the grounded theory study detailed within this thesis indicates that through the mutually beneficial relationships they form with their clients, therapists may change anyway. Whether the changes that the therapists experience can be called ‘transformative learning’, however, remains unclear.

Although personal development is often referred to in terms of gaining increased self-knowledge, Williams and Irving (1996), suggest that it is more than an increase in self-knowledge: it involves a change in a person’s way of being. It has been suggested that transformative learning also involves a change in thinking: Kasl and Elias (2000, p.233) points out that transformative learning ‘is the expansion of consciousness in any human system’, which is characterised by the formation of new perceptions. Similarly, Keegan

(2000) argues that it refers to a change in a person's way of thinking, rather than just a change in confidence levels, behaviour or knowledge.

My research findings suggest that a consequence of their work with clients, therapists may experience personal development: They might gain knowledge (they can become more aware and self-aware, for example) and confidence, and their behaviour may change (they may become more challenging, or take more risks). However, since therapists may also become more open, accepting (including self-accepting), humble and compassionate, as a result of their client work, it may be argued that their thinking can change and they can form new perceptions through the work they do. Put more simply, transformative learning might also occur.

A recent definition of transformative learning provided by Mezirow (2000, p. 7-8) suggests that it is 'the process by which we transform our taken-for-granted...mind sets...to make them more inclusive, discriminating, open, emotionally capable of change, and reflective'. In becoming more accepting as a result of their client work, I suggest that therapists become more inclusive. In learning about the usefulness and/or constraints of theory and models in their work, for example, it may be argued that they become more discriminating. They may also become more open, and change, both personally and professionally, as a result of their experiences with clients.

While his 2000 definition of transformative learning includes the ability to be more reflective as an *outcome*, Mezirow's (1981) 10 stage model of perspective transformation focuses on self-reflection (stage 2) as a necessary *part* of the process of transformation. Mearns's (1997a) 3 step model of self-development also seems to rely on self-reflection, since the first two steps are 'awareness of a self-development need' and 'understanding of that need'. Although the findings of my grounded theory study indicated some of the participants felt that they learn by reflecting, one felt that she has learnt to reflect less as a result of her work. In addition, some felt that their learning seemed to have occurred outside of their conscious awareness, where conscious reflection does not occur.

My CSSI study indicates that therapist learning may arise as a result of reflection, but it can also arise as a result of gradual or sudden insights, feelings, bodily sensations, and images. Neither Mearns's (1997a) 3 step model of self-development, nor Mezirow's

(1981) ten stage model of perspective transformation can therefore be usefully applied to my research findings. However, both my grounded theory study and my CSSI study also indicate that counsellors and psychotherapists are able to reflect on and learn from their work as a result of talking to others. This talking could, in some cases, be similar to the rational discourse that Mezirow (1991a) has suggested gives rise to critical reflection.

Mezirow's (1981) 10 stage model of perspective transformation begins with a 'disorienting dilemma'. Similarly, my grounded theory study findings suggest that learning can begin in a very dramatic and disorienting way. However, in line with Clark's (1993), Scott's (1991) and Lange's (2004) criticisms of Mezirow (1981), my findings indicate that learning from client work does not always begin in such a remarkable way.

Taylor (1997) points out that in contrast to Mezirow's (1981) linear model of perspective transformation, some studies have found the process to be 'more recursive, evolving and spiralling in nature' (*op. cit.*, p. 44). Mezirow himself later admitted that the course of perspective transformation does not always follow his sequence (Mezirow, 1985).

Likewise, Daloz (1987) has suggested that personal development does not happen in a gradual, linear way. The findings of my grounded theory study suggest that for therapists, learning from their client work may seem to be a gradual process. However, I found no evidence to suggest that it is a linear process.

Taylor (1997) points out that it has been shown that emotion, the unconscious, intuition, spiritual influences, and relationships are significant in transformative learning. Mezirow ignores these factors in his earlier work, but refers to all but spiritual influences in a more recently published book (Mezirow, 2000). With regard to relationships, Courtenay *et al.* (1998, p. 79) write about the 'important role that others play in transformational learning'. My research focuses on the learning and change that arises through a relationship: the relationship that a therapist forms with her clients. As mentioned above, the findings suggest that the unconscious might play a role in this learning.

Emotion may also be important in therapists' learning, as well as in their personal development: My CSSI findings show that trainee therapists might learn that their work



can be both difficult and painful and rewarding and worthwhile through engaging in this work. Engagement in an activity that leads to personal development may stimulate emotion (Donati and Watts, 2005). In line with Taylor (1997 and Mezirow, 2000), the CSSI also shows that therapist learning may arise in the form of gradual or sudden insights, feelings, bodily sensations, and images, some or all of which may be conceptualised as intuition. My findings make no mention of spiritual influences but this may be because I have not conceptualised the data in this way. According to Miller (2002), learning from a spiritual perspective involves our whole selves, as well as unlearning and letting go. My findings are not in conflict with this idea.

## Limitations

The studies presented in this thesis are limited in a number of ways. As Miles and Huberman (1994, p. 11) point out, 'Final conclusions may not appear until the data collection is over...but they have often been prefigured from the beginning, even when a researcher claims to have been proceeding 'inductively''.

I did not hope for any particular research outcomes at the start of my doctoral studies, but I did have some ideas about what my research findings might be. In retrospect, I see that these ideas were perhaps linked to my own interests in the topics of sexuality, death and confidence.

As detailed in chapter 1, I noted in my research journal that I thought that therapists who had worked with HIV positive clients might have had to face and become accepting of both issues around sexuality and death. I am personally interested in both of these topics. Tom, one of my grounded theory participants noted that 'I think that sex and death is what therapy is about'. For me, as someone with a background in biology, sex and death are what physical life is also about.

Interestingly, only death was mentioned by my participants: During my phase one study, four therapists who had worked with clients with HIV reported addressing their own death, and seven noted that they had faced death in general and were more able to be with death in others, as a consequence of their client work. However, my literature review later

indicated that practitioners working with elderly clients, bereaved clients, terminally ill clients and those in intensive care might also be reminded of their own mortality.

At the start of my doctoral studies, I also noted that I thought that therapists in both of the two cohorts that I would interview might have gained confidence and be more approachable and comfortable with themselves as a result of their work with clients. The topic of confidence has been of relevance for me for many years, as detailed in a later section of this chapter, and my findings reflect this. During my phase one study, thirteen of the thirty-nine participants said that they had become more confident, four noted that they had become more open, and six reported that they had become more self-accepting. In addition, during the phase three study, Neil and I found that confidence in our abilities as therapists was an important issue for each of us.

Like my initial ideas about possible research outcomes, my experiences of education, learning and transformative learning, may have influenced my choice of research topic, and also my findings. As stated in chapter one, in the role of a tutor, I believe that I learn with the people I teach, and through the relationships we form together. Similarly, the findings of the studies presented in this thesis suggest that therapists can learn and change through their relationships with their clients.

In writing about my teaching and learning experiences, in chapter one, I also noted that what I learnt at school and university, as well as whilst traveling, seems to be linked to emotion. It is perhaps not surprising, then, that during the CSSI I became aware that engaging in therapeutic work and learning from this can be emotional: I observed that it is difficult and painful, yet rewarding and worthwhile.

In a section on my own experience of what I believe to be transformative learning, in chapter one, I noted that I experienced some but not all of Mezirow's (1981) ten step model. For example, I did not experience a conscious 'critical assessment of assumptions

(step three), but I am aware, in retrospect, that my assumptions have changed significantly. Unsurprisingly, perhaps, the findings of my research studies do not support Mezirow's (*ibid.*) ten step model, and, like me, the phase one study findings indicated that some participants felt that some of their learning seemed to have occurred outside of their conscious awareness.

With regard to my grounded theory study, all interviews were an hour or less, and each participant was interviewed only once. The interview data obtained for each participant is not, then, a full and complete representation of their perceptions of their learning and change experiences. Follow-up interviews would have no doubt led to further useful data, and 'the conversations...might have continued indefinitely' (West, 1996, p. xi). Furthermore, since many of the participant therapists will no doubt continue to learn and change as a result of their ongoing client work, interviews with them simply provided 'stories and speculations without endings' (*ibid.*)

My nervousness and lack of experience at interviewing led to a number of problems which also limit my findings: I was, at first, not able to fully concentrate on what the participants said, and as a result, I sometimes wasn't able to ask good follow-up questions, leading to 'holes' in the transcripts. In addition, I wasn't as able to put some participants at ease as I would have like to have been, and they may have replied to my questions with more guarded answers in response to my questions than I had hoped for.

Kvale (1996, p. 50) points out that, 'The transcribed interview text renders an incomplete account of the wealth of meanings expressed in the lived interview situation'. Transcripts are therefore not objective records. In carrying out a constructivist grounded theory study, I acknowledge that I had an effect on the study, during the transcription and other stages. As Maggie, one of my phase one participants said, 'When you're dealing with people, one can, as a researcher, only report one's own interpretation of what is found on the day'. However, she added, 'This is not to undervalue interpretative findings. I believe all science is about interpretative and invariably temporary findings' (Maggie, 2004).

In an attempt to address the confirmability of my grounded theory research, I sent their interview transcripts to my participants. Eighteen of the thirty-nine phase one participants responded to this communication, but only four asked me to make changes to their transcripts. Of the four theoretical sampling study participants that I sent transcripts to, three replied, and one asked for changes to be made. I cannot tell whether the twenty-two counsellors and psychotherapists who did not respond to my communication were satisfied with the way that they had been portrayed in their transcripts.

In addition, only twelve out of the forty-three participants that took part in my grounded theory study responded to a communication in which I attached a draft of my findings. All were happy with the way that they were portrayed, but I do not know how the remaining thirty-one therapists feel about the way in which I have used quotations taken from their transcripts.

Since I was only able to find four therapists who were willing to be interviewed about the two very specific and challenging topics that my theoretical sampling study focused on, the findings of the theoretical sampling should perhaps be viewed ‘at a more intuitive, impressionistic level than [findings produced using a more] objectivist approach’ to grounded theory (Charmaz, 2000, p. 526).

With reference to the model of therapist change that arose from my grounded theory study, this is ‘a general map and will not always apply to the particular individual’ (Page, 1999, p. 34). It is not, and cannot be representative of each of the participant’s experiences. As van Manen (1997, p. xii) puts it, ‘Is each of our experiences not unique, even though we may use the same words to describe those experiences?’ In addition, it may not make mention of many learning and change experiences that other therapists, not interviewed as part of my study, could articulate.

The findings of the co-operative self-study are limited because the study focuses on only two trainees. As one of these trainees, I was aware of the grounded theory study findings,

so may have been influenced by these. Although Neil was not aware of these findings, he may have become indirectly influenced, through our discussions. Furthermore, data collection could have continued after the nine month period, Neil and I continued to practice and therefore continued to learn. ‘The ideas presented [within chapter 4]...must [therefore] be viewed as changing and developing over time, not as static entities’ (Laverty, 2003, p. 3).

The studies in the thesis attempt to describe learning and change experiences. Yet, as van Manen, (1997, p. xii) says, ‘I can never fully give an account of what I experience in a particular moment or place. What belongs to my inner life seems quite beyond words’. He adds, ‘...experience is always more immediate, more enigmatic, more complex, more ambiguous than any description can do justice to (van Manen, 1997, p. xvii).’, ‘The truth is that we can never capture experience’ (Ellis and Bochner, 2000, p. 750), and I have probably not been able to capture it fully within this thesis.

In line with Rogers (1961, p. 61), I conclude that:

It should of course be added that this knowledge, like all scientific knowledge, is tentative and surely incomplete, and is certain to be modified, contradicted in part, and supplemented by the painstaking work of the future. Nevertheless there is no reason to be apologetic for the small but hard-won knowledge which we currently possess.

## **Recommendations**

Further studies could be carried out to complement and add to the findings of the studies presented in this thesis. The list of areas in which boundary flexibility might occur in counselling and psychotherapy identified by my theoretical sampling study is no doubt incomplete, and further research carried may uncover other areas. Future research is also needed in order to elucidate potential links between positive and negative effects of the use of boundary flexibility on client work, and area of flexibility, client characteristics, therapist characteristics, and other factors.

The theoretical sampling study could be expanded to include several therapists who have worked with dying or bereaved clients and have addressed their own death as a consequence of this experience. In addition, a CSSI that makes use of data collected over a number of years and from a number of trainee therapists would add depth to the findings of the CSSI study presented in this thesis.

Links between client learning and change and transformative learning might also be explored with the use of an empirical study, and this could include child and adolescent clients as well as adults. Research could also be carried out on the learning and change that takes place in pairs of therapists and clients, over a period of time. What is more, the therapists interviewed as part of my grounded theory study could be interviewed again at one or more points in the future to clarify whether the learning and changes that they talked to me about had stayed with them. Courtenay *et al.* (2000) and Baumgartner (2002) participants with HIV were found to have undergone irreversible transformations, and the same may be true for the grounded theory participants.

## **Implications for Practice, Supervision and Training**

One of my research questions focused on the implications of my research findings for improved practice, training and supervision. Feltham (1999, p. 184) argues that

If clients value most highly the simple components of acceptance, being listened to, being believed, having someone interested in them, and so on...and many practitioners in retrospect value most highly what they have learned from their actual work with clients and from reflecting on it in formative supervision...then why do we not make these our areas of focus, instead of the many arcane or far-fetched theories we espouse in training?

The findings of the research studies presented in this thesis are of relevance to one of Feltham's (1999) areas of focus: the learning and change that therapists experience as a result of their work. It seems unlikely that they could replace the theories that are taught in training, but I suggest that they could be used by counsellors and psychotherapists, alongside their chosen theoretical orientations, for professional development purposes.

My findings may also be of special relevance to trainees, and could be included as part of training courses. As Carlson (2005, p. 212) points out,

Maybe we need to talk more about therapist change in our training programs. Maybe this needs to be highlighted...rather than exploiting clients through their personal changes...the therapist's change...[is] in the best interest of the client. It [is] the therapist's change that [makes] it possible for the client to change...Denying the existence of this mutual change would seem to be unprofessional, if not a distortion of reality. Therapists need to accept the fact that change is reciprocal, and is healthy as long as it is not harming our clients.

Bondi (2006, p. 46) suggests that research findings should be seen as ideas to be 'put out there for others to use in unexpected ways'. Providing a list of ways in which my research findings could be applied in training and supervision may therefore be unhelpful, and may prevent them being used in other ways. Yet sharing my research findings with trainees and practitioners who have little or no understanding of research methodologies may also be problematic.

I have avoided writing this section for some time, as I struggled with the knowledge that the research-practice gap in the fields of counselling and psychotherapy will have an impact on the ways in which my research findings may be used. Whilst engaged in this struggle, I wrote the following, (Turner, 2006c), which I titled 'But does research really matter?':

You don't have to be a researcher to find the studies [presented in the September 2006 special issue of the *Counselling and Psychotherapy Journal* (CPR): *Technology in Therapy*] informative to your practice', Terry Hanley, one of the guest editors of that issue, pointed out in the September issue of *Therapy Today* (September 2006, p. 47). Perhaps not. But I suggest that you do at least have to have had an adequate social science research training in order to read the papers critically and therefore make an informed choice about what is relevant to your practice.

Although the BACP are attempting to rectify the situation, sadly, many counselling and psychotherapy training courses do not currently include an adequate research training. For example, my (otherwise fantastic) diploma in Integrative Counselling has not, so far, provided me with any research training at all. A two hour scheduled session, part of which was on 'the place and value of research in counselling', was cancelled at the end of my first year and replaced with a (very useful) session on grief and loss. Another session on research in counselling is scheduled into the course timetable for later this year. *If* it goes ahead, I will have had a total of about two hours of research training within a 450 hours of professional counselling training. Hardly enough training to spark an interest in quickly flicking through a copy of CPR, let alone enough to be able to read the journal critically.

The theme for the 2007 BACP annual research conference is 'Research Matters'. But does it really matter to those trainees and practitioners that have little or no research training? Do they ever try to read the articles published in CPR? If not, they will have missed some interesting articles. With regard to the most recent (September 2006) edition, I was particularly interested in reading West and Hanley's discussion of a failed research project, and their 'message that...it is okay to get it wrong and failure does not need to be shuffled under the carpet' (West and Hanley, 2006, p. 24). Honesty about research failure, they suggest, 'may help researchers to remain humble enough to learn from...mistakes' (*ibid.*)

As a PhD student, currently working on a thesis titled 'Changed by the encounter: the learning and change that counsellors and psychotherapists experience as a result of their client work', West and Hanley's (2006) message is particularly relevant to me. Although none of my research studies have failed, I have made some mistakes in carrying them out. And making these mistakes has been a difficult but important part of my learning. Similarly, practitioner's mistakes, if they are not 'shuffled under the carpet', can become important learnings. West and Hanley's (2006) message echoes my own research findings: I recently completed a piece of research in which I studied the learning and change that a co-researcher and I experienced as a result of our client work over a period of nine months.

In his write-up, my co-researcher noted:

I have learnt that overall, mistakes in practice cannot be mistakes, only opportunities for further awareness for both the practitioner and the client (Neil, 2006).

But the question remains: Does research really matter? And more specifically for me, does my PhD research really matter? Perhaps not, if trainees and practitioners don't read what I have written about it.

My research has been beneficial to me (see the final section within this chapter), and this outcome has, for me, made my doctoral studies worthwhile. Yet my research findings could also be of use to others travelling 'along the sometimes bumpy road to counsellor growth' (Lent *et. al.* 2006).

With the limitations of my research in mind, trainers working with diploma level trainees could use figures 4 and 5, which together provide a model of therapist learning and change, in facilitating a session on therapist learning and change. These figures could be used in combination with the writings of Goldfried (2001), and Kottler and Carlson (2005) amongst others, along with a cautionary note in line with that of Heron (1992, p. 222): 'the models shown here are like lenses which give a selective view. There are other lenses with other views. And those that are practical prescriptions are only an invitation to further inquiry'.



The findings of my CSSI indicate that the learning that counsellors and psychotherapists experience as a result of their client work might disappear from their conscious awareness if it is not recorded. If it is recorded in writing, the process of writing might clarify and deepen the learning. In addition, the findings of my grounded theory study indicate that therapists can learn through discussion with others. Trainers and supervisors might therefore wish to encourage trainees and practitioners to record what they learn as a consequence of their client work, as it arises, so that it can be discussed with others during time set aside for this purpose.

Royle (2006, p. 25) notes that in the training of therapists, there is a ‘lack of preparation for the emotional effects of the work when starting out...We need to learn how to keep ourselves safe and well, just as much as we need to learn about counter-transference or the core conditions’. The findings of my grounded theory study, in terms of the difficult aspects of counselling and psychotherapy that the participants brought to light, may therefore be of interest to trainees. Some of the challenging aspects of counselling are also highlighted in the individual portrait I wrote as part of my CSSI.

In addition, my grounded theory study indicates that counsellors and psychotherapists are able to reflect on and learn from their work as a result of being interviewed about their learning and change experiences. Supervisors might therefore question their supervisees about their learning and change on, perhaps, an annual basis, and then spend time discussing the themes that arise and any relevant changes to practice that can be made.

## **The Impact of the Research on the Researcher**

Wosket (1999, p. 70) writes, ‘A belief I hold strongly is that qualitative research, at its best, can provide a positive and growthful learning experience for the respondent(s) as well as for the researcher’. Ellis and Bochner (2000, p. 746) add, ‘Why should we be ashamed

if our work has therapeutic or personal value?’ I suggest that researchers should not only not be ashamed if their work has therapeutic or personal value, they should also view this as an important outcome of the research, especially if they also work as practitioners. My view is in line with Ellis and Bochner (2000), who add, ‘You might also judge [the] validity [of a study] by whether it...offers a way to improve the lives of participants and readers or even your own’ (*op. cit.*, p. 746).

Lincoln and Guba’s (1985) parallel trustworthiness criteria include ‘ontological authenticity’ (the improvement and expansion of participant’s understandings), ‘educative authenticity’ (the enhancement of participant’s knowledge of the understandings of others), ‘catalytic authenticity’ (action that is stimulated by the research) and ‘tactical authenticity’ (the extent to which research empowers action). Although these focus on participants, they could, and perhaps also should, be applied to researchers.

Clarkson notes that her PhD research into therapeutic relationships ‘was furthermore itself conceptualised as relationship’ (Clarkson, 2003, p. 334). Similarly, in working on this thesis on therapists’ learning and change, as a trainee counsellor and researcher, and as a person, I have also learnt a great deal: My understandings of research methodologies and methods and of the topic of therapist learning and change have improved and expanded, and I have learnt more about myself and other people. As van Manen (1997, p. 163) puts it, ‘...research is often itself a form of deep learning, leading to a transformation of consciousness...’.

I have also changed. For me, in line with Lincoln and Guba’s (1985) ‘catalytic authenticity’ criterion, the action that has arisen as a result of my research is linked to the confidence I have gained during my doctoral studies. I have attempted to include reflexive pieces of writing throughout this thesis. Since ‘reflexivity is about how the research impacts on the researcher as well’ (Jeremy, quoted in Etherington 2004d, p. 204), I have included a description of the ways in which I have learnt and changed as a result of my research, below.

## **The grounded theory study**

Van Manen (1997, p. 126) notes that in interpretive research, 'writing is closely fused into the research activity and reflection itself'. He adds that 'the writer produces text, and he or she produces more than text. The writer produces himself or herself' (*ibid.*). During my grounded theory study, I kept a journal in which I recorded my own learning and change, whenever I noticed it. About a year and a half into my doctoral studies, I wrote my first entry, and in the act of writing that entry, I became aware of the extent of the impact that interviewing counsellors and psychotherapists for my grounded theory study had had on me:

Since giving up a PhD in Biology over 4 years ago, I have, until quite recently, felt that gaining a PhD would be the only way to gain confidence in my skills and abilities. I felt that the day I was awarded a PhD would be the day I became confident - the PhD would be proof of my abilities. It was a case of jumping over a hurdle, landing safely on the other side and living happily ever after. I am starting to become aware, however, that the process of doing a PhD is helping me to gain a greater self-confidence. And now, amazingly, the process is becoming more important to me than the outcome for me.

I have recently become painfully aware that my lack of confidence leads to an inability to express myself verbally - I lose words...I speak too quietly...I can't look at anyone, I feel stupid, I lose more words...and the topic of conversation becomes an incomprehensible fog inside my head. I feel embarrassed and as soon as I can, I flee the situation. I now realise that I have inextricably linked intelligence and ability with language skills. I have labelled myself as 'unintelligent' or 'not as intelligent as some', and, feeling embarrassed I have buried my feelings about this.

I have considered myself very lucky to be funded to do a PhD, and perhaps unworthy of that funding. I have considered my qualifications to be an indication of hard work, rather than innate intelligence and have avoided telling people I meet about my academic background or current studies, assuming that I could not meet their expectations of an 'intelligent person' if I did.

Perhaps inspired by the therapists I have interviewed, many of whom have been very honest with me about their weaknesses and failures, as well as their strengths and successes, I recently decided to be honest about my feelings of intellectual inadequacy. I first told my Mum, who was very understanding, but pointed out that I was expressing myself very well as I was talking to her. My honesty led to the realisation that when I am comfortable with another person I can express myself - it is only when I feel intellectually intimidated that I lose words and the self-respect that appears to be superglued to them.

Then I took a bigger risk: I told my Gestalt personal development group (consisting of mostly qualified and practicing counsellors and facilitated by two very experienced and articulate women with PhD's) that I was there to gain self-confidence and that I often lose words. I spoke to the floor, and I noticed seemingly huge gaps, silences, in my speech. And I lost words. And I felt embarrassed. But when I looked up I saw ten friendly, concerned faces. No judgement, and no ridicule, as I had perhaps expected. Perhaps most importantly, I was given feedback like my Mum's: They said they didn't notice the gaps and lost words. They said I just seemed shy. Since that experience, my confidence has been growing steadily. I have deliberately put myself in positions and

situations that I would normally flee from, and I have survived them...

For days I was nervous about talking about my interest in spirituality for two minutes during the 'spirituality in education' seminar I recently attended. 'I won't write a speech and memorise it', I thought to myself, 'I'll just try to say something then and there'. But on the day of the conference, sitting and listening to other ('intelligent') people's introductions I began to panic. I felt my heartbeat racing, my hands became sweaty. I strained to listen to what was being said, but I couldn't concentrate. My turn was moving steadily closer. I couldn't stop myself from thinking about what I was going to say, so I made a brief outline: My upbringing, my professional life, my academic life. I didn't want to lose those words, so I made them into a mantra: upbringing, professional, academic... upbringing, professional, academic... Upbringing...professionalacademic...upbringingprofessional...academic...

And then it was my turn. I regurgitated my mantra quickly, then attempted to talk about it. I talked to the swirly carpet on the floor. At one point I lost a word and there was a silence and I was embarrassed. I tried to think of a replacement word, but I couldn't, so I started the sentence again. And it worked and I got through it...and I survived.

Cheryl [one of my supervisors] suggested I write about my own learning and change experiences during my doctoral studies, and for that reason, I started writing this journal entry. I never suspected that the very act of writing would affect me so much. And I thought I would say far less than I have done when I started writing. I am fascinated, right here, right now, with the realisation that has become clear, through writing this journal entry - my research work *has* impacted on me - it *has* changed me. Yesterday I thought that I had learnt only intellectually from my grounded theory study, and I wanted to carry out heuristic research work in order learn experientially about the ways in which counsellors learn and change as a result of their client work. Today, in writing this journal, I have become aware that my grounded theory study has perhaps *prepared* me for a heuristic study.....After listening to practicing counsellors talk about their learning experiences I am now more ready not only to articulate my own, but also to experience my own.

It is uncomfortable to read this journal entry now, towards the end of my doctoral studies, and I feel embarrassed at the thought of others reading it. Yet as Lawton (1997, p. 2) points out, 'Most researchers will experience embarrassment or even pain at some time during their PhDs'. He adds, 'Research is difficult - more difficult than most things you have to do in life' (Lawton, 1997, p. 17). Reflexive research, I would argue, is particularly difficult.

Ellis and Bochner (2000, p. 738) explain that 'the vulnerability of revealing yourself, not being able to take back what you've written or having any control over how readers interpret it...can be humiliating'. Yet they also note that when a researcher includes

herself in a research study, she gains the opportunity of understanding herself and others more deeply. In reading the above journal entry, I have become aware that during my doctoral studies, I have continued to develop confidence in myself, both academically and more generally. This idea is reflected in later journal entries. In entry two, about four months after I wrote the first journal entry, I wrote about my developing academic confidence:

Christine [one of my supervisors] and I have both noticed that I have become more confident in the last 10 months: I talk more openly and confidently in supervisions. I have written a letter to the editor of CPR, commenting on the methodological flaws of one of the articles printed in the latest edition of that journal [Turner, 2005c]. Having been to two conferences on my own, I am more confident in talking to people about my work. I lose less words. I feel more articulate and less nervous.

Kvale (1996, p. 3) presents ‘two contrasting metaphors of the interviewer – as a miner and as a traveller’. In the traveller metaphor, which is most relevant to my own experience, the interviewer is on a journey, listening to the stories told by the people he meets on the way. As Kvale (1996, p. 4) points out, ‘The journey may not only lead to new knowledge; the traveller might change as well’. Five months after writing entry two of my learning and change journal, after one of my final interviews for my theoretical sampling study, I wrote about the way in which the experience of that interview affected my social confidence:

I had a really enjoyable interview on Friday, and after the interview, the participant and I talked for an hour or more about our own opinions of different aspects of counselling and psychotherapy. I felt happier with myself and more confident afterwards. On the way home, I saw a friend of a friend, and decided I would say hello.

I would normally have avoided saying hello, because I would have felt shy with this person. But I was feeling so happy and confident that I decided to say hello. The person and I got chatting, walked towards town together and then she invited me to a small party with her. I would have normally politely declined, saying I was very tired and needed to get home, but although I was actually quite tired, I was also energised by my interview, so I decided to accept the invitation.

I ended up agreeing to go to a dinner with the people at the party, and then to a live music concert. I got home about four hours after I intended to. I walked back towards my home with another person I have avoided (because I have felt intellectually intimidated by her), and I felt quite confident talking to her. She even said that she noticed that I talked to people I had never

met at the dinner and concert and that I was more confident than her because she couldn't do that!

I am aware that this improvement in confidence may be due to a conscious effort over the past few months combined with the self-development opportunities offered by my counselling training course and personal therapy, but the good experience I had at the interview definitely impacted on the way I behaved last night. I think that as my newfound confidence is still quite shaky, though - if I had had a bad experience in the interview I would not have said hello to the person I met at the train station. I e-mailed the participant when I got home, and she replied soon afterwards. The meeting was mutually beneficial. She wrote: 'I enjoyed meeting you too and it was such a pleasure to rabbit on! I am so used to listening...'

This participant was not the only participant of my grounded theory study to have benefited from the experience. As detailed in chapter two, several of the participants noted that their interviews had provided them with the opportunity to reflect on and learn from their work as a whole. Wosket (1999, p. 70) writes,

A belief I hold strongly is that qualitative research, at its best, can provide a positive and growthful learning experience for the respondent(s) as well as for the researcher.

My next study, the self-search co-operative inquiry, was also a positive, growthful learning experience for me.

### **The co-operative self-search inquiry**

'In our view, good research is an expression of a need to learn and change, to shift some aspect of oneself', Reason and Heron (1995, p. 136) write. West (1996, p. 12) adds:

I came to realise that in asking questions of others, I was asking questions of myself; and in wanting to understand the conditions of effective learning in other's lives, I wanted to understand these in my own. All research crosses boundaries between self and others.

In carrying out the CSSI I deliberately engaged in a process that I knew would lead to personal and professional learning and change. The learning and change that has arisen for me as a result of engaging in this study is documented in some detail in chapter four of this thesis. In that chapter, I noted that my confidence in my ability to be a good therapist has increased as a result of my client work. I have also learnt more about therapy, more about

myself, and about some of the gratifying and challenging aspects of counselling. I have learnt, as Paul Wachtel (cited in Dryden, 1995, p. 147) puts it, 'Doing therapy is one of the most exciting, but also one of the most difficult and often either...frustrating or disturbing, kinds of work.' Although my CSSI is now complete, as I continue to engage in client work, I continue to learn and change. As one participant, Bryony put it, 'I sort of go in with anticipation and look forward to learning...'

### **My research overall**

My colleagues and I noticed how frequently MSc students told us about the sometimes profound personal and professional development they were experiencing through their research training and experience. We began to anticipate these transformations (their word). Many research students, however, seemed surprised at these transformations, not expecting research training to affect them personally as well as intellectually (Etherington, 2004, pp. 48-49).

Similarly, at the outset, I did not expect that my doctoral studies would have such a profound personal effect on me. As well as the changes I have detailed above, that have occurred in relation to two research studies I have carried out, as a result of learning to think and write critically for my doctoral studies, I notice that I now think more critically in other areas of my life. This has had an impact on my experience of the counselling training that I am currently engaged in, my teaching work and my wider relationships.

So like Etherington (2004, p. 18), 'I signed on to do a PhD and thus began a powerful, sometimes lonely, and transforming journey'. 'During this study I have been moved, surprised, excited, curious, and transformed by what people have told me...I have also been troubled, anxious, angry, doubtful and bored at times, and wondered why on earth I started down this road. But I have learned from *all* of this' (*op. cit.*, p. 9, original emphasis). 'That is, after all, what research is – a process of learning from particular kinds of experiences' (Brew, 1993, p. 89).

One view is that a PhD must be a piece of scholarly enquiry, deliberately limited in scope but perfectly executed – a 'masterpiece' in the tradition of craftsmen who demonstrate their competence at the end of an apprenticeship by producing an example of their work without any blemishes. The other view of a PhD is that it is a worthwhile experience (Lawton, 1997, p. 27).

Although this thesis is not a perfect masterpiece, my doctoral studies have been executed in a scholarly and critical manner, and my findings add to the current body of literature. In addition, it has certainly been a worthwhile experience. The experience has come to an end, but, (in the words of one of my participants, John), ‘I think I’ll continue learning...’

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To be willing to be open with the client  
means we allow ourselves to be impacted by them’

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# Appendices

Some of what we have learnt is trivial;  
some has changed our lives forever.

(Daloz, 1987, p. 1).

## **Appendix A1: ESRC Studentship Research Proposal**

### **Counsellors' Transformational Learning Experiences in HIV and AIDS counselling.**

#### **BACKGROUND AND RATIONALE**

This research project's aim of gaining an in-depth understanding of counsellors' transformational learning experiences in HIV and AIDS counselling firmly locates it within the ESRC's 'Knowledge, Communication and Learning' theme. The study's findings will fill a gap in the present research literature on transformational learning and provide counsellors, their supervisors and counsellor training institutions with insights and understandings which could enhance the quality of their work and help to ensure their successful performance with regard to HIV positive clients.

#### **HIV and AIDS Counselling**

It is estimated that there are over 50,000 people infected with HIV (Human Immunodeficiency Virus) in the UK, with thousands of new infections being reported each year (Terrence Higgins Trust, 2003). The HIV virus weakens the immune system of an infected person, leaving him/her vulnerable to many infections and diseases. Most people infected with HIV eventually develop AIDS (Acquired Immune Deficiency Syndrome), which is characterised by life-threatening infections and tumours.

Healthcare professionals recognise that people infected with HIV, whether asymptomatic and healthy or diagnosed with AIDS, might suffer from a great deal of psychological stress. They therefore often recommend counselling. In addition, infected people often self-refer for counselling, either to a counsellor in private practice or one employed by an HIV charity or other relevant organisation (Bennetts, 1992). In their seminal work, Miller and Bor, (1989, p.3) point out that HIV and AIDS counselling is important because "[it] can help patients to adjust to their condition...and contribute to the co-ordination of medical and social care".

#### **Transformational Learning**

Since it was put forward in 1978, Mezirow's theory of transformational learning has stimulated a great deal of discussion within the field of adult education. He suggests that transformational learning is "the social process of constructing and appropriating a new or revised interpretation of the meaning of one's experience as a guide to action" (Mezirow 1994, p. 222-3), and argues that critical reflection is an important part of this

process. Taylor (2001) criticises Mezirow's over-emphasis of the significance of critical reflection and suggests that unconscious processes and emotions also play a part. Drix (2000) also draws attention to the imaginative and spiritual dimensions of transformational learning, both of which Mezirow's theory ignores, but which are supported by Bennetts (2003). My study will attempt to discover if and how each of these factors play a part in the transformational learning counsellors' experience as a result of working with HIV positive clients.

### **Counsellors' Transformational Learning Experiences in HIV and AIDS Counselling**

Transformational learning often leads to changes in a person's character. Since the personality of the counsellor is such an important element in counselling, counsellor training and ongoing professional development places a large emphasis on transformational learning (Nelson-Jones, 1991).

Bennetts (2003) defines transformational learning in terms of experiences that impact on a person's thinking, feeling, acting, relating and being. For a counsellor, these experiences may occur during training, ongoing professional development, supervision or whilst working with clients. They may also occur in other areas of daily life. This project focuses on the transformational learning experiences that counsellors' have had as a result of working with one or more HIV positive clients.

Little research has been carried out on counsellors' learning experiences (McLeod, 1990). In addition, only a handful of empirical studies on this topic include the use of interviews: Miller (2001) has studied the positive and negative impacts of treating torture survivors on counsellors' personal and professional lives. Kottler and Blau (1989) drew on personal experiences, therapist disclosures and case studies in the literature in discussing how failures can act as learning opportunities for counsellors. And Seibold and Avants (1999) interviewed 10 marriage and family therapist trainees in order to describe how learning from personal therapy was transferred to work their with clients.

Most studies on counsellors' learning experiences have used questionnaires with rating scales to gather data on counsellors' feelings and confidence levels, difficulties that were experienced in counselling sessions, and counsellors' perceptions of their performance (McLeod, 1990).

Some books on HIV and AIDS counselling briefly mention what the authors have learnt from their work. For example, Green (1989) describes how he learnt not to gloss over areas of difficulty in order to reassure clients. However, no known books or research articles focus specifically on counsellors' transformational learning experiences in HIV and AIDS counselling. In contrast, several studies on the transformational learning experiences of HIV positive people have been carried out (see for example Baumgartner, 2002; and Simoni, Martone and Kerwin, 2002). My project will undoubtedly complement and add to these studies by offering parallel insights on the transformational learning of counsellors.

### **Research Questions**

I intend to address the following research questions:

- How do therapists perceive that they have learnt and changed as a result of working with their clients?
- What factors do therapists perceive are involved in the learning and change process?

- How do the learning and change experiences that therapists who have worked with HIV positive clients perceive they have had differ from the learning and change experiences that therapists who have not worked with this client group perceive that they have had? In what ways are they similar?
- Can the theory of transformative learning be usefully applied to the learning and change experiences that therapists perceive that they have had?
- What are the implications of my research findings for improved practice, training and supervision?

## **METHOD AND METHODOLOGY**

I propose to undertake a qualitative study within the interpretative paradigm. This approach will allow me to gain an in-depth understanding of participants' transformational learning experiences as well as the meanings and interpretations they attribute to them. Since interviewing is a widely used, flexible way of gathering data that is both detailed and personal, unstructured and semi-structured interviews will be used in my study (McLeod, 1990). In each interview, participant counsellors will be asked to reflect on their practice and to talk about the way in which it has transformed them.

The Grounded Theory methodology will be used to analyse the interview transcripts. The aim of this methodology is to generate a theory which emerges from and is grounded in data (Glaser and Strauss, 1968). The transcripts will first undergo a process of 'open-ended coding'. This will involve analysing each one, sentence by sentence, to find category and subcategory labels (words or phrases which summarise parts of the data), whilst also constantly comparing the emergent categories with each other and refining them as necessary. When the open-coding stage is complete, connections between the resultant categories will be determined and one or more main categories will emerge. A 'substantive theory' that all counsellors, supervisors and trainers can go on to work with will then evolve from these.

For the first part of my project, two Grounded Theory studies will be carried out: a study of counsellors' learning experiences in HIV and AIDS counselling and a study of the learning experiences of counsellors who have never knowingly counselled an HIV positive individual. Data will be collected for both studies simultaneously, and if relevant, categories and interview questions used in any one study will also be applied to the other study. In this way, some of the similarities and differences which might exist between the two data sets will become clear.

I will begin the study by carrying out unstructured interviews with two counsellors who have worked with HIV positive clients, and two counsellors who have not. The four transcripts that arise from these interviews will be subjected to open-ended coding. Emergent categories will then be used to formulate questions to be used in the next set of interviews, and also to analyse subsequent interview transcripts. Each subsequent interview may also give rise to new categories and in this way, each interview might add to the emerging theory. Theoretical sampling (involving participants with diverse characteristics in the study) will later be used to strengthen this emerging theory (Glaser and Strauss, 1968).

In the second part of my project, further studies will be carried out on any categories thought to be unique to the HIV and AIDS counsellors' data set, in order to gain a better understanding of them. In the flexible style of interpretative research, the

methodology used and participants involved in this part of the project will be determined by the categories to be investigated.

### **Sampling and Research Timetable**

Participant counsellors will be sought opportunistically, through advertisements in the journal of the British Association for Counselling and Psychotherapy (BACP), by approaching charities and organisations that employ counsellors and by making contact with individual counsellors using e-mail addresses listed on relevant website databases. Instead of deciding on a sample size at the outset of a grounded theory study, Glaser and Strauss (1968) advise continuing the research until 'theoretical saturation' occurs: until further interviews do not add anything new to the emerging theory.

Therefore, since I will not know, at the beginning of my research, how many interviews will be necessary for each Grounded Theory study, my project timetable must be fairly flexible. However, as I intend to allow roughly a year for data collection and analysis during the first part of the study, I will restrict my sample to a maximum of 40 participants. I will allow a further year for the studies I will carry out into the categories which could be exclusive to HIV and AIDS counsellors' transformational learning experiences. In order to avoid imposing pre-existing assumptions on the data, a detailed literature review will only be carried out after my research work has been completed (McLeod, 2001). The final year of my doctoral studies will therefore be spent on this literature review, as well as the writing of my thesis and various research reports.

### **Credibility, transferability, dependability and confirmability**

The traditional scientific notions of validity, reliability and generalisability can not be used to judge a theory based on flexible interpretative research (Glaser and Strauss, 1968). The quality of my research and the theories it gives rise to will be assessed in terms of their credibility, transferability, dependability and confirmability (Seale, 1999). Glaser and Strauss (1968) suggest that criteria used in judging the credibility of a Grounded Theory study should be based on the strategies used for collecting, analysing and presenting data. I will collect, analyse and present my data in accordance with their suggestions. Additionally, Strauss and Corbin (1994) recommend cross-checking the credibility of Grounded Theory analysis with the aid of member-checks. I will therefore send each participant a copy of their interview transcript and my analysis of it, so that they can make comments and changes, as necessary.

In presenting my findings, I will quote directly from interview transcripts so that the reader will be able to see how I arrived at my conclusions. In addition, I will provide anonymous background details on each counsellor studied, so that readers will be able to judge the transferability of my findings to their own and other's situations. Finally, I will allow readers to assess the dependability and confirmability of my research by providing a reflexive, self-critical account of how the research was carried out.

### **Ethical Considerations**

Before starting this research project, I intend to seek clearance from Exeter University's School of Education Ethics Committee. In line with the School's ethics policy, I will give prospective participants the option to refuse to take part in my research, and will gain informed written consent from all participants who do decide to take part. This will include making clear to participants that they are free to withdraw from the research at any time.



I will ensure confidentiality for all participant counsellors by carrying out all interviews in a safe and private environment and will avoid using real names or revealing distinguishing information about them in my research reports. In addition, I will guarantee anonymity for their clients by asking counsellors not to disclose any real names or give any distinctive descriptions. If, in talking to me, a counsellor inadvertently reveals personal client details, this part of the interview will not be transcribed and the recording will be destroyed after the transcription stage has been completed. Participants will be given the chance to read and if necessary, to alter quotes used in my research reports. Finally, I will remain open to ethical issues that may arise during the proposed study.

## RESEARCH OUTPUTS

As stated in the ESRC's Thematic Priorities Document (2000), knowledge and communication are the foundation of our ability to perform successfully. They are also of fundamental importance in counselling. Since my findings will be of direct relevance to those involved in training counsellors, this project therefore clearly fits into the ESRC's 'Knowledge, Communication and Learning' research theme. My research results will help to inform the curriculum development of counsellor training courses, many of which currently contain little or no guidance on counselling clients with HIV and AIDS (Hunt, 1996; House, Eicken and Gray, 1995).

As well as trainers, this research will also be of interest to counsellors themselves. As the number of people infected with HIV rises, many counsellors will find themselves working directly or indirectly with HIV and AIDS-related issues, regardless of their work settings (House, Eicken and Gray, 1995). The findings of an in-depth study of counsellors' transformational learning experiences in HIV and AIDS counselling could therefore potentially be relevant to all practicing counsellors and their supervisors. In order to communicate my findings to all counsellors, (in line with the ESRC's aim to "increase 'knowledge transfer' between social scientists and the users of their research" (ESRC, 2000)), my research results will be published in the practitioner's journal of the BACP. They will also be communicated in BACP research conferences, academic journals, and, in response to requests from counsellors who have already expressed an interest in participating in the study, my findings and their implications for practice may be published in a book.

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## **Appendix A2: Participant recruitment advertisement**

### ***PLEASE HELP!***

**I am looking for participants for my PhD research work on “Therapists’ learning and change experiences in HIV and AIDS counselling”. If you have ever counselled a HIV+ve client, I would very much like to interview you about your experiences.**

**Please contact Sarah:**

**sarahinholland@hotmail.com or 07956 269 775.**

## Appendix B1: Phase one participant recruitment letter

[Address]

[Date]

Dear Sir/Madam,

I am currently studying for a PhD in Educational Research at Exeter University. My first supervisor is Dr Christine Bennetts. I have an MA in Counselling Studies and am very interested in carrying out research on the learning and change that therapists experience as a result of working with people with HIV. Very little research work has been carried out on counsellors' learning experiences in therapy, and no study has yet looked at therapists' learning experiences in counselling clients with HIV. For this reason, I believe that my study is important.

I am writing to ask permission to interview you about your experiences of counselling clients with HIV and AIDS and also to ask your colleagues at [organisation] for an interview. The interviews will be informal, and each will last approximately an hour. I will be pleased to share my findings with you and your colleagues. Confidentiality is ensured for all participants and their clients will remain anonymous. Please note that you are under no obligation to take part in my research study, and if you do decide to take part, you may withdraw at any time without explanation. Also please be aware that the interview process may bring up unpleasant memories or difficult issues.

I look forward to your reply.

Yours Faithfully,

Sarah Turner (Ms).

## **Appendix B2: Phase one participant recruitment e-mail**

Dear [name],

I found your contact details on the [BACP / Pink Therapy website]. I am a student at the University of Exeter. I am writing to ask you if you would be willing to be interviewed as part of my PhD research on the learning and change experiences that counsellors and psychotherapists have as a result of their work with clients. I would like to ask you about any important learning experiences you have had during your counselling work, how these have affected you personally and professionally.

The interview should take no more than an hour, and your identity will remain confidential in all research reports I write. In addition, I will send you a copy of the interview transcript and my analysis of it, which you will be given the opportunity to make changes to.

Please note that you are under no obligation to take part in my research study, and if you do decide to take part, you may withdraw at any time without explanation. You should also be aware that the interview process may bring up unpleasant memories or difficult issues. If, however, you are willing to be interviewed, please reply to this e-mail, or phone 07956 269 775, so that we can arrange a suitable time and place.

Best Wishes,

Sarah Turner.

## **Appendix B3: Phase two participant recruitment e-mail**

Dear [name],

I contacted you several months ago about my PhD research project on the ways in which counsellors and psychotherapists learn and change as a result of their client work. I have now completed my first study and will soon start interviewing for a second study, focusing on the ways in which some counsellors and psychotherapists have come to address their own death and/or work within more flexible boundaries as a result of their client work.

If you are still interested in taking part in an interview with me, and feel that you could talk about addressing your own death and/or working within more flexible boundaries as a result of your client work, I would very much like to arrange a time and place to meet. I would be happy to meet you at your home or workplace, or somewhere else, if you'd prefer. The interview will last around an hour and might bring up difficult issues or unpleasant memories. However, previous participants have found that being interviewed can also be a useful opportunity to reflect on their learning. Please note that you are under no obligation to take part in my research study, and if you do decide to take part, you may withdraw at any time without explanation.

I look forward to your reply.

Best Wishes,  
Sarah Turner.

## Appendix C: Participant consent form

### THERAPISTS' LEARNING AND CHANGE EXPERIENCES

#### PARTICIPANT CONSENT FORM

I understand that Sarah Turner's research work on 'therapists' learning and change experiences' will be submitted to the University of Exeter as part of her PhD thesis. This work may also be published in specialist journals and used in conference presentations. In all reports, the identities of the counsellors and psychotherapists interviewed will remain confidential and their clients will be anonymous. Therapists are asked not to reveal the real names of any of their clients during interviews and will be allowed to choose a pseudonym (a false name) for themselves for use in research reports.

I agree to take part in an interview for this study and consent to a tape recorder being used. I understand that I may be asked to take part in further interviews in the future, but that have the right to refuse. In addition, I am free to withdraw as a participant of this research project at any time.

I am aware that I will be given the transcripts and analysis of any interviews I take part in, and I will be given the opportunity to make changes to it, if I wish to do so. I agree to allow quotations from transcripts to be used in Sarah Turner's academic work, journal articles, other publications and conference presentations.

Chosen Pseudonym.....

Signed.....(participant)      Date.....

Signed.....(researcher)      Date.....

## Appendix D: Transcript covering letter

[Address]  
E-mail: Sarah.K.Turner@exeter.ac.uk  
[Date]

Dear [Participant],

Thank you very much for allowing me to interview you on [date], for my PhD project. I'm sorry that I was not able to write sooner.

I enclose a copy of the interview transcript, as well as my analysis of it (in the left margin of the transcript). I have analysed the transcript by looking for 'categories' (bold if I think they might be relevant to learning experiences that have resulted from your client work, and not bold if I think that they are relevant to other important issues) and 'sub-categories' (in brackets). Italicised categories and sub-categories refer to clients. The categories are quite general as they are to be potentially used in the analysis of all my interview transcripts. The category names may also change slightly in the future as I compare them with later transcripts, so that I end up with category names that fit all the transcripts that they are relevant to. Please let me know if you would like to change, add to or delete any of your responses, and also if you are not happy with any of the categories and sub-categories that I have used.

I would like to include a few interview transcripts and my analysis of them in my thesis so that the examiners can see how I have analysed each transcript. However, if I do include your transcript, I will not include any specific details about your background, as this could potentially reveal your identity: I have summarised what you told me in answer to the first questions and deleted or altered any specifics you mentioned throughout the interview. Please let me know if you would be happy to allow me to include your transcript in my thesis, and if so, which parts, if any, you would like me to omit for this purpose.

I will let you know about my research findings, when I finish the project. Thank you again for your help and support.

Best Wishes,

Sarah Turner.



## Appendix E: Brief details for each participant

### Group A

<u>Pseudonym</u>	<u>Sex</u>	<u>Background to HIV counselling</u>	<u>Training / Orientation</u>
<u>Client experience</u>			
Jill	F	Social work + nursing Various: children and adults	Various
Annie	F	? Various: over 10 years experience	with THT / Integrative
Zoe	F	Setting up HIV organisation Telephone and face to face	Humanistic + Psych. / Psych.
Carl	M	Personal therapy and experience Young people and HIV +ve people	/ Psych.
Colmat	M	Offered a job in this area Various	/ Existential + CBT
Maggie	F	? Various clients and issues	Mainly PC
Tristram	M	Personal therapy and experience Hospital setting and private practice	/ Integrative
Louise	F	Personal therapy and experience Over 10 years experience	Integrative / Existential
John	M	Wanted to work with people Various: individuals and couples	TA
Simon	M	Priest Organisation and private practice	Transpersonal
Finn	M	Wanted to work with HIV Various: around 9 years experience	/ Mainly PC
Soren (time)	M	Personal experience Various: + a lot of HIV experience	/ Integrative (changed over
Stephen	M	Personal experience Telephone, groups and individuals	Gestalt
Andrew	M	Personal experience + chance Various	Psychoanalytic / 'General'
Tom	M	Didn't specifically chose this Crisis counselling	Person-Centred + TA
Fergus psych.	M	Personal experience Organisation and private practice	Humanistic + Body-centred
Prudence	F	Massage course	Adlerian + Existential /
Existential		Various ages, only individuals	
Clare	F	Worked for Citizens Advice Bureau A lot of EAP work	/ Integrative
Bryony	F	Nursing Various	Adlerian

('F' is female, 'M' is male; 'personal experience' may include experience of being in a sexual minority, being HIV positive or knowing people who are/were HIV positive. 'THT' is the Terrence Higgins Trust; 'Psych.' is psychodynamic; 'CBT' is cognitive-behavioural therapy; 'PC' is person-centred, 'TA' is transactional analysis; 'EAP' is employee assisted programme. '?' refers to details not given).

## Group B

<u>Pseudonym</u>	<u>Sex</u>	<u>Background to counselling</u>	<u>Training / Orientation</u>
		<u>Client experience</u>	
Eve	F	Psychology and philosophy degree	Various
		About 250 clients	
Alice	F	?	Integrative
		Qualified recently	
Angela	F	Wanting to work one to one	Integrative and Gestalt
		Mostly EAP work	
Richard	M	Social work	Humanistic
		Males and females + EAP work	
Rose	F	Personal therapy	Humanistic
		Various	
Elly	F	Social work	Humanistic
		Many clients, various issues	
Teresa	F	Wanting to help + social work	Core Process / PC
		In a college and private practice	
Alex	F	Wanting to help + personal reasons	Mainly PC / integrative
		Wide range	
Claudia	F	Personal therapy	Psych.
		Depression, anxiety, trauma, abuse	
Irene	F	Personal therapy	Integrative
		Wide range including EAP work.	
Claire	F	Working for a charity	Psych.
		Currently working in mental health	
Nkeiru	F	Voluntary work + personal reasons	Mainly PC / integrative
		Mainly women, various cultures	
Janet	F	Volunatry work	PC
		A lot in mental health	
Ruth	F	?	Humanistic integrative
		Male and female functioning clients	
Wilma	F	Discovery of Reich's ideas	Body centred + Gestalt /
Eclectic		Mostly long-term work	
Susan	F	Personal therapy	Humanistic
		Currently mainly postgrad. students	
Lauren	F	Various	Adlerian / Integrative
		Primary care and private practice	
Catherine	F	Personal therapy	Humanistic / Body centred
		Various, mostly long-term work	
Lynne	F	?	Psychodynamic / Integrative
		Various, children and adults.	
Nicola	F	Personal interest	Integrative and cognitive
		Hospital, university, private practice	

(‘F’ is female, ‘M’ is male; ‘PC’ is person-centred; ‘Psych’ is psychodynamic; ‘EAP’ is employee assisted programme; ‘postgrad.’ is postgraduate; ‘?’ refers to details not given).

### Theoretical Sampling Study

<u>Pseudonym</u>	<u>Sex</u>	<u>Background to counselling</u>	<u>Training / Orientation</u>
		<u>Client experience</u>	
Anne	F	Wanting to do something meaningful 6 years	Transactional Analysis
Steven	M	Psychology degree University, hospital, pp etc.	/PC and existential
Clare	F	Personal therapy Children and adults	/Integrative
Ruth	F	Personal therapy 20 years	Psychology and psychoanalysis

(‘F’ is female, ‘M’ is male; ‘PC’ is person-centred, ‘pp’ is private practice)

## Appendix F: Vignette of each participant

### Group A

**Jill:** Trained in social work in the early 1970's, and has done counselling as a social worker. She has used counselling skills and also done formal counselling work with HIV positive people in 1990's, as a HIV social worker. She also trained as a counsellor during this time. "The work I do at the moment is a mixture of three things, none of them are HIV-related, although from time to time they have involved HIV. The main paid job is with MENCAP. I work as a counsellor providing a service for families who have children with disabilities. That's 3 days a week. And I do some private work as a counsellor. And I do some voluntary work at the medical foundation, as a psychotherapist."

**Annie:** Trained as a bereavement counsellor, with the Terrence Higgins Trust as an HIV/AIDS counsellor and as a cancer counsellor, and later as an integrative psychotherapist. "Well, I've been working with clients since...[the early 90's]...I think. And during that time I've seen a range of clients. From short-term work with individuals to long term work with individual couples, obviously people facing life-threatening illnesses and conditions, death, dying, and all sorts of other difficulties: relationship difficulties, communication difficulties, sexual identity, a range of things really."

**Zoe:** Set up an organisation for helping people with HIV and AIDS with some other people in 1980's. This led to an HIV helpline, which she trained to work on, despite fears about her stammer: "Then to find that I really liked the [HIV helpline]. I thoroughly enjoyed it, and the stammer wasn't an issue because in fact it helped. When you've got say a young gay man...he rings up, he's got a woman who answers the phone. Then he discovers that I'm not too perfect – there's something the matter with me. And I actually found that the stammer did help and I used that. But then I started thinking that all I've got is a voice, no body language whatsoever. So then I started thinking about training to learn counselling skills [mentions a part-time humanistic course] and coming into the last year second term I suddenly realised that counselling was my niche. I was doing it just for the [HIV helpline] and suddenly I became aware that 'this is me'. I thought 'this is what I'd like to do'. I discussed it with my husband, then I looked at what type of model I wanted to use. [Mentions another course, this time psychodynamic]. "I was interested in what makes me, me, what makes you, you, what makes a person who they are. So I decided to train in that way because you are looking at the background of people and things. In counselling, if people know about their backgrounds, I do believe passionately that it can help them to change. So it was because of that that I trained, and it was because of the [HIV helpline] that I got into HIV".

**Carl:** Is a psychodynamic counsellor and is training to be a supervisor. He has worked with young people and university students as well as HIV positive clients. Having experienced a lot of personal therapy, he decided to train as a counsellor.

**Colmat:** His method of working is existential, although he incorporates cognitive behavioural techniques into his practice. He has worked with a variety of clients and has previously worked for an organisation which offers counselling to gay and lesbian clients. He decided to work as an HIV counsellor when offered a position in an organisation set up by an acquaintance. This, he says, "was an amazing learning experience for me".

**Maggie:** She has completed a certificate and a diploma in counselling, which were largely person-centred but included other approaches. This included a minimum of 120 supervised practice hours, 40 hours of personal therapy and 5 hours a week of theory, skills development and personal development group experience. "I feel it was a good course". Maggie has worked as a counsellor for MIND, and as a counsellor in a Comprehensive School. She is currently working for CRUSE. Presenting issues she has worked with include HIV, childhood abuse, rape, violent abuse, self-harm, and confused thinking and related life issues.

**Tristram:** Describes himself as an integrative psychotherapist. He first trained as a dentist, but did not find it completely satisfying. As a result of some problems he was experiencing, he had personal therapy, and through that became interested in becoming a therapist. He worked as a counsellor in a hospital before setting up a private practice. Until about 3 or 4 years ago, he had carried out a lot of work with HIV positive clients, including running a group for gay men with HIV and work for the Terrence Higgins Trust. Although his practice is general, he works with a lot of gay men.

**Louise:** She "fell into" counselling as a result of going for counselling herself. She entered an integrative training certificate course (although the course director was an existential therapist). She had had personal experiences of HIV, including a friend's husband and two very close friends who were positive, so chose to work as an HIV counsellor (within an HIV organisation) for her training placement. Inspired by her certificate course director, she then studied for a diploma in existential psychotherapy. As well as continuing her initial placement, also began working with HIV related issues as a counsellor for a bereavement counselling organisation, and also as a counsellor for another HIV organisation. She felt that the existential approach fitted in well with her client group who were, at the time (the beginning of the 1990's), having to come to terms with an early death.

**John:** Has a degree in psychology and an MSc in transactional analysis psychotherapy. He previously worked in marketing, but wanted to do something that seemed more important to him, involving people, so decided to become a psychotherapist. He normally sees around twelve private clients a week as well as being head of counselling for an employee assistance programme. He sees clients with a variety of presenting issues, as well as couples. He is aware that he attracts a lot of clients with borderline characteristics.

**Simon:** He started working as a couples counsellor, then trained as a transpersonal counsellor. He has been working as a sexual health counsellor for an HIV organisation which offers short-term counselling, for 3 years. He also has a private practice. He was a priest and worked as a counsellor during this time. He then gradually moved away from working as a priest, and became a full-time counsellor. As a gay man, he "found it very interesting and exciting to be working with gay men as clients" in the HIV organisation he now works for.

**Finn:** He is predominantly a person-centred therapist, but has done some solution focused training. He spent the first four years of his practice working in HIV counselling, mainly with gay men, but also with African clients, their families, friends and partners. He then worked in a cancer hospice with the family and friends of patients (some of whom were HIV positive). During the last five years, he has worked for a lesbian, gay and bisexual alcohol and drug project. Many of his clients there have been HIV positive, although that has not been their presenting issue. He has a private practice, and also works for the armed forces. Mentions that he used to be an actor, but wanted to do something different. In the early 90's, he decided that he wanted to work with HIV. He then decided to train as a counsellor.

**Soren:** His theoretical orientation is integrative (psychodynamic, incorporating cognitive behavioural elements), although it has changed over the years. As a psychologist, he works with each client differently. With HIV positive clients, he tends to use cognitive behavioural and relational methods. He has a lot of experience of working with HIV, including working for several HIV organisations. He has worked mainly with gay men, although he has also worked with some heterosexual couples and heterosexual females. The bulk of his HIV positive clients are within the 25 to 40 age group. He also works as a counselling psychologist for the NHS, and has come across HIV positive clients within that role. As he is a gay man himself, he had an interest in working with gay men, which led him into HIV counselling. "You can't get around it working with gay men".

**Stephen:** He worked for a year on two HIV/AIDS telephone lines, one in America (around seven years ago) and one in UK. He also worked for an organisation for gay men and lesbians, co-facilitating two groups of HIV positive gay men, each in six evening sessions and two whole day sessions. He finished a diploma in Gestalt counselling two years ago. He fits his private practice around his full-time job, so sees on average one to three clients a week. He mentions that he "fell into" it rather than it being a conscious choice. He lived in an area of America with a high prevalence of HIV. His lover had died from AIDS and he had been recently diagnosed. After getting involved with the local AIDS support group as a volunteer he trained to work on their help line. He then decided to return to UK and to train as a counsellor, and at around the same time began to work on another HIV help line. After completing his training, he worked with the groups.

**Andrew:** He comes from a psychoanalytic background and is Freudian. He calls himself a "general counsellor" and has not specialised in any way. He currently works with a trainee counsellor who "happens to have HIV".

**Tom:** His first training was in South Africa in the 1980's, in person-centred counselling. He later trained in transactional analysis. As crisis counsellor he has worked with a variety of clients experiencing crisis. He has also worked for a lesbian and gay organisation, counselling mostly gay men and also some couples. He didn't specifically choose to work with HIV positive clients, although many of his clients are positive.

**Fergus:** Started training as a humanistic counsellor in the early 90's. He then trained in body centred psychotherapy. His client group reflects his own issues: "I'm a gay man, I'm living with HIV myself". He started working for a lesbian and gay counselling organisation as a volunteer and later taking private referrals. He then had to give up counselling for a time, in order to devote his energy to a full-time editing job. He recently became self-employed as a journalist and therapist, and also began working again as a volunteer for the lesbian and gay counselling organisation. He works with a range of clients and has quite a lot of experience of working with HIV positive clients.

**Prudence:** Her theoretical stance is existential, although she has trained in Adlerian and Existential psychotherapy. She works with all age groups, only sees individual clients, and at the time of the interview, had a large number of counselling student clients. A massage course, which involved discussion of clients' feelings led prudence to the decision to train as a counsellor.

**Clare:** Her theoretical perspective is integrative, and that she now does a lot of EAP work. Before becoming a counsellor, she worked for the Citizens Advice Bureau. She recognised that one person's problems was not a result of problems with her Social Security and was instead a result of "her view of life or her view of herself". She also had personal therapy, and recognised the benefits of that.

**Bryony:** Her training was Adlerian. She has a background in nursing and works with a variety of clients including those with drug and alcohol issues, on EAP's and who have been referred by their GP's. She has also worked with a few HIV positive clients, and works as a trainer and supervisor.

## **Group B**

**Eve:** She did an MA in psychology and philosophy, and training in Person-Centred Counselling, group analysis and psychodrama, as well as attending a range of courses and workshops. She has also trained and worked with 'Relate' practiced as a volunteer psychotherapist abroad and read a great deal. "I've worked with about 250 clients. 30 here at [a centre] who have been singles only – single clients only – and they have been referred through mental health units, having been referred to mental health units through their GP's. And I've worked with private clients, who came to my house. That was a bit longer term, say about 18 months. And then there are a couple of other places I've worked, but I'm not going to bother with them because its only for a year. And in Relate, probably the average time I saw clients was 10 sessions, but sometimes it was 30, and sometimes it was one. I think about 3/4 of the clients I saw at relate were couples – that's lesbians and homosexuals as well as heterosexual couples".

**Alice:** She qualified from an integrative course relatively recently, and experienced working with employees as part of her course. She now works with any client who comes for counselling (for as long as the client wishes), and also for an agency, working with people who have been referred from their workplace, for between 4 and 6 counselling sessions each.

**Angela:** Wanted to work in a one to one way with others, and was inspired to do a hypnotherapy course. She later felt that doing a counselling course was necessary for one to one work with others. She did a certificate then a diploma in counselling in a university environment, and also trained as a Gestalt counsellor. She also spent two years observing a child as part of a research project, which influenced her thinking greatly. Her clients have mostly come from employment assisted programmes and a hospice in which she works as both a one to one and group counsellor.

**Richard:** Worked as a social worker for a number of years but not doing as much counselling as he would have liked to do as part of the job. After retiring, he began a humanistic counselling course. He has worked with a lot of male clients, many of whom have been depressed and abused. He has also worked on employer assisted programmes and feels that some of the best work he has done has been with female clients.

**Rose:** Experienced the benefits of couple counselling and was inspired to train as a counsellor as a result. Has also had personal experiences which have led her to work with road traffic accident sufferers. In her private practice, she sees a variety of client types, although there are certain clients that she refuses to work with.

**Elly:** Has a background in social work and had counselled as part of that role. After twenty-five years as a social worker, she decided to become a counsellor. She chose to work humanistically because this perspective is closest to her own philosophy of life. She has worked with many clients, and many types of clients.

**Teresa:** Had quite a difficult childhood and family life, and as a result, wanted to help people. She became a social worker, then, after having a child, moved into working in further education. Later, she felt drawn to doing a counselling diploma, then worked as a college counsellor before setting up a private practice. She has had helping jobs whilst setting up her private practice. “[I’m] very much person-centred. And my psychotherapy training is core process psychotherapy...It’s a Buddhist based psychotherapy, so it leans into the Buddhist spiritual, psychological and philosophical teachings, to enable one to be with the client.”

**Alex:** Wanted to help people and had an unfulfilling job. At the same time, she was experiencing problems in her marriage. She enjoyed the introductory counselling course she did and decided to continue training as a humanistic therapist. Although her training was largely person-centred, she has gone on to explore other ways of working. She has had a wide range of clients.

**Claudia:** Became interested in counselling when she was getting divorced and was having personal therapy. During that time, she learnt more about her strengths and weaknesses. After her children had grown older, she trained as a psychodynamic counsellor. She has worked with clients presenting with issues of depression, anxiety, sexual abuse, and trauma. She had not worked with anyone with alcohol or drug abuse issues at the time of the interview.

**Irene:** Had counselling when her first marriage ended, over twenty years ago. She then trained as a social worker and as a counsellor, whilst also continuing to self-develop. Her theoretical model is integrative and based on Ken Wilbur’s spectrum of consciousness. This is centred on the idea that each of the main theoretical approaches address different levels of consciousness, so that they are, in a way, complementary. She has tried to gain expertise in each of the main theoretical approaches and uses different approaches with different clients, depending on the level of consciousness they present with. She has a wide range of clients who self-refer and also works for employee assisted programmes.

**Claire:** Counselling as part of her work for MIND and decided to undertake training in order to “do it more effectively”. The training available at the time was psychodynamic. She currently works with clients who have mental health problems.

**Nkeiru:** Saw an advert for Relate Counsellors, several years before deciding to train, which sparked her interest. Later, as a result of a series of personal crises, she had counselling. She then decided to train. Her training was humanistic and largely person-centred, but her personal therapy was psychodynamic. She uses both approaches in her client work. She has also undertaken training in inner child work, which she makes use of with clients. “So it’s a bit of a mixture really, integrative, eclectic, messy, just being me.” She works mainly with women, as women’s issues, and particularly sexual abuse are her main interests. She has also worked with people from various different cultures.

**Janet:** Is a person-centred counsellor who works with a variety of clients. She works for a centre which supports mentally ill people, so has worked with some quite seriously and permanently mentally ill people, as well as people who have been through a period of mental illness. She was a Samaritan volunteer from an early age. She originally worked in an engineering-related field, but decided that she wanted to do something different, so trained to be a counsellor. After training, she took some time off counselling work to be with her young children. She has been working in the centre which supports mentally ill people for about 3 years.



**Ruth:** Her theoretical perspective is at the humanistic end of the spectrum. She is influenced by Gestalt and body orientated psychotherapy, but has an integrative approach, including perspectives from the object relations school of thought. Clients she works with tend to be people who are functioning in the world, who are largely over 20 and both men and women.

**Wilma:** Is a body psychotherapist and thinks that therapeutic change happens in the body in parallel with other changes. She has undertaken Bio-energetic and Gestalt training and although she is accredited as a humanistic therapist, she feels that in some ways she is quite eclectic. She sees most of her clients long-term, some are traumatised or have experienced sexual abuse, some have borderline personality types, and some are very vulnerable to being overwhelmed. She had a background interest in Marxism, but felt that the individual was somewhat overlooked in these ideas. She became interested in what makes individuals as they are and later discovered Reich.

**Susan:** Works as a counsellor, lecturer and researcher in a university. She is a humanistic counsellor who works with mainly postgraduate students. She was first a client and became interested in the process during that time. She has had a number of different counselling experiences as a client and as a result has decided that humanistic counselling is right for her.

**Lauren:** Has an Adlerian foundation and works with an integrative perspective. She has worked with a wide range of clients and is trained in couple and family counselling. She works in primary care and private practice and works with many people who have been referred by their GP's. There are a variety of reasons for her deciding to be a counsellor. In her first career, she found that many of the patients she worked with were distressed, so she began working with some therapeutic approaches. Her interest also stems from intimacy dynamics and communication challenges in her family background.

**Catherine:** Is a body psychotherapist with a humanistic integrative background and she uses touch as a therapeutic tool. She works with a variety of clients, some for short-term periods, but mostly in long-term work. She calls herself a psychotherapist, not a counsellor. She experienced being a psychotherapy client for a number of years before starting training. She had ended her first career and wanted to do something different. She enjoys the way contact is made with other people in psychotherapy.

**Lynne:** The types of clients she works and has worked with are very varied. Her youngest client has been 4 and her older client was in his late fifties. This has led her to develop a more integrative approach than she originally came to counselling with as a psychodynamically trained counsellor. She later did a masters degree in art and therapy and now describes herself as an integrative therapist who uses creative arts whenever appropriate.

**Nicola:** Has completed two trainings: integrative psychotherapy and cognitive analytic therapy. She has worked in a hospital, and in private practice and currently works as a university counsellor. She worked in business management and was interested in mental health in the workplace. Once she began reading around the subject, she also found that counselling and psychotherapy theories helped her to grow personally as well as professionally.

## Theoretical Sampling Study

**Anne:** Is a transactional analyst and has been working with clients for 6 years. She tends to see her clients for long periods and she is still seeing some who she started to work with 6 years ago. She originally trained as a lawyer, but decided that she wanted to do something more people-focused and meaningful for her. She first came across psychotherapy whilst working with adolescents.

**Steven:** Is essentially person-centred, with a strong existential component, but is mindful of other approaches particularly psychodynamic and cognitive behavioural. He currently works in a university and in the genetics department of a hospital. He also has a small private practice. He has previously worked in a physical health setting with people who were coming to terms with physical disability. He studied psychology as an undergraduate, and was interested, at that time, in practical applications. He worked in mental health, then trained to be a therapist.

**Clare:** Is an integrative practitioner - She works with transference, but also tries to provide the core conditions, and her work is arts based. Kohut and Jung have both been influential. She works with individuals, including children and adolescents, as well as adults. "More and more, in the child work, I find myself working with the parents, so I have kind of moved from something that has been fiercely individual, to now seeing the work as being the aren't-child relationship as the client rather than the child as the client." Her first experience of therapy was as a client. Around 20 years ago, her mother died suddenly, and two grandparents also died around the same time. Her marriage also broke down during this time. She went into therapy for around four years, and afterwards decided that she would like to train to be a therapist. The training also complemented the charity work she was doing.

**Ruth:** Identifies herself as a psychologist – her initial training. She trained as a psychoanalytic psychotherapist and uses the concepts of transference and countertransference in her work. Through her work, she tries to free clients from traumas and difficulties that they have experienced so that these do not affect the client's current lives too much. She sees adults, and that the youngest client was 18, and the oldest was 70. She has mainly seen neurotics, but has done some good work with clients with borderline personality disorders. Presenting issues have included people who are workaholics, have been physically, sexually and emotionally abused; have relationship problems, addictions and have difficulties after childbirth. She has also seen one client with HIV. She had experienced psychotherapy herself in order to work through personal issues. She then became a psychology student, continuing her psychotherapy as a client, and later decided to train as a psychotherapist herself.

## Appendix G: Tom's transcript

*Me: Could I start by asking you for a bit of background information? So your theoretical perspective, and the type of client groups you have worked with.*

**Tom:** [Mentions that his first training was in South Africa in the 1980's, in person-centred counselling. He later trained in transactional analysis. As crisis counsellor he has worked with a variety of clients experiencing crisis. He has also worked for a lesbian and gay organisation, counselling mostly gay men and also some couples]

*Me: OK. I ask this question just for background. If you don't want to answer it, that's fine. What were your reasons for deciding to work with HIV positive people?*

**Tom:** [He mentions that he didn't specifically choose to work with HIV positive clients, although many of his clients are positive].

*Me: During this interview, I would like to ask you about any important learning experiences you have had as a result of working with HIV positive clients, and how these experiences have affected you. Does anything spring to mind?*

**Tom:** I find it difficult to specify what's different in working with people who have HIV. Because my theoretical perspective would demand that I be open to engage with all my clients and therefore change in response to them, and I do that with all my clients. The bizarre thing is that the most usual experience I have in working with people who are HIV positive is joy. Which comes after the fear and the sadness and the pain, and its their transformation in discovering that life can be joyous even with a terminal illness that constantly rewards my optimism and hope. And there have been...some of the bigger challenges I have had are working with clients who didn't know or were not originally positive when they came to see me. The came for other reasons completely. In the middle of therapy, for some reason they discover that they are positive and...[Tom's cat diverts his attention for a short period of time]...so...and I can think of really three specific clients where HIV wasn't meant to be part of the work but became part. So it challenges my sense of and the clients sense of what they are supposed to be doing in therapy, because it does become the focus of primary concern...or it can. And then there is the challenge of balancing what other work the client wanted to do with counselling for the fact that they are HIV positive. So in terms of changing me, its about having to be flexible and erm, to be able to respond to momentary things as well as an overall contractual goal for psychotherapy. I'm not sure if I'm changed by that, but its something that keeps me on my toes.

HIV counselling  
differences (none)

Inspirational clients

*Me: You mentioned that you often experience joy in working with HIV positive clients.*

**Tom:** I think that there can be moments in therapy where there is intimacy, which, in TA terms would be described as spontaneity, authenticity, responsiveness...and growth, all at the same time. The most common response from clients who are HIV positive is that 'it has given me a kick up the pants'. And we are talking more recently of course, because in the early 80's it was completely different, it really felt like a death sentence. I am really talking about my more recent experience where people have said 'it has made me look at my life'. However painful or irritating it is, such a blow is what it takes for people to look at their lives. It does that, or it can do that. So discovering those moments of joy through the intimacy validates, substantiates a sense that psychotherapy can work and that there is something to this business of relationship and intimacy.

Positive effects

**Inspirational clients** Experiences those moments with clients reinforces any sense of positive life force. It reinforces that humanist notion that people like to grow.

*Me: Has that impacted on you in any way, or not?*

Personal experience (illness) **Tom:** Well, I experience this from both sides of the equation I guess, so...yeh, working with clients who find positive ways of managing something that is really difficult always offers me back hope and...yeh...seeing how people transform their own anger into something life sustaining rather than self-destructive also continually feeds me, I suppose, just in a very human way.

**Inspirational clients**

*Me: It was about the possible differences between counselling HIV positive clients and clients who are not positive or are not aware that they are positive.*

**Tom:** Well, when it comes to working with gay men, I find it strange if a gay man doesn't talk about HIV impacting his life in some way. It would seem strange to me that anyone could wander around the gay world today and actually not notice the existence of HIV around. It would be a topic that I would choose to introduce into the therapy, if it was appropriate. If someone was ignoring it. If a young straight girl comes to see me it wouldn't be something I would hold in the same focus. If she was keeping herself safe, then it wouldn't be so much of an issue. It wouldn't seem so strange that she wasn't focusing on it. But it would be strange if a gay man didn't take it into account in their life story, because its been around for about 25 years.

*Me: Have you ever had a learning experience with a HIV positive client that you have then taken into your work with another client?*

**Tom:** What I've already mentioned. There's something about learning to balance and to move between what may be a crisis focus, dealing with that and the afterlife of that, verses...

[Tom's alarm sounds and the tape is switched off briefly]

HIV counselling differences (none)

**Tom:** I think I am resisting the notion that people with HIV are a special case, I think. And you can't kind of generalise around everybody with HIV and say as a group they are different from people without it. There are interesting circumstances about HIV, but women with breast cancer, other types of cancer, all kinds of terminal illness that affect us are there. So its really an example of something much broader than itself. So that's one of the problems I have. Its like the very first time I was dealing with a client who revealed that they had been abused, and I rushed off to supervision and said, "this is so special, this is so difficult, this is so terrible". The response was really, "Well, what is so different from other work you have done already?" The process of healing are the same. Experiences I have had with people with HIV...I think I have said it, the continual affirmation of hope in what certainly at the beginning was an absolutely hopeless experience. And nowadays isn't quite so hopeless, but presents all sorts of other kinds of difficulties. Today people with HIV may be 20 or may be 40, but they are faced with asking questions about life which are completely out of their life stage. I think gay men or anybody who gets a deep shock that they are carrying around a virus that is going to kill them, and there is no cure, to get a deep shock like that makes you have to deal with questions that are not usual for your life stage. So its about learning to the absolute individuality of each person's experience, which is very, very different.

One of the biggest mistakes I ever made and perhaps the biggest learning I ever had in dealing with HIV was not in dealing with somebody who actually contracted HIV but with somebody who came to me and told me that he was having risky sex. And I was quite naive and green at the time, it was a while ago, and I got into trying to make him stop. That was the biggest mistake I ever made. Because there was no way I could make him stop. And there I learnt quite rapidly what I had learnt theoretically, but there I learnt in the experience what needed to be done was to listen to where the client was, to get really interested and to stick with the client's own experience. And then we could think about whether he wanted to change his behaviour. But trying to get him to change his behaviour at first was an absolute no no.

*Me: I think what you say about not grouping everyone who has HIV into one category is absolutely true, and other counsellors have said the same.*

**Painful work**

**Tom:** Well, when you asked me earlier did I choose to work with HIV...I don't deliberately choose to work with HIV *because* of that. I have done that and its too much. To be willing to be open with the client means we allow ourselves to be impacted by them. And the impact of having a 20 year old or a succession of 20 year old people come through your door saying, "I'm positive how am I going to deal with this? I'm in crisis and I can't tell anybody else". The impact of that is enormous. Its very, very, very heart-wrenching. Absolutely heartbreaking. And its easy in those organisations that work with HIV to stick with the positive and lose the heartbreaking part. Because the people who come in are likely to want to be able to learn how to cope. We can be really good at helping them to cope, but not quite as good at sitting with the heart-wrenching stuff. Its enormously challenging. This was before I discovered that I was positive too, I learnt that there was a limited amount of HIV work I could be doing on a day to day basis. So some of my clients happen to be positive, some aren't. If I have a lot of clients at one time, as a matter of routine I ask clients if they have any health problems that I should know about. There have been times when I have turned somebody away with HIV because I had enough. And I have a good referral network, so I can do that. There would be one of my colleagues around that would be available for that person at the time.

**Counsellor protection**

*Me: You mentioned joy, and now you are mentioning a less positive side of working with clients with HIV....*

**Tom:** And its the side...I mean I'm quite politically motivated, and there's an importance in focusing on 'we're the same' and so on, but there is also a need to have a sense that...certainly the modern image of psychotherapy has the tendency to devalue the dark side, the shadow, the pain. We are quite aware that we heal someone's pain when they are being abused, we help people to integrate those kinds of experiences into their lives and so on. But where humanist therapy stops being radical and forgets what psychoanalysis has taught us about the bleakness of the human soul and its potential for destruction and self-destruction...sitting with those things...And HIV can bring us close to those things, if we let it. There's lost of contexts where people work with HIV and where its difficult to let themselves do that, and I think by allowing myself to, by controlling how much of other people's HIV I have in my life, in my work life, I can give more room for that. For those really unanswerable existential messes.

*Me: You don't have to answer this question, but I'm wondering if counselling people with HIV has had an impact on your view of your own HIV status or not?*

**Experience (effect on non-counselling life)**

**Tom:** Well I mean I have been working with people with HIV or AIDS since the early 80's, and I discovered that I was positive in 1996. Although I most probably had it for a fair while before that. In some ways it smoothed my passage, because I knew everything. I paid attention and learnt about the medical information, the treatment information, what support was there...So I knew everything about that. But it also meant some really quite difficult experiences in deciding whether to tell my clients and being informed by their stories of telling other people. So on the one hand I was really well fed with what other people had experienced this might be like – good, bad, medium, alright, horrid. I had all those experiences to support me already. But then it was the issue of telling my clients, and wondering about when we make an agreement to see somebody long term what does it mean. Really being very thoughtful about that, continuously in supervision. But other people's experience, as usual, is nothing against one's own....From my own experience

**Experience (effect of non-counselling life)**

I've learnt not to trivialise the impact of it. In the age when we can g to the clinic and get fed pills, nowadays we can take one pill twice a day even, and it doesn't really matter if you eat or you don't eat as long as you take the pills regularly. Everybody says 'fine, go back to work, do your job', but I had to curtail my work, because HIV whether you are on the pills or not on the pills is stressing the body, is putting a great demand on you. If I want to be in top form in that room down there [Tom's counselling room] then I have to take care of myself. And I have to take care of myself in a slightly different way. So I have learnt not to trivialise my clients experiences, very, very much so. And that's somewhat counter to what is happening in the NHS in terms of funding.

*Me: Can you think of any differences between counselling HIV positive clients and clients who are not positive or are not aware that they are positive?*

**Tom:** I only think that HIV is really an important issue for anybody examining how they relate to the world these days. And it's obviously particularly important for gay men, but nevertheless impacts on different communities in important ways. There is something archetypal in its importance for me in that it brings sex and death together in such a collision that any one of us will respond to that in different ways. And I think that sex and death is what therapy is about, so in some ways HIV makes material what our fantasies hopes and dreams are all about. And it's a very interesting way of exploring those things. It's an issue for gay men who aren't positive and might want to stay that way. And it's an issue for straight people. More so currently, but obviously with less intensity. I got lost a bit. What was your question?

*Me: Is there anything else you can think of with regard to your learning experiences with HIV positive clients?*

*Positive effects*

**Tom:** Back to the topic! I wrote about a client who found out that he had HIV during his time of therapy. I wrote about this in my case study, and it provoked...I wrote about it under the heading of 'HIV is the best thing that has ever happened to me'. And this provoked strong reactions from the people who marked it. They either saw where it was coming from or they were very perturbed by this whole idea. And I guess that reminded me that there is still around quite powerfully a heterosex belief that people with HIV brought this on themselves, that it's a self-destructive act, so on and so forth. I have learnt that anybody who works in the field in any way has to be so careful about saying things. What I said earlier about sex and death, it provokes the dragons or the beasts in one's head, the general psyche, it really, really does.

*Me: OK.*

**Tom:** I'm afraid I haven't been very helpful.

*Me: No, it's been really helpful. Thank you.*

*Experience (effect of non-counselling life)*

**Tom:** Because I was really thinking, struggling, what is different about working with someone with HIV? And I ask myself the same questions because I am interested in how certain psychotherapies don't treat people who are gay very well. And what would constitute gay affirmative therapy and what would be useful. It's really...when I get down to it, I say you should treat people who are gay exactly like anybody else. But what you have to realise is that what is unspoken in our heads becomes vitally important. It's the unspoken attitudes, opinions, beliefs that we perhaps aren't even aware of holding that become vital. Where I was theoretically before I knew I had HIV was in a good place for working with my clients. But discovering for myself probably meant that I was even more...I had the kind of experience to help prevent those negative structures, comments, remarks or even thoughts or attitudes that aren't spoken, things that happen at a transferential level.

*Me: Thank you.*

**Tom:** No problem.

## Appendix H: Lauren's transcript

*Me: Could I start by asking you for a bit about your background? So your theoretical perspective and the types of client groups you have worked with.*

**Lauren:** [Mentions that she has an Adlerian foundation and works as an integrative perspective. She has worked with a wide range of clients and is trained in couple and family counselling. She works in primary care and private practice and works with many people who have been referred by their GP's]

*Me: You don't have to answer this question, its just for background. But what were your reasons for coming into counselling, if you want to tell me?*

**Lauren:** [Mentions that there are a variety of reasons. In finding many of the patients she worked with distressed in her first career, she began working with some therapeutic approaches. Her interest also stems from intimacy dynamics and communication challenges in her family background]

*Me: During this interview I would like to ask you about the important learning experiences you have had as a result of counselling clients and the changes they may have lead to. Does anything spring to mind?*

Counsellor learning  
(gradual change)  
(all at once)

**Lauren:** I have been working for 25 years as a therapist and I think that changes can happen in very, very subtle ways over a long period or shocking ways and very, very sort of immediate. So the ones that I'm aware of that come up for me are the more sort of in your face. Before you came, I thought, I have a very simple card index file of all the clients I've seen, hundreds and hundreds and hundreds of them, so I thought I would just look at that as a prompt really. So the ones I share there will be that bias towards that shock factor I think, and that may not be being fair to the changes that I have experienced over a number of years. Erm, I just let myself be free when I'm reflecting on this, and I just let them just emerge as they just spontaneously did before I actually looked at all these hundreds of names. The first one that came up is a comparatively more recent one, so this is not chronological. I guess the whole issue is around boundaries and what that means therapeutically, and how, erm, if you like, the danger of religion in psychological approaches and therapeutic approaches. I was seeing a client anyway and was aware about something else. I need to be a bit...in possible view of publication...anyway, the client was seeing me about other issues and as the issues emerged her son was very troubled, and so there was a parallel story going on separate from the presenting issues. And then he went missing. This was over a long term counselling relationship, so it was happening lets say over about a year. So he's missing, they're searching here and abroad. And then I get a phonecall to say that his body his been found abroad. So there's a phonecall late at night. It's a boundaried situation, but the client phones me to say that the police have just called round to say his body has been found. And I say that I will come round and see you tomorrow morning at your home. And I do, and I hold her hand, and she weeps, and I feel weepy with it now. So I was there for about a quarter of an hour and in fact I had to go on because I was working at a GP's surgery. I report this to my supervisor, that's right, I phone her up just to tell her the situation, and I'll see her in a few days. When I see her the supervisor says that in the meantime she has seen her supervisor for a supervision and tells me that I have outrageous boundaries, that this is clearly breaking all taboos, and just really questioning whether she can work with me. This is a supervisor I had worked with for about 5 years with a very good relationship and mutual respect. So that was a major transformation in terms of me working through, yes, you could argue over-connection with the client, it transpired that the client's son was a similar age to one of my sons, so this was being challenged too, that I was in a kind of over-identification situation. Within the Adlerian approach, unlike the psychoanalytic, its not totally taboo to do that kind of thing, maintaining boundaries, so there was a clash of cultures here, which was my stuff, and my shock and involvement and so on, but I think this was a...well, we worked it through my supervisor and I, she owned that she had perhaps over...

in the shock and the distress of a very horrible situation, I'm not going into great details about it because to give further details would be inappropriate, but it was all very shocking. It felt like an over-protectiveness.

*Me: What did you learn from that experience?*

**Boundaries  
(flexibility)**

**Counsellor is human**

**Counsellor learning  
(reflection)**

**Lauren:** My learning there was that there can be elasticity in boundaries whilst maintaining them. I have never been in the client's house again, I have never had a phonecall again, we carried on therapy. For me I maintained that strong philosophy that I can be an ordinary human being in the face of trauma and at the same time I owned my own involvement and looked at that and needed to be challenged about that. So that was a major learning thing. Its something about the fact that there can be boundaries but they can be like an elastic band that has stretch but can still be maintaining. It really made me think a lot and it stayed with me very, very deeply. It made me reflect, write a lot, think a lot about the whole danger, I would say about therapy, counselling taking away our ordinary humanness. And rules and regulations as opposed to ethical practice. I think the BACP framework now is vastly improved now as a document in terms of really looking at that.

*Me: And has that experience affected your ideas about supervision?*

**Lauren:** Yes, very much so. That was a key...so I was in a place to reflect a lot about supervision and get a lot of input about that. And another key thing was really looking at what I think can be a dangerous rigidity within, its not just psychoanalytic practice, but the blank sheet idea. And yes, boundaries are hugely important, I hold them incredibly dear. So there's the paradox really. I think boundaries are enormously important, its knowing what to do with them. So this was about a kind of process that was happening and how the sort of supervisory supervision of supervision of supervision, where does it end? Who is judging who? Actually, is the client getting lost in this? Potentially.

*Me: Do you have any other experiences you want to talk about?*

**Boundaries  
(flexibility)**

**Lauren:** Oh loads! Erm, when I reflect on that, in the flow of it, way back was a client who died. It echoes this, but it was much earlier in my career...A client who had what looked like an absence in the session. And was complaining of challenges, was saying 'I have strange sensations, I was driving and suddenly didn't know where I was' this sort of thing. This client was going through a very stressful time, so I said, 'I think its really important you go to your GP about this'. There was no obvious problem, but the GP did decide to refer. The neurologist did contact me and we discussed it and said that this person was very stressed. So it wasn't as common at that time to do the MRI scans, but sadly she was developing a brain tumour and died. I think two things. One I visited – she was not in a position to have counselling. She lost her speech and so on, which was very tragic. So there was how to do counselling with that? Maintain that counselling without her having any speech, in a hospital setting, so again it was moving it out of the boundaries. It affected me in a number of ways. In terms of that ongoing need for us to really see the whole person, psyche-soma aspect really, and always that need to be very vigilant about that. And something about the elasticity of boundaries again. That they can be maintained, but need to be flexible. And just being very sad. It's a situation where again, another agenda appears, and working through to the day before she died. So although this wasn't hospice work I found myself in that position. It affects me very deeply in terms of both the deep sadness and the privilege of working with somebody through that terrible experience. The boundaries in terms of that the family is going to be there. We are not in a little box in an ivory tower, there are going to be people there. This is the stuff of our work, so it is again learning how to work with that. I think I work better with that now, in terms of how to handle those multiple bits, I'm not saying I did that wonderfully in that situation, but it was the learning that the therapy does not just neatly stop when it can no longer be in the room.

*Me: Have these experiences affected the way you are outside of the therapy room?*

**Humility**

**Lauren:** I guess it has had enormous impact really. I don't know whether I can put my finger...I think its just that I'm much more humble.



Counsellor learning  
(gradual change)

I have a tendency towards arrogance and so on and I think just increasingly, that's the ongoing drip, drip, drip of this work, that far from feeling I have... again the contradiction of with increasing experience, increasing awareness, the pinprick on the universe kind of stuff. And the grandiose notions 'I want to go and help people, I want to bring peace to the world', this kind of stuff are not helpful. It doesn't make it insignificant what we do, it just needs to be put in some kind of perspective... I mean I don't know how much time we have, but I just scribbled down some things.

Awareness  
(increased)

*Me: If you have time, that would be great.*

Painful work

**Lauren:** Yes. Well, I see I got there, there, then I put an arrow down to suicide. In twenty five years as far as I know I have only had one client who has committed suicide but it was very huge. I think that comes back to the little pinprick bit again. Very tragic, a whole team approach – the GP was involved, a psychiatrist was involved, we were all very busy and she committed suicide, in a very horrible way, which is unusual for a woman. That had a huge impact in terms of the inevitable kind of reflection, 'what more could I have done? What should I have done? I should have done this that and the other'. I'd seen her the day before, and I actually saw her with her partner. Yes we could have sectioned her. And I think that is a reality, we could have done more. I recall getting the call from the GP when I was just in between clients, in the 10 minutes I give between clients, I got this call and having to work with the next client after that. That affected me greatly. I became very over-fearful that every client could commit suicide. I had to work through over-compensation there. The huge loss of trust in myself in judgements, and something about the learning was moving it away from that intellectual bit that we can't be responsible for our clients. I think we need to be responsible for ourselves as ethical and appropriate practitioners... I was very twitchy for a long time after that. And the learning, it needed time. There was the immediacy of the shock, but the kind of ongoing learning, rebuilding that. And also I may have missed a bit, so that's reality too. I'm not perfect.

Counsellor learning  
(gradual change)

**Counsellor is human**

*Me: Being human, again?*

Counsellor learning  
(reflection)

**Lauren:** Yes, I think it's a theme. Just in reflecting, its interesting, we are all imperfect beings. What are other... dreaming. Dreaming the clients dreams. Its only happened once, although I will pick up in the room the person's body experiences, or I'll pick up their thinking by whatever means that is. But one time I had seen a client in a GP practice who was being reticent and clearly there was something very big troubling her. So I then, that night, wake up screaming and this is not something I have ever done or known that I have ever done, because what I'd had was a nightmare of an image of just one area of the body, and this particular person is wearing a very specific sort of tartan and something terrible is going to happen. And it was so vivid, and the next week the client shared exactly that in terms of something that had happened. It made me think about looking cross culturally, and the shaman kind of dreaming the dreams of the client. So there's a lot that I thought about this strange job that we do. It didn't feel extraordinary in that this is the stuff that is there in all of us as individuals and we do pick up what is there and people transform that into many things. Whether they transform it into a form of religion or a spiritual thing, there is some other thing that goes on in the therapy room. It was a trigger really for me to reflect quite deeply on that whole process and the existence of that sort of communication and what we do with that.

*Me: Did it affect your ideas about that?*

**Lauren:** Well I think it crystallised something which is an important part of therapy along with empathy and things like that. It made me think much more broadly about the human psyche really and take it out of the therapy room, and wonder. I don't have any kind of belief, I think I suspend belief, it's a curiosity really. But I think it's a much clearer hook to hang on... and be respectful I think, of what is often pushed aside as mystical or weirdo or... One can look at it in terms of people who are given labels.

Counsellor learning (reflection) What's happening here, maybe looking at societal stuff of what happens collectively in terms of messages received, and so on. It was a trigger for a lot of further reflections about the human psyche and what we are about. I haven't come to any conclusions, but I think just to maintain that openness. I know you might have many other questions, so I'd better...

*Me: My questions here are really prompts in case you don't have anything else to say, so I'd rather hear your examples.*

Risk taking (usefulness) **Lauren:** Oh, alright. Well there's the whole issue of touch, and I had brought up earlier in my experience the idea that 'thou shall not touch'. I think that was very helpful earlier because I didn't have experience in my training and post qualifying. It was really useful because I didn't have the experience to really have that internal supervisor to be monitoring 'hang on, how much is this me longing to collude in something or to rescue?'

I think as the years have gone by I'm much, much more open to touch and to use that as a therapeutic intervention. Its still very much about boundaries, thinking what is appropriate, what is not, what is actually going to be useful in the work, what would be unhelpful. Sometimes that risk taking of particularly working with clients who are focusing on early abandonment stuff, deep abuse, neglectful issues particularly. I can think of a situation where I really took a risk of lying down, on this floor with the client, just lying there alongside. And there's touch and just stillness. I risked that, just moving, if you like, with the flow. So just something about learning to assess risk. I'm thinking of one client in particular. Now this is a female client and I doubt whether...I mean I have used touch with male clients, just in terms of a very simple hug, and of course there are equal issues with a woman in terms that sexual issues could be there of course, but the work, particularly with this person has really moved things on in terms of knowing and appreciating what is something deeply therapeutic. Sitting in our chairs is fine and on the whole completely appropriate. There's abuse in counselling and then it could almost be abusive not to use touch in other ways. I think that's the learning, in long-term work, how to risk using touch in a way that can be deeply healing. So it felt very risky and also it felt right, it was working. That can be extraordinary. That moment it was very much about just parenting. I am not just a blank sheet, I am being substitute parent at that point, and that's OK. That's very important for her therapeutic movement. So the

Counsellor learning (gradual change) learning was happening over a long time, there was the earlier in my career of 'oh that person needs a hug', I didn't do it, but getting hooked in to the notion of rescuer. There might have been some blurry bits in that transition, but it did involve risk. This client has helped me learn what is appropriate and interestingly, this client is now able to sit on the chair. Erm, well there's going back an early experience of me not being very proud of myself at all, and learning long after the day, so this is more, pretty sort of solar plexus sort of stuff, really. Early on when I was newly qualified and there was very little on sexual abuse in the literature. In terms of training and so on comparatively little. And this client who was talking about a very violent partner, and clearly sexually violent, so we were able to talk about that, but she also talked about how her daughter was saying how she hated the partner and put out little notes saying 'the bastard' and so on and so forth. Then my first training around sexual abuse issues, I look back and in that again initially I went over the top, everywhere I looked people were being sexually abused, but its just I particularly look back to that case and again I'm not going to give details but every indication was that this young person was being sexually abused. That was rather hideous learning.

Awareness (increased) So there's not the listening to the parallel process and not actually taking it to supervision to be addressed. Actually I don't think my supervisor at the time would have known either. So the learning is really what is the societal culture I'm living in? The phrase I really like and use a lot is herrings don't know the meaning of salt water. So if I'm swimming in it I don't really see it. But then of course I was just plunged in a sea of a very challenging and demanding course on sexual abuse and then everything seemed sexual abuse, kind of lurched into that other scenario, so I had to find some kind of middle place. The training was a huge learning but it was the way it linked particularly to that case. But it also probably represents a myriad of other things I missed, lost, didn't get. So its something about all of those. The culture wasn't tuned into it, even though it was only 20 years ago. I think that's all I want to say in terms of experience, because its all quite demanding talking about it.

*Me: Of course. I'll switch the tape off. Thank you....thank you.*

## Appendix I: Formulating interview questions

As stated in the section on interviewing, during the process of carrying out the first four interviews for my grounded theory study, I became aware that I would benefit from having a list of interview questions to use as prompts in future interviews. A list of questions was formulated using the categories that had arisen as a result of the analysis of the first four transcripts (two from ‘group A’ therapists, and two from ‘group B’ therapists). These categories are shown below.

### ‘Group A’ Therapists:

- \***Acceptance** (of difference, facilitates change)
- \***Confidence** (gained, lost)
- \***Counsellor protection**
- \***Counsellor learning** (relearning)
- Counter-transference**
- Experience** (use of in other counselling work)
- \***Honesty**
- \*Inspirational clients
  
- ‘**Not knowing**’
- \***Personal development** (linked to professional development)
- \***Self-disclosure** (appropriate use of, inappropriate use of)
- \***Self-knowledge**
  
- Speaking out**
- \***Talking** (as part of the learning process)
- \***Training Inadequacies** (no HIV)
  
- \***Training inadequacies** (too academic)

### ‘Group B’ Therapists:

- \***Acceptance** (self, labels not important, facilitates change)
- Awareness** (increased, of motives, use in personal life, can lead to change)
- Boundaries** (importance of)
- Challenge** (appropriate use of, can move a client on)
- Client as counsellor**
- \***Confidence** (gained)
- Communication** (importance of)
- Counsellor is human** (being yourself)
- \***Counsellor learning (learning from clients, always more, from bad experience, from difference, from experience, gradual change)**
- \***Counsellor Protection**
- \***Honesty**
- \***Inspirational clients**
- Intuition** (as a therapeutic tool, use in personal life)
- \***Personal development** (own therapy)
- Risk taking** (part of job)
- \***Self-disclosure** (client self-acceptance, appropriate use of)
- \***Self-knowledge** (bracketing, client’s, increased)
- \***Talking** (as part of the learning process)
- Theory** (constraints of)

All categories shown in figure 3 that are marked with a star (\*) were found to be present in both the ‘group A’ and ‘group B’ data sets. In contrast, the categories that are not marked were only found in one of the data sets. These unmarked categories were used to formulate the interview questions shown overleaf

Interview questions from categories relevant to learning and change experiences mentioned by 'group A' participants only:

<u>Category</u>	<u>Interview Question</u>
<b>Counter-transference</b>	Have you learnt anything about transference or counter-transference from your work with clients?
<b>Experience</b> (client type to type)	Have you ever had a learning experience with one client group that you have made use of in counselling a different client group?
<b>'Not knowing'</b>	<i>(I could not think of an appropriate question).</i>
<b>Speaking out</b>	<i>(I could not think of an appropriate question).</i>

Interview questions from categories relevant to learning and change experiences mentioned by 'group B' participants only:

<u>Category</u>	<u>Interview Question</u>
<b>Awareness</b> (increased, of motives, use in personal life, can lead to change)	<i>(I could not think of an appropriate question).</i>
<b>Boundaries</b> (importance of)	Have you learnt anything about boundaries from your work with clients?
<b>Challenge</b> (appropriate use of, can move a client on)	Have you learnt anything about challenge in counselling from your work with clients?
<b>Client as Counsellor</b>	<i>(I could not think of an appropriate question).</i>
<b>Communication</b> (importance of)	Have you learnt anything about communication from your work with clients?
<b>Counsellor is human</b> (being yourself)	<i>(I could not think of an appropriate question).</i>
<b>Intuition</b>	<i>(I could not think of an appropriate question).</i>
<b>Risk Taking</b> (part of job)	Have you learnt anything about risk-taking from your work with clients?
<b>Theory</b> (constraints of)	Have you learnt anything about theory from your work with clients?

## Appendix J: Research journal extracts

- Entry 4** *Interview 1:* Jill (group A). I was very nervous. This affected my ability to form a trusting relationship with her, I think, and perhaps explains why her answers seemed guarded. She was seemed helpful and forgiving, though.
- Entry 6** *Interview 2:* Eve (group B). I enjoyed this interview: An interesting person!
- Entry 7** *Interview 3:* Alice (group B). This was a great interview. The participant gave me so much to think about, and she was so relaxed and supportive. I feel a bit more confident about my study now.
- Entry 8** *Interview 4:* Annie (group A). This one didn't go very well, at all. In hindsight, I was totally insensitive and asked a really intrusive question. I hadn't understood what was being said, and asked for clarification, which forced the participant to disclose something very personal. I felt really embarrassed. Waiting for a train back home today, I reflected on my interview with Annie. The other participants seemed to be able to talk for the whole hour, but I found it really difficult to keep Annie talking, and ended up finishing the interview a bit early because she had nothing more to say. How can I make it easier for myself if this happens again? I know I need to be a lot more confident and relaxed when I'm interviewing. But I also suddenly thought that I could formulate interview questions from the categories that have arisen from the first four interviews, so that if a future participant doesn't seem to have anything more to say, I can use one of these interview questions as a prompt.
- Entry 9** *Interview 5:* Zoe (group A). A really nice person and really open. It seemed as if she wanted me to stay longer, but I had to get to the next interview.
- Entry 10** *Interview 6:* Angela (group B). This went OK, although I think she was annoyed when I paraphrased something at one point. She seemed to be trying to find the right words, but didn't appreciate my efforts to help! She talked around the subject quite a bit, and I wasn't firm enough in bringing her back to the topic of her own learning and change experiences. But it was a worthwhile interview, anyway.
- Entry 11** *Interview 7:* Richard (group B). My first male! He was very calm and interesting.
- Entry 12** *Interview 8:* Rose (group B). She mentioned something about learning to writing notes during sessions after tape recorder had been switched off. Said that she would add this to the transcript when I sent it to her.
- Entry 13** *Interview 9:* Elly (group B). Had problems with the tape recorder, but enjoyed the interview anyway.
- Entry 14** *Interview 10:* Teresa (group B). A really lovely person, who also said that she'd enjoyed my style of interviewing.
- Entry 15** *Interview 11:* Alex (group B). I felt a bit intimidated by this participant, but she was quite friendly. She just seemed so confident! I have done ten interviews now – this was the 11<sup>th</sup>, and I'm still not self-confident as an interviewer. I wonder if I would be better at putting the participants at ease if I was more self-confident. At the same time, I also think that because I must come across as very nervous, I don't seem threatening or academic at all, and that might help the participants to be more open.
- Entry 16** *Interview 12:* Claudia (group B). I felt a bit more confident today. It went OK.
- Entry 17** *Interview 13:* Irene (group B). She very kindly met me at the station to give me a lift to her house. A friendly, very learned person. I felt OK.
- Entry 18** *Interview 14:* Carl (group A). I turned up early, which the participant didn't appreciate. He seemed a bit guarded at first, but opened up after a little while. It was interesting.
- Entry 19** *Interview 15:* Colmat (group A). I felt very nervous during this interview and quite inadequate, whilst he seemed really confident. I forgot my watch and couldn't see a clock, and panicked throughout. I ended the interview a bit early, because I was afraid of taking up too much of his time by accident. He didn't seem to say much about his own experiences at all.
- Entry 20** *Interview 16:* Prudence (group A) I was almost late arriving at our meeting place, so I felt flustered. She was really nice, though, and I soon felt calmer.
- Entry 21** *Interview 17:* Claire (group B). She was really nice. I felt fine and it went well.

- Entry 22** *Interview 18:* Nkeiru (group B). Busy person, so I feel privileged to be able to interview her. And she gave me a lift to her house too. A lot of the therapists have been so kind.
- Entry 23** *Interview 19:* Janet (group B). She was sweet, although I worried that my questions were sometimes quite challenging.  
*Interview 20:* Ruth (group B). The participant wasn't sure about taking part, but said that it had been OK at the end. I felt OK.
- Entry 24** *Interview 21:* Wilma (group B). She was interesting to talk to. I felt quite calm.
- Entry 25** *Interview 22:* Maggie (group A). She put a lot into the interview. I feel privileged.
- Entry 26** *Interview 23:* Tristram (group A). Second side of tape did not record, despite initial tests. I'm annoyed and disappointed. I made some notes, and e-mailed Tristram. He said that he would prefer to write about the experiences he mentioned but which were not taped, then send this to me, rather than being re-interviewed or just including the transcript as it is.
- Entry 27** *Interview 24:* Louise (group A). Very confident and potentially intimidating woman, but actually I felt OK. Am I finally getting more confident in the interviewing or was it just that Louise was a nice person too?
- Entry 28** *Interview 25:* John (group A). Currently working with his first HIV positive client. Has agreed to further interviews if necessary. The interview went well, although he couldn't say very much because he was only talking about one client.
- Entry 29** *Interview 26:* Simon (group A). Very nice, friendly, humble man. Very open. I felt privileged to interview him, although slightly nervous because of some of the things he talked about.
- Entry 30** *Interview 27:* Finn (group A). Lovely man. Such an honour. I felt relaxed and interested.
- Entry 31** *Interview 28:* Susan (group B). Went off the topic sometimes. I felt OK.
- Entry 32** *Interview 29:* Soren (group A). Really nice person. I felt OK.
- Entry 33** *Interview 30:* Clare (group A). Has had 1 HIV positive client, but could not talk about that client at length. She was interesting, and I felt comfortable.
- Entry 34** *Interview 31:* Lauren (group B). This was a really useful interview, I think. She was very open. She ended the interview because she had been talking about something distressing. I felt happy to respect her need to end.
- Entry 35** *Interview 32:* Catherine (group B). It was OK, and I felt OK. I worried that she talked too quietly and the tape recorder didn't pick up what she had said, but I played it back afterwards and it seemed OK.
- Entry 36** *Interview 33:* Bryony (group A). Has had 1 or 2 HIV positive clients, but could not talk about them at length. I was OK.
- Entry 37** *Interview 34:* Lynne (group B). Seemed nice. I was a bit nervous, but OK.
- Entry 38** *Interview 35:* Stephen (group A). A real pleasure, although I felt nervous.
- Entry 39** *Interview 36:* Andrew (group A). I didn't feel so nervous today. It was OK.
- Entry 40** *Interview 37:* Nicola (group B). I felt slightly inadequate – she seemed so articulate. But I was OK and it went OK.
- Entry 41** *Interview 38:* Tom (group A). He was nice. I felt very self-aware, but OK.
- Entry 42** *Interview 39:* Fergus (group A). I wondered how I'd feel after quite a few months of not interviewing, but I was OK. It went OK.
- Entry 44** I came across something important today, whilst transcribing interviews. Teresa said, "If somebody else came with the question, I hate to say this to a researcher, but it would be different. It's the same in therapy as well". It feels important to mention this in my thesis, because I think she has a very good point!
- Entry 46** As I am transcribing I notice that many therapists mention that supervision is important in their work. I am learning that it is also very important for my research work...Christine and Cheryl have been so supportive. Transcribing is hard work, though. What I hear on the tapes is really interesting, but the process is so slow! I force myself to carry on...
- Entry 50** In transcribing the interviews I am picking up so much more than I did during the interview itself – focusing on not appearing too nervous and trying to form the outline of the next question I would ask in my head, I was obviously able to fully listen to what the participants were saying as I interviewed them.

During the transcription of the tapes, I have noticed that some therapists, who at the time of the interview I had thought said very little of substance actually said quite a lot, and vice versa.

- Entry 52** I'm starting to write up the phase 1 grounded theory findings now. I notice that the hazy ideas in my head look wonderfully clear on paper. The writing process seems quite creative, even though I'm just reporting the findings. I enjoy seeing it all come together.
- Entry 54** In thinking about presenting my phase 1 grounded theory findings in the form of a diagram, I have been playing around with circles...and suddenly what I had created looked like a flower, and a metaphor about therapist changed appeared!
- Entry 58** *Theoretical sampling study – interview 1:* What a great interview! What a lovely, honest, interesting therapist! I have lost a lot of interest in my doctoral studies recently, but this interview has renewed my interest and made me feel excited again.
- Entry 59** *Theoretical sampling study – interviews 2 + 3:* Not as inspiring as the first interview. Certainly worthwhile in terms of my doctoral studies, but they both, and especially the third, left me feeling rather flat, unconfident, incompetent and unworthy of doing a doctoral studies. I was pretty inarticulate, probably because I felt quite intimidated by the participants. The third, especially, seemed so confident... Perhaps I should have waited another ten years before doing this doctoral studies....I feel rather out of my depth.
- Entry 62** What a great final interview! I really ended on a high....It has been interesting to notice just how much I seem to be affected by the relationship I form with an participant.
- Entry 63** Reading *Becoming a Reflexive Researcher* (Etherington, 2004) on the train today inspired me to write this entry. I haven't written in this journal for a while. Partly, I think, because I have been engaged in writing entries in a different journal, for my phase 3 study. But in thinking about my doctoral studies today, I also realised that for the past month or so, I have been avoiding my PhD as much as possible. I had to force myself to write my most recent entry in my phase 3 learning journal. At the back of my mind, I admit that I have been feeling a bit unsure about my phase 3 study. It seems rather self-indulgent. Is it? And will it be of any use to anyone else? And does it matter? Am I wasting my time? I wonder how my co-researcher is getting on. What is more, I don't feel too confident about my PhD or about myself as a 'researcher' at the moment....I don't feel as if I have much control over it. I recently read that Reason and Heron (1995) note that all co-researchers should be prepared for chaos (feeling confused and lost during the inquiry) and should allow this to occur, so that new understandings can emerge out of it. I certainly feel quite confused and a bit lost. It feels really difficult to just stay with this, though, but I'll try.....
- Entry 65** I had a dream about working in a laboratory last night. This theme recurs in my dreams, and normally I have this type of dream when I am feeling stressed. It originates from a very stressful time in my life when I was a research student, working in a laboratory. Often in the dream, I need to do an experiment to meet a deadline, but for some reason I just can't get it done. This time, though, my dream was slightly different: I dreamt that a lab I was employed to work in was turned into a forest. I was pleased in the dream, and pleased when I woke up. I wonder what this means.....
- Entry 70** I have finally stopped avoiding my thesis, and I am now keen to get it finished. I have been working on chapters 1-4, which I have quite enjoyed. I am still avoiding the final chapter, but I now realise this is not because I am worried that the examiners won't like it, I am actually worried that I won't like it! The 'so what?' question might not be satisfactorily answered through my writing. My research has had a huge impact on me, and that alone as an outcome is good enough for me. Ideally, though, I would like it to be of potential use to others.
- Entry 71** I've finished. I've looked forward to this for years, but now I feel a bit sad as well as relieved. Although its often been difficult, I've enjoyed my PhD.

## Appendix K: Sample memos

### **21.10.05 Learning from Training, supervision and personal therapy**

Although I specifically asked about the experiences that they had during work with clients, many counsellors and psychotherapists I interviewed mentioned that they have learnt from training, supervision and personal therapy. For example, about a training she did on the subject of loss, Angela (group B), said:

Just realising how multi-faceted any loss is. So if I'm working for a local firm and they close down, I've not only lost my income, but I've lost my colleagues, my identity...I don't know why I'm imagining I'm a bloke, but maybe I've lost my wife's esteem...hundreds and hundreds of losses. And although at one level that's obvious, it sits with me as a clearer awareness in the counselling room now. So if a client talks about any kind of loss, be it a death or a relationship loss or something less big, its almost certainly going to deprive them in lots and lots of different ways, many of which they possibly haven't even quite thought about consciously. (*Angela, group B*).

I should include this finding in my final theory.

### **14.11.05 Few differences**

Therapists have said that there is little or no difference between counselling an HIV positive client and a client who has not presented as HIV positive. Zoe, for example, pointed out that 'the counselling skills and techniques are the same', and Carl added: '...there aren't that many differences. You are working with the same things, at least my experience has been that you are working with the same things that everybody comes to counselling with'. This may explain the lack of differences in the learning between the two cohorts of counsellors and psychotherapists.

### **3.12.05 Category types**

Two types of categories seem to have arisen – those relevant to the learning and changes therapists experience in their work and those that affect their outside lives as well.

### **5.12.05 Category types (see also memo 3.12.05)**

There are actually three types of learning and change categories: 1. Categories relevant to the learning and changes therapists experience in their work, 2. Categories relevant to the learning and changes practitioners experience in their outside lives, and 3. Categories relevant to learning and changes that therapists experience in both their work and outside lives.



## **Appendix L1: Research conference feedback**

## **Appendix L2: Research conference acceptance**

## **Appendix M: Letter to CPR**

## **Appendix N: Grounded theory study ethics approval**

## Appendix O: CSSI ethics approval

School of Education and Lifelong Learning

### Certificate of ethical research approval

#### **STUDENT RESEARCH/FIELDWORK/CASEWORK AND DISSERTATION/THESIS**

**You will need to complete this certificate when you undertake a piece of higher-level research (e.g. Masters, PhDs, EdD level).**

To activate this certificate you need to first sign it yourself, then have it signed by your supervisor and by the Chair of the School's Ethics Committee.

For further information on ethical educational research access the guidelines on the BERA web site: **HYPERLINK** "<http://www.bera.ac.uk/publications/guides.php>" <http://www.bera.ac.uk/publications/guides.php> and view the School's statement in your handbooks.

**READ THIS FORM CAREFULLY AND THEN COMPLETE IT ON YOUR COMPUTER** (the form will expand to contain the text you enter).  
**DO NOT COMPLETE BY HAND**

**Your name:** Sarah Kistler Turner

**Degree/Programme of Study:** doctoral studies in Educational Research

**Project Supervisor(s):** Dr Christine Bennetts and Dr Cheryl Hunt

**Your email address:** sarahinholland@hotmail.com

**Tel:** 07956 269 775

**Title of your project:**

doctoral studies title: 'Changed by the encounter': The learning and change that counsellors and psychotherapists experience as a result of their work with clients.

Working title of phase 3 project, to which this form relates: 'Learning and change in working with clients: A co-operative self-search inquiry'

**Brief description of your research project:**

This research project follows on from the grounded theory inquiry for which ethical approval was previously sought and gained from the School of Education and Lifelong Learning. In order to gain a more in-depth and longitudinal perspective of therapist learning and change, as well as an experiential understanding to complement and perhaps add to my grounded theory study findings, a different methodology will be employed. This will draw from both the heuristic (Moustakas, 1990) and co-operative inquiry (Heron, 1996) methodologies. The learning and change that myself and a co-researcher experience as a result of engaging in client work over a period of about a year will be recorded, analysed and presented in my thesis and perhaps other research reports.

**Give details of the participants in this research (giving ages of any children and/or**

**young people involved):**

2 participants: myself and an adult male co-researcher.

**Give details regarding the ethical issues of informed consent, anonymity and confidentiality (with special reference to any children or those with special needs) a blank consent form can be downloaded from the SELL student access on-line documents:**

Informed consent has been sought and gained from the co-researcher who, in the spirit of the co-operative inquiry methodology, will be involved in making research decisions throughout. He was given the option to refuse to take part in the research and is aware that he may withdraw at any time. He is also aware that he may choose, at any time, to remain unnamed in research reports.

Gaining consent from clients is not appropriate, as it is the researchers' learning and change that will be focused on, rather than any client material. Gaining consent from clients may actually be unethical, as this may shift the focus of the therapeutic work, in their eyes, from themselves to the researchers. The researchers' primary aim will be to provide an ethical, sound and adequately supervised therapeutic service to the clients, while their secondary aim will be to record any learning and change that they have experienced as result of providing such a service.

Client anonymity will be guaranteed by ensuring that any records of learning and change produced are free of client names and distinguishing details. A third party (an academic supervisor) will be also asked to read all research reports in confidence, to ensure that they are free of any distinguishing client details.

**Give details of the methods to be used for data collection and analysis and how you would ensure they do not cause any harm, detriment or unreasonable stress:**

My co-researcher and I will record our learning and change experiences, as they arise, in journals as well as in a range of other creative ways, as necessary (Heron, 1996, Moustakas, 1990). However, client details will not be recorded as part of this data, to ensure client anonymity. The data will be analysed in accordance with Moustakas (1990) and my co-researcher will be involved in this process. Harm, detriment or unreasonable stress to clients will be avoided by focusing primarily on providing an ethical, sound and adequately supervised therapeutic service for our clients and only secondarily on recording our learning and change outcomes. (Our learning and change outcomes would be of no worth, in fact, if our clients were to be used for the purpose of the research only, without providing an adequate therapeutic service). The reflective practice that the proposed research will catalyse may well be of benefit in our client work.

**Give details of any other ethical issues which may arise from this project (e.g. secure storage of videos/recorded interviews/photos/completed questionnaires or special arrangements made for participants with special needs etc.):**

In line with the British Association for Counselling and Psychotherapy's (BACP's) ethical principle of self-respect, as outlined in their *Ethical Framework for Good Practice in Counselling and Psychotherapy* which states that therapists should engage in 'seeking counselling or therapy and other opportunities for personal-development as required' (BACP, 2002, p. 4), both myself and my co-researcher are currently in and will remain in personal therapy throughout the proposed study. This will also enable us to reduce the risk of using our client work to resolve our own personal issues, which concurs with the BACP's ethical principle of non-maleficence (BACP, 2002). We are both members of the BACP and our work will be guided by their *Ethical Framework for Good Practice (ibid.)* throughout. Furthermore, we have both trained at Master's level in counselling and are currently engaged in diploma level training courses, which provide us with further skills training, tutor and peer support and feedback as well as self-development opportunities which are relevant to ourselves as evolving, ethically minded practitioners.

The proposed research will be carried out in accordance with the *Ethical guidelines for researching counselling and psychotherapy* set out by the BACP (Bond, 2004). Myself and the co-researcher will remain open and responsive to any further ethical concerns which might arise during the proposed study and we will

discuss these in a safe and confidential environment, seek expert advice as appropriate, and act on them as they arise.

**Give details of any exceptional factors, which may raise ethical issues (e.g. potential political or ideological conflicts which may pose danger or harm to participants):**

None known.

## **References**

Bond, T. (2004). *Ethical guidelines for researching counselling and psychotherapy*. Rugby: British Association of Counselling and Psychotherapy.

British Association for Counselling and Psychotherapy (2002). *Ethical Framework for Good Practice in Counselling and Psychotherapy*. Rugby: BACP.

Heron, J. (1996). *Co-operative Inquiry: Research into the Human Condition*. London: SAGE Publications Ltd.

Moustakas, C. (1990). *Heuristic Research: Design, Methodology and Applications*. London: SAGE Publications Ltd.

***This form should now be printed out, signed by you below and sent to your supervisor to sign. Your supervisor will forward this document to the School's Research Support Office for the Chair of the School's Ethics Committee to countersign. A unique approval reference will be added and this certificate will be returned to you to be included at the back of your dissertation/thesis.***

## **Appendix P: Conference report**



## **From Research to Practice: A Student's Perspective**

A report from the 37<sup>th</sup> Annual International conference of the Society for Psychotherapy Research, July 2006, held at the University of Edinburgh.

### **Overview**

As a student member of the BACP, I was very fortunate to have been selected for a bursary to attend the 37<sup>th</sup> Annual Society for Psychotherapy (SPR) research meeting, held at Pollock Halls in the University of Edinburgh, between 21<sup>st</sup> and 24<sup>th</sup> June 2006. Being both a doctoral studies student at the University of Exeter, studying the learning and change that counsellors and psychotherapists experience as a result of their client work, and as a trainee counsellor on a diploma course at Huntingdonshire Regional College, I was particularly interested in this year's SPR meeting theme: 'From Research to Practice'.

The conference was attended by well over 500 delegates from all over the world, some of whom I was able to speak at length to during the many social events made available by the conference organisers. The poster sessions, papers presented, workshops, panels and discussions covered a wide range of research topics. I attended sessions on defence mechanisms and anxiety, personality and theoretical orientation, clients' experiences of psychodynamic psychotherapy for bulimia nervosa, dream work, anger and sadness in psychotherapy, and counselling in schools, as well as several others. I also listened to a keynote speech on what has been learnt from ten years of measuring session by session outcomes given by Michael Lambert (from Brigham Young University, USA). I learnt that therapists are generally over-optimistic in predicting the outcomes of their work: many more clients are not helped or get worse as a result of therapy than practitioners expect.

### **The first session**

The first session I attended was a pre-conference workshop on the grounded theory methodology (Glaser and Strauss, 1968). (This is a way of doing research in which the findings arise from the data gathered and are not preconceived in the form of a hypothesis at the outset.) I was disappointed that the research studies presented in this session seemed to make use of only part of the grounded theory methodology. Theoretical saturation (when further data collection adds nothing new to the existing theory) was briefly mentioned only once, and theoretical sampling (where further data collection is carried out to expand on or improve the existing theory) was not mentioned at all. Partial use of the grounded theory methodology seems common in counselling and psychotherapy research, and I have written about this elsewhere (Turner, 2005).

### **The gap between research and practice**

Towards the end of the workshop on grounded theory, one of the presenters noted that although she had found her research findings useful in terms of her own interests and needs, her participants said that they had found them both irrelevant and inaccessible. This led to a lively discussion about the problem of the divide between research and practice in counselling and psychotherapy.

It was suggested that because most diploma courses in counselling and psychotherapy do not include a sufficient amount of training in research methods, counsellors and

psychotherapists are not trained to read, and more importantly, to critique research reports written in the often complex and incomprehensible language of academia. This needs to change.

Researchers also tend to publish their findings in academic journals that are not accessible for practitioners. Yet Tim Bond (2004, p. 15) suggests that it is an 'ethical expectation that [researchers]...seek opportunities to communicate any learning from research that is relevant to participants [and] practitioners'. Researchers need to start writing about their research in accessible language and publish it in magazines and journals that therapists actually read.

It is my understanding that process research tends to begin with the interests and needs of one particular researcher or group of researchers, whilst outcome research focuses on testing the effects of therapy on clients and building up an evidence base for practice. As I listened to the discussion about the gap between practice and research in counselling and psychotherapy, I wondered about the perhaps neglected needs and interests of non-research active practitioners (and of clients, trainers, trainees and supervisors) in terms of research. Perhaps future work needs to be carried out in this area.

### **Compassion and Culture**

In the remaining part of the report, I give an account of two sessions that, as a practitioner as well as a researcher, I found most interesting at the SPR conference: A panel session on compassion in therapy, and one on research methods and culture.

#### **Compassion in therapy**

According to Barbara Vivino (from at California Institute of Integral Studies in San Francisco, USA), there is an unspoken assumption that compassion exists in therapy, and clients tend to assume that therapists are compassionate. Yet there is little on compassion in the literature. Together with Barbara Thompson (working in private practice in Maryland, USA), and Clara Hill (from the University of Maryland, USA), Barbara Vivino presented an interview study of 14 therapists who were nominated as being very compassionate by their colleagues. These therapists noted compassion is different from empathy because it involves the desire to actively remove the client's suffering. However, it also often involves maintaining good boundaries.

I was interested to learn that some of the therapists interviewed said that they had developed compassion as a result of their interactions with clients. In a study in which I interviewed 39 counsellors and psychotherapists about the learning and change that they had experienced as a result of their work with clients, six said that they had become more compassionate. Barbara Vivino and her colleagues also focused on the ways in which compassion can manifest itself in therapy, and the types of clients it may be more or less easy to be compassionate.

The factors that limit compassion for therapists and the strategies that therapists use to return to a compassionate state were also discussed. However, it seems as if further research is needed in this important but under-researched area.

#### **Research methods and culture**

Shelia Spong (from the University of Wales, in Newport) spoke first about her research on feminism and counselling. She noted that counsellors are generally in a position of power

relative to the client. This is something that I have noticed in my own practice, but it has only been touched upon in my training so far.

Chris Jenkins (from the University of Manchester) then talked about his ideas about presenting research in a way that will lead to an empathic response from those that hear about it. He noted that people's responses to reports containing participant stories are generally very different those containing statistical measures. With reference to the gap between practice and research in counselling and psychotherapy, he commented, "Therapists' aren't going to change their practice [in response to research reports] without being moved in some way [by them]".

Finally, William West (from the university of Manchester) presented his work on Kenyan students' expectations on beginning a masters degree course in counselling studies, set up by the University of Durham and currently validated by the University of Manchester. The students he talked to seem to share many of the concerns that I remember having at the start of my own masters degree course in counselling studies at the University of Durham. Yet unlike me, they were also concerned about being taught in English and having to practice in another language.

### **Conclusion**

In summary, the SPR conference covered a wide range of topics, many of which would have been of interest to practitioners. Two of the panel sessions (on compassion in therapy and research methods and culture) were of particular interest to me, as both a research student and trainee counsellor. The relevance of research to practice was an underlying theme throughout and it was concluded by several delegates that research needs to be presented to practitioners in a clear and interesting way. As Chris Jenkins commented, "Therapists' aren't going to change their practice without being moved in some way".

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- Bond, T. (2004). Guidelines for researching counselling and psychotherapy. *Counselling and Psychotherapy Research*, vol. 4, no. 2, pp. 10-19.
- Glaser, B. and Strauss, A. (1968). *The Discovery of Grounded Theory: Strategies for Qualitative Research*. London: Weidenfeld and Nicolson.
- Turner, S. (2005). Comment on David Murphy 'A qualitative study into the experience of mandatory personal therapy during training' CPR, 5, 1, March 2005. *Counselling and Psychotherapy Research*. Vol. 5, no. 3, p. 262.