

THE COUNSELLOR'S SELF
IN THERAPY

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Abstract

The person of the counsellor, or what is sometimes referred to as the counsellor's self, is the focus of this thesis. How the counsellor's self is described and manifested during therapy constitute the two main research questions. Various perspectives are presented from psychoanalysis, behaviour therapy, cognitive behaviour therapy, person centered therapy and systems therapy. While issues pertaining to the counsellor's self have been explored predominately by systems therapists, this study extends previous research by involving interviews with counsellors from a range of orientations.

The study is conducted within an interpretative research paradigm, and data are collected and interpreted according to a qualitative approach. Semi-structured interviews with 16 counsellors, from a range of theoretical orientations, constitute the primary method of data collection. Other data sources include a short questionnaire sent to the same counsellors, the researcher's reflective journal as well as recorded meetings between a peer debriefer and the researcher.

Study participants describe the counsellor's self as a multifaceted, positive and integrated entity. The counsellor's self includes participant's professional knowledge and skills as well as their beliefs, values, thoughts, feelings, personal style and an unknown aspect of self that some participants referred to as their unconscious. While somewhat influenced by past relationships and the client, the counsellor's self is primarily autonomous and defined by the individual counsellor. Although the counsellor's self has the capacity to change over time, in different environments and with different clients, the self also includes notions of stability and consistency. The counsellor's self is involved in therapy as an inevitable presence, a deliberate tool and a stance. Participants highlighted the importance of self-awareness and various professional and personal constraints on the involvement of self. A central function of the self in therapy is in the therapeutic alliance.

The study has implications for the training and supervision of counsellors and future psychotherapeutic research.

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I would also like to thank my parents who have provided much support and encouragement over the years. To my partner in life, best friend and love, Darryl, I owe much, particularly for his encouragement, motivation, constant belief, love and support. Finally, I would like to dedicate this thesis to my two beautiful daughters whose own sense of self is constantly inspiring, grounded and honest.

Statement of Authorship

Except where reference is made in the text of the thesis, this thesis contains no material published elsewhere or extracted in whole or in part from a thesis by which I have qualified for or been awarded another degree or diploma.

No other person's work has been used without due acknowledgement in the main text of the thesis.

This thesis has not been submitted for the award of any degree or diploma in any other tertiary institution.

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Prologue

The purpose of this prologue is to position myself, in terms of my own motivation and personal interest, prior to beginning the formal part of the thesis. As Denscombe (1998) and others (Guba, 1981; Nagy, 1994) have suggested, making the personal position of the researcher explicit, demonstrates and acknowledges researcher bias and expectations, and enables readers to make their own judgments about researcher influence. Accordingly, my own experiences as a client, therapist and supervisor are presented here and serve to outline the focus and boundaries of the topic.

I am a registered psychologist and was trained in the scientist-practitioner model of therapy and practice. As a trainee therapist¹ I 'practiced' on other University students, and many of these sessions were taped for evaluation purposes. On one occasion I was setting up the video camera with a student when we started to discuss the problems we both faced juggling study, work and relationships. The moment the video was in place I fell into counselling mode and the 'session' then began. At the conclusion of the session, with the camera safely switched off, the student laughed and remarked that she got more from talking to me before the session than during the counselling hour. As a trainee I was unsure what this meant about my counselling skills and assumed that in time my counselling would become more effective and comfortable. However, it did start me thinking about the difference between me as a person, and me as the professional counsellor, and whether there should or ever could be, a relationship between the two seemingly distinct parts of myself.

¹ While the various differences between counsellors and therapists have been highlighted (Clarkson, 1994; Feltham, 1997; Hendrick, 1987; Jevne, 1978) some argue that these distinctions are based on status and self-interest (Dryden & Feltham, 1992; Feltham, 1995; Lomas, 1981; Wosket, 1999). Either as counsellor or therapist the practitioner is acting as a change agent (Satir, 1994). Consequently, for simplicity, brevity and ease, the terms counsellor and therapist, and as well as counselling and psychotherapy, are employed interchangeably throughout this thesis.

The importance of the personal qualities of the therapist was further reinforced when I decided to receive therapy myself. Rather than select a therapist on the basis of experience or qualifications, I was aware that what mattered most was that my therapist engaged with me as a feeling and caring person, and knew how to live and love well herself. Similarly, working as a therapist has demonstrated to me that my own thoughts, feelings, personal history and past experiences are critical to the way I understand and work with clients, in useful ways and at other times, and with some clients, not so useful, as the following two examples demonstrate.

Working with Jane² demonstrated that my 'self' could be helpful and creative. Jane was in her sixties and had been severely sexually traumatized as a child. She was experiencing sexual problems with her husband and had not talked to their only child for several years. She was stuck and unable to see what she needed to do, though she was adamant that she did not want to 'go over' the past again. We developed a genuine relationship, and generally talked easily, though I often had the sense that we spent many sessions 'talking around' her issues. After some time, various images repetitively came to my mind and due to their benign nature, I decided to speak openly to her about them. As our relationship was open and trusting, we together discussed what these images meant and how they might apply to where she currently was, where she wanted to go and what she needed to do. At the end of therapy, which continued over several months, she talked about the significance of our relationship, how important therapy was for her and how comfortable and real she felt working with me. The part of me that is creative, open to visual imagery and ambiguity was a critical part of my therapeutic work with Jane.

However, I have also found that who I am may hinder therapy, as demonstrated in the work I undertook with Mary and her husband, Cal. During therapy, Mary accused her husband of having an affair, and after going over all the available information, it was clear to all three of us that something was obviously happening which Cal was not able to explain. Finally, in frustration Mary turned to me and asked whether I thought he was having an affair. I hesitated, for while there were many indicators, I was loath to openly

² The names of clients described here are not their real names.

accuse Cal of having an affair, and furthermore, I was worried about Mary. She had married late, recently had a baby, and was desperate for this marriage 'to work'. I said that I took what the husband had to say on face value; he said that he wasn't having an affair and so I believed him. Mary was crestfallen, and said that she must be going crazy. This incident upset me deeply and in discussing the case with a colleague I realised that I too wanted this marriage to work for Mary and that I did not want him to be having an affair. The part of me that dislikes conflict and change, stemming from my own upbringing, got in the way of me working effectively with both Mary and Cal.

As a supervisor of numerous therapists, I have also been struck with how differently therapists work. In my position as Senior Guidance Officer (educational psychologist) one of my responsibilities was to review transferring students' files. Some of these children had received support over many years and, as evident by these files, different Guidance Officers worked with the same child in a multitude of ways. As most Guidance Officers in Queensland had been exposed to the same training methods, it seemed that the way in which they perceived and conceptualised their clients' problems reflected their own personal style, beliefs and limitations, rather than any particular theory.

My training, counselling and supervision encounters as well as my own experiences of being a client, demonstrated that the counsellor's self had the potential to impact on therapy, constructively as well as detrimentally. The counsellor's self seems to be more than personality, traits and attitudes, although the concept that I am describing certainly contains these features. The self that therapists bring to their clients also includes his or her beliefs, values, style, thoughts, private wishes, imagery, and fears. This personal presence encapsulates a counsellor's history, personality, insecurities and strengths and his or her individual way of perceiving and relating to the world.

These various case studies led me to consider the place of the counsellor's 'person' or 'self' in therapy. My initial hunch was that the counsellor's self would have a critical impact on therapeutic outcome. Before I could investigate this question however, I needed to first define or describe what the counsellor's 'self' was. Again, before

questions of efficacy could be sought, the second question seemed to be, 'How is the counsellor's 'self' involved or present in therapy, if at all? In other words, what is it that therapists bring to their clients, as people, and how does this affect their counselling work? These questions seemed to be the two sequential and logical issues to consider before questions of efficacy could be investigated and consequently became the primary foci of my thesis.

The literature that follows will be used to extend my own experiences and to refine and narrow the focus of the research undertaken in the present study. This prologue acknowledges my personal involvement in the issues under investigation and also serves to highlight my own 'self', as a counsellor and a researcher, and the way in which my 'self' may shape and direct the overall course of this thesis. In addition, the self-reflection and articulation of my own 'self' as a researcher, mirrors the process I will be undertaking with counsellors regarding their 'self' while working with clients.

Chapter one: Introduction

The aim of this thesis is to investigate how various therapists describe and experience the self in therapy. The section that follows clarifies the study focus and outlines the potential contribution a study into the counsellor's self might make to the psychotherapeutic literature. A literature review regarding the counsellor's self in therapy then follows in Chapter two.

Study focus and research questions

As the research foci of the present study arise from the perceived issues and gaps in the existing theoretical and research literature, they are mentioned here briefly and will be further elaborated after the literature review.

It has been difficult to find a term or word that neatly encapsulates the quality first presented in the prologue. Relevant terms from the literature include 'self' 'person' and 'personal presence' (as they pertain to the therapist), as well as more theoretically specific terms such as, 'congruence' and 'countertransference'. The primary focus of this thesis is the personal features of the therapist, including his or her beliefs, values, thoughts, feelings, dreams, fears, personal limitations and life experiences. When referring to these qualities globally, the terms usually employed in the therapeutic literature include the 'person' or 'personhood' of the therapist (Carlock, 2000; McConaughy, 1987; Satir, 1987, 2000; Smith, 2000) and/or the 'counsellor's self' (M. Baldwin, 1987b; Duhl, 1987; Keith, 1987; Pinsof & Catherall, 1986; Tester, 1992; Wosket, 1999). Thus, the 'counsellor's self' and 'person' will be employed when describing the personal qualities of the therapist, though specific aspects of self, such as the therapist's emotional life, (as inherent in the concept of countertransference) will also be considered in the literature review.

There are two main foci in this study.

1. How therapists, from a range of theoretical orientations, describe the ‘self’, or ‘person’ that they bring to therapy.
2. How the counsellor’s self is manifested during therapy, if at all, for therapists from a range of theoretical orientations.

Rationale and significance of the study

Defining and clarifying the place of self in therapy is useful in research that focuses on therapist variables associated with effective outcomes in therapy. Further research into the counsellor’s self also has implications for the selection, training and supervision of therapists.

Therapist variables and therapy outcome

The therapist variables associated with effective outcomes are considered in various studies (Ahn & Wampold, 2001; Bergin & Lambert, 1978; Berman & Norton, 1985; Beutler & Consoli, 1993; Beutler, Crago, & Arizmendi, 1986; Beutler, Crago, & Arizmendi, 1994; Coady & Wolgast, 1996; Crits-Christoph, 1991; Herman, 1993; Luborsky, McClellan, Woody, O'Brien, & Auerbach, 1985). A variety of factors have been investigated, including the therapist’s theoretical orientation, training, experience, age, gender, religious conviction and personality. While results on specific therapist variables are generally shown to be inconclusive, some (McConaughy, 1987; Satir, 1987, 2000; Wosket, 1999) suggest that the self of the counsellor plays an important role in the counselling environment. However, before efficacy studies regarding the counsellor’s ‘self’ can be undertaken, what is understood by the term, the ‘counsellor’s self’ and the experience of ‘self’ in therapy, needs to be clarified.

Counsellor demographics, such as age, sex, socioeconomic background and ethnicity have been examined (Ametrano & Pappas, 1995; McCullough, Worthington, Maxey, &

Rachal, 1977; Sue, 1990; Watkins, Terrell, Miller, & Terrell, 1989). While these studies have tentatively shown similarity between client and counsellor on variables such as age and gender facilitates therapeutic retention, on the whole, these factors do not play an important part in identifying a successful therapist (Beutler et al., 1994).

The training and experience of counsellors has been another counsellor variable considered (Atkins, 2001; Berman & Norton, 1985; Durlak, 1979; Hattie, 1984; Stein, 1995). Durlak (1979) compared the effectiveness of professional counsellors (therapists with postgraduate degrees in counselling) to paraprofessional counsellors (for example, parents, volunteers, students) on various outcome measures and found that outcomes of paraprofessionals equaled or surpassed the clinical outcomes of the professionals. Consequently, Durlak (1979) concluded that education, training and experience were not predictive of therapy outcome. Other studies since that time (Atkins, 2001; Berman & Norton, 1985; Hattie, 1984; Stein, 1995) have also shown that the relationship between level of training and therapeutic outcome is tenuous and that counsellor training and experience has a weak relationship with successful counselling.

Various therapist attributes and states have been found to impact negatively on therapy outcomes. Mohr (1995) cites various studies which demonstrate that a lack of counsellor empathy, poor technique, disagreement with the client about therapy process and content, and negative feelings such as anger and hostility towards the client, have all been associated with negative outcomes. The largest therapist impediment to client success in therapy, however, was found to be the therapist's underestimation of the client's problems (Mohr, 1995). While stressing caution regarding causality, Mohr (1995) does suggest that therapist variables may cause negative outcomes, during the course of therapy, with some clients.

The personality and wellbeing of the counsellor has been another research area. Specifically, the effect of counsellor personalities (Holloway & Wampold, 1986; Sexton, 1991) as well as coping styles (Holloway & Wampold, 1986), locus of perceived control (Koeske, 1995) religious beliefs (McCullough et al., 1977), extroversion/introversion

(Hinz, 1991) values and beliefs (Lafferty, 1989), counsellor wellbeing (Sexton, 1991) and modesty and patience (Kunce, 1990) has been examined in relation to counselling process and outcome. Again, these findings are inconclusive and as Beutler and colleagues (1994) summarised, many of these subjective counsellor variables are “complex, interrelated but not isomorphic concepts that may interact with yet undisclosed variables” (p. 237). It has proved difficult to isolate a specific therapist personality that is directly associated with positive or negative therapeutic outcome.

Other counsellor factors include variables such as theoretical orientation and the use of specific interventions (Beutler et al., 1994; Lambert, 1989; McNamara, 1975; Norcross, 1983; Shapiro & Shapiro, 1982; Shaw & Dobson, 1988). While different clients appear to react differently to different psychotherapies (Beutler & Consoli, 1993) research findings suggest that there are no differences in effectiveness amongst therapies for most problems (Bergin & Garfield, 1994; Kazdin, 1986; Prochaska & DiClemente, 1983; Prochaska & Norcross, 1999; Smith, Glass, & Miller, 1980). However, while no one treatment or approach is uniformly superior, there is an agreement that therapy is more effective than no treatment at all (Bergin & Garfield, 1994; Kazdin, 1986; Lambert & Bergin, 1994; Luborsky et al., 1985; Orlinsky, Grawe, & Parks, 1994; Shapiro & Shapiro, 1982; Smith et al., 1980). McConaughty (1987) writes, 'We know that *something* is working' (p.307, original emphasis), this ‘something’ being the person of the therapist.

...it is the individual therapist, regardless of school, who determines the quality of the therapy... It is possible that each school has a within-group variance (determined by the qualities of the individual therapists) that is greater than the between-group variance (determined by theoretical orientation), and that it is not the techniques or theoretical strategies *per se* that are curative. The finding of no difference lends itself to the thesis that the therapists themselves as persons are more influential than their theoretical orientation or technique (p.307).

Barron (1978) argued that counsellors' choice of method, technique and orientation is inseparable from the person of the therapist. Lindner (1978) as well as Atwood and Stolorow (1993) claim that the personal problems and dysfunctions of the counsellor determine the counselling orientation they ultimately choose, and in a sense, serve to address their own internal tensions and problems. Others have found that the major

influences for therapists on selection of theoretical orientation were primarily clinical and general life experiences and their own values and personal philosophy (Norcross, 1983; Vasco & Dryden, 1994; Wilson, 1993). Strupp (1978) extends these arguments by suggesting that not only does the counsellor initially choose an orientation best suited to his or her 'self' but that ultimately his or her techniques are modified and reintegrated into an individual style.

The person of the therapist is far more important than his theoretical orientation...techniques are inert unless they form an integral part of the therapist as person... In the end, each therapist develops his or her own style and the 'theoretical orientation' fades into the background. What remains salient is a unique personality combining artistry and skill (Strupp, 1978, pp.314, 317).

Such arguments demonstrate that the 'self' or the 'person' of the therapist is more important than the orientation chosen, or the interventions employed, in both the process and outcome of therapy. The skills and interventions employed by therapists are essentially driven by who they are as a person, 'who offers more than professional expertise' (Shadley, 1986, p.128).

The importance of the therapist as a person can be identified across the spectrum of theoretical orientations and professions. For example, Carl Jung claimed,

It is in fact largely immaterial what sort of techniques [the analyst] uses for the point is not the technique but the person who uses the technique... the personality and attitude of the doctor are of supreme importance (1964, pp. 159-160).

Speaking primarily for social workers, England (1986) points out the inevitability of the counsellor's self in therapy. While he confirms the place of theory in shaping and informing a practitioner's practices, England (1986) underlines the importance of the personal style and intuition of the worker.

The worker's choice will be guided – to an extent – by his formal learning of relevant knowledge, ideology and philosophy, but the specific processes will be one which is intuitive...They may reflect this learning, but his perception is likely to be as much influenced by his previous colloquial learning as by his professional education... (England, 1986 p.29).

Coming from a systems perspective, Satir (1987) also stressed the importance of the counsellor and what he or she brings to therapy.

Common sense dictates that the therapist and the patient must inevitably impact on one another as human beings. This involvement of the therapist's 'self,' or 'personhood' occurs regardless of, and in addition to, the treatment philosophy or approach. Techniques and approaches are tools. They come out differently in different hands (Satir, 1987, p.19).

Isolating further the vital ingredient in the client-counsellor relationship, Satir (1987) points out that

We have all observed that two people using the same approach have come out with quite different results. We have also seen that two other people using quite different approaches can come out with similarly successful results (p.18).

This statement is supported by research that shows therapists from within the same orientation, using manual stipulated therapy, and who are trained, monitored and supervised throughout their therapeutic work with clients, produce different outcomes (Castonguay, Goldstein, Wiser, Raue, & Hayes, 1996; Lambert, 1989; Luborsky et al., 1985). It appears that therapists do not work solely on the basis of the techniques prescribed within a treatment manual. Luborsky and colleagues (1985, p.609) summarise these points when they write

... the therapist is not simply the transmitter of a standard therapeutic agent. Rather, the therapist is an important independent agent of change with the ability to magnify or reduce the effects of therapy. This, of course, may be obvious to clinicians who are in the position of making referrals to colleagues; however there has been little quantitative evidence to support this clinical impression.

Similarly, after reviewing the literature into the individual therapist's contribution to psychotherapy process and outcome, and on the basis of his own research, Lambert (1989, p. 482) concludes that 'it would seem defensible to recommend treating the individual therapist as an independent variable in factorial research'.

More recently Ahn and Wampold (2001) found, using meta-analyses of component studies in psychotherapy, that the person of the therapist accounts for more variability in outcome than do treatment specific factors. They found no evidence that suggests adherence to treatment manual results in superior outcomes. Instead, Ahn and Wampold (2001) point out that rigid adherence to a manual may cause ruptures in the therapeutic alliance and restricts adaptation of treatment to the attitudes, values and culture of the client. Subsequently, Ahn and Wampold (2001) conclude that research and clinical emphasis needs to be on the therapist, rather than on a particular therapy or orientation. Who the counsellor is, rather than his or her theoretical orientation, or the specific techniques used, appears to be an important and consistent variable within the counselling context. Consequently, according to these arguments, the person of the therapist may be considered a general variable associated with effective outcomes in therapy, or what is sometimes referred to as ‘a common factor’, across therapies.

During the past thirty years, attempts have been made to identify the common factors associated with successful outcomes in therapy across a variety of approaches, or non-specific to any one particular theoretical orientation (Goldfried, 1982; Karasu, 1996; Miller, Duncan, & Hubble, 1997; Norcross & Grencavage, 1989; Prochaska & Norcross, 1999). In addition, research has found that experienced counsellors, regardless of their orientation, are more similar than different in the way they practise (Barlow, 1984; Crits-Christoph, 1991; Goldfried, 1982; Norcross & Grencavage, 1989). A key variable associated with successful therapy is an effective alliance between the therapist and the client (Andrews, 2001; Castonguay et al., 1996; Miller et al., 1997; Prochaska & Norcross, 1999; Teyber, 1997). However, it is still unclear how therapists establish and maintain a positive therapeutic alliance, though it has been suggested that the personal qualities of the therapist are intrinsically involved in this process (Andrews, 2000; Geller, 2001; Herman, 1993; Smail, 1978). Two studies have also shown that systems therapists use their self to build and maintain an alliance with clients (Oke, 1994; Shadley, 1986). Thus, the counsellor’s self may be a vital therapist variable associated with effective therapy, across a variety of orientations. Understanding the stance or qualities that

therapists bring to the encounter with clients would contribute to an understanding of what makes psychotherapy effective.

Overall, while the above literature indicates that the ‘person’ of the therapist effects the process of therapy, what is meant by the term, ‘the counsellor’s self’ and therapists’ experience of self in therapy, as will be shown in the subsequent literature review, is lacking a basis in empirical data. This study is not aimed at establishing whether the counsellor’s self is a variable that enhances therapy. Instead, this research constitutes an attempt to define the term, the ‘counsellor’s self’ and to investigate how the self might be manifested during therapy. These issues need to be addressed before questions of efficacy can be considered. As definitions and concepts are the building blocks of theories (Denzin, 1978), a comprehensive definition of the term, ‘the counsellor’s self’ may enhance research and theory development regarding therapist variables. In addition, once established, a comprehensive definition of the counsellor’s self may promote understanding regarding the therapist within the context of the therapeutic alliance and as a possible common factor in therapy. Information regarding the counsellor’s self is also potentially valuable for the training and supervision of therapists.

Focus of self in training and supervision programs for counsellors

Personal development programs and/or personal counselling have been encouraged for counsellor trainees and practitioners as a means of understanding and accepting who they are, and uncovering their personal limitations and dysfunctions. Dryden and Thorne (1991) contend “training, if it is to be effective, must involve a high degree of self-exploration on the part of trainees with the aim of increasing their self-awareness and self-knowledge” (p.4). The rationale for personal development programs for therapists is that their overall effectiveness in their work with clients will be enhanced once they are aware of their ‘self’.

There has been considerable diversity in the type of self development programs and activities for trainee and practicing therapists, including personal therapy or analysis, peer

counselling, journal writing and personal development books (Johns, 1996). Art, movement, dance and collage are other, less conventional self-knowledge type activities developed for counsellors (Johns, 1996). At the conclusion of training, supervision provides another opportunity whereby the personal issues of the supervisee may be explored and understood (Loganbill, Hardy, & Delworth, 1982).

While there are a number of studies regarding the efficacy of personal development programs and activities, much of this research fails to establish a connection between the use of the counsellor's self and therapeutic effectiveness (Enright, 1970; Morran, Kurpius, Brack, & Brack, 1995; O'Leary, Crowley, & Keane, 1994; Salmon, 1972; Watts, Trusty, Canada, & Harvill, 1995; Wheeler, 1991; Wilcoxon, Walker, & Høvestadt, 1989). For example, Salmon (1972) evaluated the effectiveness of Gestalt self-awareness exercises in a training program for counsellor trainees. She concluded that while the specific exercises ran in this program had no influence over counselling effectiveness, other self-awareness activities might, nonetheless, prove effective (Salmon, 1972). Similarly, Wheeler (1991) in a review of the effects of personal therapy for counsellor trainees found that while personal therapy was of some benefit to counsellors, it made little or no difference to client outcomes. Consequently, it is difficult to generalise about the worth of self-development programs for counsellors.

Various self-development programs focus on different aspects or 'parts' of the therapist, perhaps because of the lack of clarity in the definition of the counsellor's self. For example, some focus on a therapist's memories of his or her family (Wilcoxon et al., 1989) or the therapist's physical reactions when with a client (Enright, 1970). What is being developed in experiential self development programs is often unclear and at times culturally biased, deficit based and ill informed (Cook, 1999; Prosky, 1996; West, 1982). Consequently, training and supervision programs for therapists either focus only on a certain aspect of the counsellor's 'self', or alternatively omit the counsellor's 'self' completely, implying that it is unimportant or too difficult (Baldwin & Satir, 1987a).

In addition, the various studies examining the efficacy of personal development in counsellors make the conceptual leap that by becoming aware of different aspects of the person, (for example, an understanding of childhood experiences) the counsellor will then be more effective. Cooklin (1994) argued, "the link between the therapist's actual behaviour and range of responses after achieving these insights is rarely clarified" (p.287). The processes, or the specific behaviours, strategies and interventions, that counsellors engage in as a consequence of self development type programs, has seldom been articulated, particularly in the research literature. Gaylin (1994) reiterates this argument.

There has been relatively little research on how the personal qualities of therapists (viz. their aspects of self) affect their behaviour in the therapy session, and what influence this has on clients (p.386).

In summary, there is a lack of knowledge regarding *how* personal development activities might impact on a therapist's behaviour. Consequently, defining and clarifying the involvement of the counsellor's self in therapy might provide important information for the training and supervision of counsellors by identifying the core areas of self that counsellors need to develop, enhance or inhibit.

Structure of the thesis

The thesis commenced with a prologue that served to outline my motives and experiences of the present topic. Chapter one introduced the study, and included a brief overview of the study focus and aims, the research questions and an outline of the potential contribution a study into the counsellor's self may make to psychotherapeutic training, practice and research. In Chapter two, the person of the therapist is reviewed according to various theoretical and research perspectives including psychoanalysis, person centered, behaviour, cognitive behaviour and systems therapy. The developmental literature is also reviewed. Empirical and theoretical gaps and issues are highlighted, indicating two points. First, therapists from a range of orientations have not been asked how they describe the counsellor's self or their experiences of self in therapy. Second,

the counsellor's self tends to be regarded as either useful or harmful and not with the potential to be both, in much of the available literature on the counsellor's self.

A multi-perspective framework, drawn from the available research and theoretical literature, is then presented and provides a basis for the current research. The underlying assumption in this perspective is that there is no objective reality or truth and that there exist many possible ways of describing and positioning the counsellor's self. This framework constitutes an original approach to summarizing the available literature on the counsellor's self and involves considering the counsellor's self as intra-personal, inter-personal and trans-personal. The intra-personal position defines the counsellor's self in terms of the therapist's phenomenological experiences, including his or her thoughts, feelings, dreams and images. The inter-personal approach defines the self by the therapist-client relationship as well as the broader historical, social and cultural context in which therapy occurs. The trans-personal description of the counsellor's self represents a merging between the counsellor and client's self.

The methodology of the current study is presented in Chapter three. The rationale for an interpretative approach, utilising in-depth, semi-structured interviews, is outlined. Data for the present study consist of interviews with therapists from a range of theoretical allegiances, their subsequent interview transcripts, responses to a short questionnaire, and the researcher's insights as presented in recorded conversations with a peer debriefer and in a reflective journal. Potential methodological concerns are raised, which may be perceived to be inherent in an interview format, as well as the advantages and disadvantages of explicitly involving researcher insights.

The three sets of findings from interviews with 16 social workers and psychologists are then presented in Chapter four. First, the terminology that participants considered most appropriate to identify this phenomena is presented. Second, how therapists describe the counsellor's self is outlined. Finally, the issues identified by participants regarding the manifestation of self in therapy are presented.

The findings are then discussed in Chapter five, in relation to the previously established multi-perspective framework. In addition, tentative connections are made between therapists' description of self with their experience of self in therapy. In Chapter six, data drawn from the researcher's reflective journal and recorded meetings with the peer debriefer, are presented, concerning various methodological issues of the project as well as researcher insights regarding the counsellor's self.

The thesis concludes in Chapter seven. The implications for the study, in terms of the training and supervision of therapists, as well as for counselling theory and research are presented. The problems and limitations of the study and possible future directions then follow. An epilogue outlining the researcher's final position concludes the thesis.

Chapter two: The counsellor's self in therapy: a review of the literature

There are over 400 counselling theories (Prochaska & Norcross, 1999) and subsequently many different ways a therapist's beliefs, emotions, attributes, values, personality, vulnerabilities and life experiences are presented, valued and explained. Selected theoretical and research perspectives regarding the counsellor's self are presented in this chapter. Research gaps and theoretical issues are reported, highlighting the deficit in research across theoretical perspectives and a focus on the counsellor's self as either constructive or harmful. A multi-perspective framework is then drawn that provides a means of summarising the available information regarding the counsellor's self. The literature review concludes with the research questions.

Theoretical and research perspectives on the counsellor's self

In this section, the person of the therapist is reviewed according to various theoretical and research approaches including psychoanalysis, person centered therapy, cognitive behaviour therapy (including behaviour therapy) and systems therapy. These psychotherapeutic perspectives constitute the main theories employed by practitioners (Jensen, Bergin, & Greaves, 1990; Norcross, 1983; Prochaska & Norcross, 1999; Steiner, 1978) and are generally acknowledged to form the basis for most types of therapies (Patterson & Watkins, 1996; Smith, 2001; Wilson, 1993). A developmental approach is also presented, demonstrating the various ways the self might change over a therapist's professional career.

Psychoanalysis

Freud (1912) urged therapists to be like a 'blank screen' so that the client could work on his or her own issues without the contaminating influence of the therapist. This contaminating influence is usually attributed to countertransference, traditionally defined as the therapists' affective reactions to the client, originating in the therapists' unresolved

needs and issues. However, the trend to a more participatory stance of the therapist, as well as a broadening of the term, countertransference, has recognized the inevitable and useful influence of the personhood of the therapist, within the psychoanalytic and dynamic tradition.

Freud (1912) emphasized the neutral observer of the analyst and consequently advocated a minimal role for therapists within the analytic environment. He urged analysts to be ‘... opaque to his patients and like a mirror, should show them nothing but what is shown to him’ so that clients’ own complexes could be projected, without interference from any personal aspect of the analyst (Freud, 1912, p.118). Freud (1912) argued that the blank screen approach was essential for the transference process to occur, a critical feature in psychoanalytic therapy.

The process of the patient projecting his or her conflictual early relationships on to the analyst is through transference. As a result of a transference reaction, the patient can re-experience in his or her relationship with the analyst, aspects of similar and significant relationships from his or her past. Therapist neutrality is important so that the patient's experience of the therapist is attributed to his or her own past, rather than to the actual person of the therapist. Therapeutic neutrality means that the analyst must not respond to the patient's emotional pull with the normal or expected responses, but instead remain impartial, unmoved and not personally effected by the patient's feelings and actions (Singer & Luborsky, 1977). Accordingly, the less the analyst is personally involved in therapy, the easier it is for the patient to see that his or her own transference involves displacements and projections of past figures in the patient's life (Frank, 1999; Jackson, 1990). In this way, the presence of the therapist's person may contaminate the transference and interfere with its resolution (Arlow, 1985; Fenichel, 1945; Fine, 1982; Langs, 1982; Strean, 1982).

Freud's (1912) reluctance for the therapist to be personally involved in therapy was due, in part, to the potentially contaminating influence of countertransference. Freud (1910) defined countertransference as the therapist's unconscious affective reaction to the client,

which originates in the therapist's unresolved, infantile conflicts. For example, the analyst may see in a particular client some aspect of his or her own mother and consequently feel him or herself to be in the position of a little girl, unable to help his or her adult patient (Tanti, 2001, personal communication).

Freud (1910, 1915) argued that the analyst's countertransference reactions were a hindrance as they contain material that the analyst has not, as yet, worked through. Cohen (1952) suggested that, in the first instance, therapists experience countertransference reactions as anxiety. The therapist's anxiety might then be expressed in a variety of ways including an unreasonable dislike for the patient, becoming overemotional in regard to the patient's problems (Cohen, 1952), a repetitive need to talk about the patient between sessions, (Arlow, 1987, as cited in Jacobs, 1993), listening too intently and becoming angry or disappointed with particular patients (Jacobs, 1993). Countertransference reactions might also implicitly influence how a therapist works.

The way in which we listen, our silences and neutrality, the emphasis we place on transference phenomena and interpretation of the transference, our ideas concerning working through, termination, and what constitutes a "correct" interpretation - these and many other facets of our daily clinical work may, and not infrequently do, contain concealed countertransference elements...(p.140) ...[it is these] subtle, often scarcely visible countertransference reactions, so easily rationalised as parts of our standard operating procedures and so easily overlooked, that may in the end have the greatest impact on our analytic work (Jacobs, 1993, p.155).

Countertransference reactions are generally considered as stemming from the therapist's early relationships with significant others and consequently directly influence his or her interpersonal style in therapy (Catherall & Pinsof, 1987). When therapists are under pressure during therapy they may revert to the original coping styles learned in their original family of origin, rather than use those learnt later in life or in training (Catherall & Pinsof, 1987). More recently, others have also pointed out that the therapist's childhood, attachment patterns with significant others, and early unmet needs will significantly influence both the decision to become a therapist and the therapist's working style and attitude (Guerin & Hubbard, 1987; Hilton, 1997; Kottler, 1986, 1995; Skovholt & Rønnestad, 1992).

While psychoanalytic therapists are urged to undergo their own analysis (McConaughty, 1987), it is generally acknowledged that it is not possible for therapists to completely resolve all their own personal issues.

All therapists, by virtue of their humanity, have unresolved personal issues that stimulate countertransference reactions at least occasionally. We believe it to be a myth that some therapists are 'above' or 'beyond' having their personal issues interfere with therapy - or, even worse, that some clinicians have no unresolved personal issues (Gelso & Hayes, 1998, p.95)

Indeed, the process of therapy often stirs up otherwise dormant or unresolved issues in the therapist's personal life. Jacobs (1993, p. 174) points out that

Not infrequently, troubling aspects of our own lives, often related to disruptive experiences and fantasies of childhood and adolescence effectively buried before and after our personal analysis, threaten to reemerge as we confront correspondingly painful material in the lives of our patients.

However, the personal aspects of the therapist are not always considered a hindrance to therapy. While it is generally acknowledged that Freud encouraged analytic neutrality, accounts about his own work with patients (Blanton, 1971; Gay, 1988; Kardiner, 1977; Needleman, 1985; Roazen, 1985) reveal that he was not as neutral as he officially prescribed. For instance, it has been reported that Freud gave massages to some of his patients and became actively involved in their lives (Satir, 1987).

The recognition that the counsellor's affective reactions may contribute usefully to the therapeutic process has arisen, in part, because of the broadening of the term countertransference (from classical to totalistic), whereby the personal reactions of the therapist are used as a guide to understanding the client, treatment dynamics or both (Hayes, 2002). Heimann (1950), for instance, wrote that 'the analyst's countertransference is an instrument of research into the patient's unconsciousness' (p.81). The personal reactions of the therapist, such as feeling sad, anxious, scared or angry, might be a useful way of understanding what is happening for the client, even if not in the conscious awareness of the client. For example, the therapist feeling despair after a patient has left the session may indicate that behind the patient's outburst of anger

that occurred during the session, there is a general feeling of hopelessness (Tanti, 2001, personal communication).

Winnicott (1949) differentiated between three types of countertransference reactions. First, he identified the emotional reactions of the therapist sourced from the therapist's unresolved conflicts. This definition is aligned with Freud's original concept of countertransference. Second, he considered countertransference to also include aspects of the therapist's personality that help him or her to be therapeutic. These tendencies, belonging to the therapist's personal experiences and development, make his or her work with clients unique. Finally, Winnicott (1949) recognized that countertransference may be 'objective', and consist of the therapist's emotional reactions based on the actual personality and behaviour of the client.

The second part of Winnicott's definition, which focuses on aspects of the therapist's unique personality, is, Bochner (2000) points out, seldom recognized, though in many ways inevitable. Khan (1974), a colleague of Winnicott's, described this type of countertransference as the 'non-pathological capacity of the analyst's affectivity, intelligence, and imagination to comprehend the total reality of the patient' (p.206). The personal character and experiences of the therapist is stressed, rather than training or lack thereof. While there are some (Basescu, 1990a, 1990b; Weiner, 1972, 1978) within the psychoanalytic literature that have further referred to the therapist's personality and unique healing capacities, they tend to focus the use of self to specific instances of verbal self-disclosure rather than implicit and indirect ways the self might be involved in therapy.

The third part of Winnicott's definition of countertransference (1949) refers to the potentially useful information about the client that is sourced from the therapist's countertransference reaction. Similarly, drawing on the work of Ogden (1979; 1982), Miller (1990) highlights the potential for the counsellor to serve as a container for the projected unconscious thoughts or feelings of the client and in this way provide important and otherwise inaccessible information about the client's own inner life. Ogden (1979)

describes the process of projection, and projective identification, (inherent in this form of countertransference) as akin to the therapist having ‘a thought without a thinker’ as in, the therapist having a thought that is not his or her own. There is considerable debate within psychodynamic circles as to whether the therapist is feeling his or her own feelings, or whether the therapist receives and somehow contains the affective reactions and mental content of the client (Grotstein, 1994; Sandler, 1987). Nonetheless, effectively using countertransference *vis-à-vis* projective identification potentially provides information about the client, though requires from the therapist the ability to differentiate responses stemming from the client, and those responses sourced from his or her own personal material (Miller, 1990). These countertransference reactions may be experienced in the therapist’s spontaneous thoughts, feelings and physical reactions (Samuels, 1989). Therapist self-awareness and self-knowledge are important attributes in order to appropriately identify these different reactions and their origin.

In more recent times Lammert (1986) and others (Bouchard, Normandin, & Seguin, 1995; Holmqvist & Armelius, 1996; Lecours, Bouchard, & Normandin, 1995) make the distinction between the personal reactions of the therapist that arise from the client and are consequently useful in interpretation, from those reactions sourced from the therapist’s own past. In this way, the emotional reactions of the therapist might be potentially contaminating or valuable, depending on the nature of the reaction, its origin and how it is managed within the therapeutic relationship.

Overall, there have been various ways countertransference has been described including neurotic, non-neurotic, concordant and complementary (Racker, 1968), interactional dialectic, reflective and embodied (Fordham, 1979) and pro-active and reactive (Clarkson, 1995). Whilst a complicated term, countertransference may be regarded as referring to different aspects of the therapist’s experience of the client, therapy and his or her self. In this way, countertransference may be considered as referring to a therapist’s reaction (affective, cognitive or physical) originating either in the client or the therapist him or herself, or in the interaction between the two.

However, there are problems aligning the concept of countertransference with the personal essence of the therapist. The concept of countertransference emphasizes the personal limitations and dysfunctions the therapist brings to therapy, or, as Aron (2001) points out, defines the therapist's experience in terms of the client's transference, rather than originating from the therapist's own self. For instance, whilst the totalistic definition of countertransference allows that the counsellor may provide additional insight into the psyche of the client, this is due to the projection of the client's own material, rather than something that originates and belongs to the counsellor. The positive and individual nature of the counsellor's self is not generally considered as an entity in its own right, in much of the psychoanalytic literature on countertransference.

There are other ways in which the counsellor's self has been reported within psychoanalytic circles. Kohut (1971; 1977) for example, disagreed with the perspective that the analyst needed to be a blank screen and presented his own views of the therapist's self. In his work with narcissistic clients, he argued that the analyst needed to provide the client with a type of developmental second chance, through his or her own self (Kohut, 1971, 1977). Kohut's (1971; 1977) definition of self is closely connected to what he called the 'selfobject', or the caregiver. A 'selfobject' is an object because in the form of a person it is actually separate from the individual. At the same time however, the 'selfobject' is subjectively a part of the individual functioning of the self and a means of understanding the self and experience of self. While the self characterizes the way in which individuals permanently structure their feelings, beliefs, and memories as their sense of 'me', it also requires the presence of others to provide a sense of cohesion, constancy and resilience. Accordingly, Kohut (1971) argued that therapists need to serve as 'selfobject' functions and be willing to let themselves be known, rather than remain shadows for the clients' projections. To this end, Kohut advocated a more human therapeutic climate rather than rigid therapist anonymity and neutrality.

Greenson's work (1967; 1972; 1978; 1969) also focused on the personal presence of the therapist. For him, this was typified by having a real relationship between the client and the therapist (Greenson, 1967; 1978). There are other psychoanalysts, particularly drawn

from the relational school of psychoanalysis (Aron, 1996; Basescu, 1990a, 1990b; Frank, 1999; Gill, 1983; Greenson & Wexler, 1969; Guntrip, 1971; Hoffman, 1983; Jung, 1983; Meissner, 1991; Mitchell, 1988; Pulver, 1991; Singer, 1977; Storr, 1972; Wachtel, 1986) who have also highlighted the importance of the therapist's personal involvement in therapy, though the degree to which analysts involve their personal lives, thoughts and feelings in therapy, varies across different psychoanalytic schools and individual therapists. Early writings on this subject tend to be prescriptive, giving advice on what the analyst should or should not verbally reveal about him or herself. For example, Greenson and Wexler (1969) suggest that the analyst may offer an expression of sympathy or compassion at a patient's misfortunes, and when the analyst has made a mistake, it was important that the analyst respond honestly. Since these early writings, there has been greater receptivity as to what constitutes a 'real' relationship, accompanied by changes in analytic foci and an acknowledgement that therapy is about two people. Aron (1996) typifies these points when he claims that the human encounter between client and therapist is not only inevitable but also beneficial to the client.

There are no therapeutic interventions delivered from a position of neutrality or transcendent objectivity; rather all interventions reflect the person of the analyst...[Not] only does every intervention reflect the analyst's subjectivity, but it is precisely the personal elements contained in the intervention that are most responsible for its therapeutic impact (p.93).

Other trends in contemporary psychoanalysis have described the self as intersubjective, a perspective that is sometimes considered as 'subject-relations' (Aron, 1996, 2001; Frank, 1999; Stolorow & Atwood, 1992; Stolorow, Brandchaft, & Atwood, 1987). Here, intersubjectivity is considered an overarching term to describe the psychological field between the therapist and client, and the self is defined by 'the interplay between the differently organized subjective worlds' (Stolorow et al., 1987, p.1) of two people in the therapeutic relationship. This means that as well as developing a cohesive and separate sense of self, the therapist also needs to be able to reflect on his or her 'self' as an object of one's own investigation as well as of oneself as an object of the wishes and intentions of others (Aron, 2001). All aspects of self are important, within this intersubjective space, according to Aron and others (Aron, 2001; Frank, 1999; Stolorow & Atwood,

1992; Stolorow et al., 1987) in defining the therapist's self and his or her experience in therapy. The focus here is on what occurs 'between' rather than within the individual client or therapist.

The Jungian approach, from within the broader psychoanalytic tradition, relates also the inter-subjective view of self. Inherent to the notion of a collective unconscious, that is, of an unconscious common to all, is the process by which the therapist and client might become 'joined' at a deeper level. Samuels (1989) refers to this in-between state, as the *mundus imaginalis*:

... two persons, in a certain kind of relationship, may constitute, or gain access to, or be linked by, that level of reality known as the *mundus imaginalis* (Samuels, 1989, p.162)

This 'shared dimension of experience' (Samuels, 1989, p.173) suggests that experiences are shared between client and therapist. They belong to both the client and the therapist and have been given meaning and significance by the therapeutic relationship. Rather than stress the origin of the experience (as the concepts of transference, projection and introjection assume) the *mundus imaginalis* is a vehicle that encompasses the whole analytic field, including the interpersonal, interactive, intra-psychic and intersubjective (Samuels, 1989).

To summarise, the emphasis within traditional psychoanalytic literature is on the dysfunctional or otherwise inappropriate personal qualities of the therapist, particularly as stemming from the therapist's childhood relationship experiences. The use of therapist's affective reactions, as a container for the client's projections, is also evident in psychoanalytic theory. The self of the therapist as existing within the dynamic of the therapeutic encounter, as well as being linked or merging with the experiences of the client has also been highlighted in more recent times.

Person centered therapy

In comparison with psychoanalysis, the contribution of the person centered therapist is critical to therapeutic progress. Carl Rogers, (1951) the founder of person centered therapy, established the personhood of the therapist as a central element in his model for client change. Accordingly, descriptions of the therapist as genuine, authentic, congruent and manifesting non-possessive warmth, empathy and a real presence can repeatedly be found in the person centered literature.

From the beginning of its development, person centered therapy recognized the importance of the person of the therapist as vital to the therapeutic process. Rather than stress technical skills or theoretical knowledge, the emphasis within person centered therapy is on the three attitudes and qualities of the therapist that are considered important in effecting change in clients. These therapist qualities include being genuine and congruent, showing and having empathy or understanding, and finally, respecting and valuing the client's ability to self direct (Meador & Rogers, 1984). If the client is able to recognise these therapist qualities, the client may then engage in the process of positive change (Meador & Rogers, 1984). These conditions are the basic tenet of person centered therapy.

Accordingly, the person centered therapist needs to be genuine and congruent in the therapeutic relationship, with their inner experiences and reactions being accurately represented in their self-awareness. Congruence is an important concept and refers to an individual being aware of what he or she is experiencing inside and translating this into his or her behaviour. Rogers (1958, p.119) defines congruence as

Whatever feeling or attitude I am experiencing would be matched by my awareness of that attitude. When this is true, then I am a unified or integrated person in that moment, and hence I can be whatever I deeply *am*when self-experiences are accurately symbolised, and are included in the self concept in this

accurately symbolized form, then the state is one of congruence of self and experience (Rogers, 1959, p.206).

Congruence means that a match between the experience of the individual and his or her internal world is achieved. It is consequently important for person centered therapists to become and express 'whatever I deeply *am*'. In comparison, incongruence refers to an individual being someone he or she is not, playing a role that has been assigned to him or her, as if he or she is 'wearing a mask' (Meador & Rogers, 1984). Specifically, incongruence refers to a discrepancy between the experience of the individual and the self picture he or she has of him or herself (Rogers, 1957).

Regarding the importance of congruence for therapists, Rogers (Rogers & Stevens, 1967, p.92) claims, "I regard it as highly important, perhaps the most crucial of the conditions". This means that the person centered therapist is genuine and exists in the here and now.

The more the therapist is himself or herself in the relationship, putting up no professional front or personal facade, the greater is the likelihood that the client will change and grow in a constructive manner. Genuineness means that the therapist is openly being the feelings and attitudes that are flowing within at the moment (Rogers, 1986, p.135).

Counsellors need to be themselves, and to be aware of who they are, and how they are feeling and thinking whilst with a client. Person centered therapists are urged to be open and accepting to themselves and their immediate experience of working with clients, rather than block, deny or otherwise avoid their internal experiences. The therapist needs to 'encounter his client directly, meeting him person to person. He is being himself, not denying himself' (Rogers, 1966, p.185) and "freely and deeply himself, with his actual experience accurately represented by his awareness of himself" (Rogers, 1957, p. 224). This did not mean, however, that the counsellor has to be a perfect human being.

It is not necessary (nor is it possible) that the therapist be a paragon who exhibits this degree of integration, of wholeness in every aspect of his life. It is sufficient that he is accurately himself in this hour of this relationship, that in this basic sense he is what he actually is, in this moment of time (Rogers, 1957, p.224).

Later, when interviewed in 1987, Rogers extends these points when he claims that

The therapist needs to recognise very clearly the fact that he or she is an imperfect person with flaws which make him vulnerable. I think it is only as the therapist views himself as imperfect and flawed that he can see himself as helping another person.... the self that I use in therapy does not include all my personal characteristics... all of us have many different facets, which come into play in different situations (M. Baldwin, 1987a, p.50, 51).

Both excerpts demonstrate that while Rogers (M. Baldwin, 1987a; 1957) does not expect therapists to be perfect, they are, however, expected to be fully present and congruent when working with clients. Being aware of emotions during therapy, even if those feelings include being angry, frustrated or bored, is an essential part of being a congruent therapist. Therapist congruence needs to be consistent with a healing mode, and accordingly, not every authentic expression of self is necessarily therapeutic (Barrett-Lennard, 1998). In addition, as not all parts of the therapist's self will be involved in therapy, the implication is that the self that therapists bring to therapy, is one which is congruent, exists for the client, and may be different from the self that exists out of therapy.

Nonetheless, therapists may be incongruent during therapy and this incongruence may assume different forms. Greenberg and Geller (2001) for instance, specify three different types of incongruence that therapists might experience. Incongruence may occur when therapists are aware of their internal experiences but deliberately do not communicate this, in a form of conscious non-disclosure (even though sometimes this is appropriate, and sometimes not). The second type of incongruence is when anxiety blocks clear awareness of internal processes. The last type of incongruence involves therapists being completely unaware of their basic internal experiences, thereby demonstrating a total lack of self-awareness. Greenberg and Geller (2001) conclude that therapists will be congruent to differing degrees, with different clients and at different times.

The therapist who is incongruent within the therapeutic relationship and remains unaware of his or her incongruence results in a negative effect on the client and the outcome of therapy (Rogers, 1957; 1959). However, when the therapist is described in much of the

person centred therapy literature, he or she is generally reported as authentic, genuine and congruent. For instance, a representative comment is as follows:

The self of the therapist is brought to the encounter with the client with a willingness to experience all that the encounter entails. She is receptive and sensitive to the fullness of the client's experience (Greenberg & Geller, 2001, p.148).

The seemingly continual representation, within the humanistic literature, of the counsellor's self as psychologically mature, authentic and congruent has led several writers (Lietaer, 2001; Rowan, 1998; Rowan & Jacobs, 2002) to observe that countertransference (and more specifically, neurotic countertransference) has been under-emphasized in the person centered literature. Lietaer (2001), for example, points out that the person centered tradition pays scant attention to the various forms and manifestations of incongruence, particularly in comparison with the psychoanalytic concept of countertransference. Rowan and Jacobs (2002, p.22) continue, 'Person-centred books devote much attention to the positive personal qualities necessary in the therapist, but much less to what blocks progress'. It would appear that the less than ideal aspects of the counsellor's self are not generally considered when describing the personhood of the therapist in much of the person centered therapy literature.

The person centered therapist is expected to be psychologically mature, take responsibility for his or her own behaviour and at the same time relate in a highly intimate relationship with another, the client. A psychologically mature therapist is open rather than defensive, communicates without ambiguity, and accurately symbolizes his or her experiences into awareness (Rogers, 1959). As Rogers (1980, p.148) points out, 'This puts a heavy demand on the therapist as a person'. Consequently, it appears that concept of congruence is an aspiration and an ideal, rather than reality, as it is unlikely that a therapist will achieve a state of perfect congruence, or psychological maturity.

There is also some debate in the literature as to whether the therapist's internal experiences should be verbally expressed to the client (Brodley, 2001; Mearns & Thorne,

1996; Tudor & Worrall, 1994; Wyatt, 2000). Rogers (1959; Rogers & Stevens, 1967) suggested that counsellor expression of congruence depended on the relevance and appropriateness of the experience in therapy. Wyatt (2000) argued that counsellors need to do more than *practise* person centered therapy; they need to *be* a person centered therapist. Rather than stress specific counselling techniques, Wyatt (2000) encourages a quality of relating in which guidelines for therapist self-disclosure are dependent on the counsellor, the client, and the quality of the therapeutic relationship. Consequently, the therapist's expression of his or her individuality reflects his or her self and personal identity. This uniqueness means that the self each therapist brings to therapy will be different, and one approach may be appropriate for one therapist but not for another (Rogers & Stevens, 1967). What might be bizarre or unusual for one therapist is entirely appropriate and genuine for another (Wyatt, 2000).

Empathic understanding is the critical way in which therapists express their understanding of the client and demonstrates also the positioning of the therapist's self in relation to the client, within the therapeutic encounter. Rogers specifies that empathic understanding, and not emotional identification is an important part of therapy and occurs when the therapist

...senses the client's private world as if it were your own, but without ever losing the 'as if' quality – this is empathy, and this seems essential to therapy. To sense the client's anger, fear, or confusion as if it were your own yet without your own anger, fear, or confusion getting bound up in it, is the condition we are endeavoring to describe (Rogers, 1957, p.226).

For the therapist this means that he or she needs to be in a position of 'standing in the other's shoes, of viewing the world through the [other's] eyes' (Kirschenbaum & Henderson, 1989, p.311). While his view later changed, Rogers did suggest that it was important for the boundary between the self of the therapist and the self of the client to be discrete.

... where the therapist endeavours to keep himself out, as a separate person, and where his whole endeavour is to understand the other so completely that he

becomes almost an alter ego of the client, personal distortions and maladjustment are much less likely to occur (Rogers, 1951, p.42).

Accordingly, Rogers' theoretical construct on the self depicts a contained concept, localized within the individual though at the same time allowing for the experiences and perceptions of others. Rogers (1959, p. 200) describes the self as

... the organized, consistent conceptual gestalt composed of perceptions of the characteristics of the 'I' or 'me' and the perceptions of the relationships of the 'I' or 'me' to others and to various aspects of life, together with the values attached to these perceptions. It is a gestalt which is available to awareness though not necessarily in awareness. It is a fluid and changing gestalt, a process, but at any given moment it is a specific entity.

This definition of self has direct implications on how therapists might perceive and experience the self in therapy. First, the self can be pinned down at any given moment, in terms of an individual's self-representations or self-concept as characterized by the 'I' or 'me'. Simultaneously however, the self is constantly in a process of development and full of possibilities, including other people's perceptions and experiences, rather than a fixed and fully formed structure or substance.

Critics of Rogers' theory of self (Holdstock, 1993, 1996; Smith, 2001) argue that this model of self emphasizes internal factors and overlooks sociological elements. For instance, Holdstock (1993; 1996) argues that Rogers' view of self is focused exclusively on the individual, or what he refers to as an 'individuocentric approach' (Holdstock, 1993, p.45). He argues that 'others are attributed a secondary and not a primary role in the life of the individual' (Holdstock, 1996, p.399). This, coupled with Maslow's (1971) notion of self-actualization, is essentially a westernized view of the self, which contrasts with the interdependent model of self, found in many non-western cultures (Holdstock, 1996). Similarly, even though the relationship between the client and therapist is emphasized in person centered therapy, the goal of therapy is nonetheless the actualization of the individual (Smith, 2001).

In response to criticism that Rogers' (1959) original self theory is overly focused on the individual, recent developments have stressed two points: first, the configurations of self and second, the inter-relational notion of self. In the first instance, recent person centered theorists have considered a multifaceted view of self, that is, a self made up of various subselves, parts of self, or configurations (Gaylin, 1994; Mearns, 2002; Mearns & Thorne, 2000). The context and presence of others will dictate, to some extent, what aspects of self are shown, or revealed (Gaylin, 1994; Mearns, 2002; Mearns & Thorne, 1996). Thus, different parts of self will stand out as defining features at different times, and with different people, in the recognition that the self is influenced by past as well as current relationships. Referring specifically to therapists, this means that all of these various configurations or subselves need to be congruent and honest whilst working with the client (Gaylin, 1994; Mearns, 2002; Mearns & Thorne, 2000).

Greenberg and Rice (1997) in a review of the humanistic literature, observe a shift in emphasis from the traditional view of self as an active agent motivated by the actualizing tendency toward growth and autonomy to a greater awareness of the self as an interpersonal phenomenon. This change can be identified in Rogers' later writing, whereby he acknowledges the importance of others in shaping and defining the self (as highlighted by Bohart, 1995; Schmid, 2001a, 2001b). Here the counsellor's self is characterized as being relational, and existing 'person to person'. Accordingly, the self changes with each interaction, and becomes an individual's 'developing self-concept' (Rogers, 1961; 1980). In reference to therapists, this means that the self he or she brings to therapy is continually formed and shaped by the client-therapist interaction.

Furthermore, the importance of the therapeutic alliance is essential in Rogers' theory of therapeutic change (1951; 1957; 1958; 1966) and critical to the way in which the therapist is, at the same time, him or herself and in a close and intimate relationship with a client (Schmid, 2002). Schmid (2002, p.59) highlights this duality when he describes the human condition as a tension between '...autonomy and interconnectedness, independence and interdependence, self-reliance and commitment, sovereignty and solidarity' and therapy as 'the dialectic connectedness of communicative relatedness and

individual development' (p.68). Rather than an 'either-or' interpretation, the self of the therapist needs to be defined as 'both-and', that is, personal as well as collectivistic (Schmid, 2002). Schmid (2001a; 2001b) has also described how even in one-to-one therapy the 'Third One' is always present, meaning that other significant people, the therapy context and the larger cultural, global context is always a part of the therapeutic dynamic.

Instead of balancing independence and intimacy issues in therapy, there are some cases reported, within the broader humanistic and existential tradition, in which the respective selves of the client and therapist might disappear for brief periods of time altogether, and the two parties merge into the same identity. Working in depth with clients in this way requires of the therapist

... to leave aside conventional ways of responding and project himself or herself fully into the client's experiencing (Mearns, 1996, p.310).

Working within the broader humanistic field, Mahrer (1983) describes this process as an assimilation or fusion of one identity with another, so that ultimately the therapist can become a part of the personality of the client. Instead of being empathic with the client, the therapist is the client, and 'instead of knowing the person's world, you are living it' (Mahrer, 1983, p.34). Drawing upon the concepts of eastern philosophy, Cameron (2001) presents the 'subtle body' to describe the experiences that may occur in therapy for both client and therapist, of opening out or expanding, and moving in and out of one's body. Neville (1999) expands on this concept when he writes that there is also a connectedness within the great web of life, including the environment. Many of these ideas have their roots in the later writing of Rogers (1980) in which he hints at the trans-personal nature of therapy.

It seems that my inner spirit has reached out and touched the inner spirit of the other. Our relationship transcends itself and becomes part of some-thing larger (Rogers, 1980, p.129).

Similarly, in more recent times the concept of empathy is recognised less as ‘looking in from the outside’ and more as a transpersonal process between two people (Cameron, 2001; Hart, 1999). Hart (1999, p.119) for instance, notes this change in Rogers’ writing on empathy over time, from an ‘as if’ quality to the therapist entering ‘deeply into the client’s world, [so that] he or she experiences becoming the other and forming one *merged self*’ (added emphasis). Cameron (2001) has also described how a therapist might experience the client’s emotions within his or her self, again demonstrating notions of a trans-personal notion of self in therapy, that is neither the therapist’s or the client’s self, but a merging between the two.

The internal experiences of the therapist have been the focus of several person centered studies, generally unpublished dissertations (Adomaitis, 1992; Geller, 2001; Nielson, 1997). Barrett-Lennard (2003) has also described developing the Relationship Inventory, which aims to measure the respective reactions of people within different types of relationships. Whilst not inclusive to the therapist-client relationship, one aspect of this inventory has been used to gauge therapists’ experiences of their clients (Barrett-Lennard, 2003). In the main however, Barrett-Lennard (2003) points out that ‘The therapist’s own sense of his/her response has received minimal (and insufficient) attention’ (p.99). Consequently, the person centered therapist’s internal experiences appear to have received minimal research attention.

In summary, the key features arising from the person centered literature, indicates the counsellor’s self as unique, individual and in process of development, full of possibilities rather than fixed and rigid. At the same time, the self can be pinned down, in terms of the therapist’s self-concept or representation. Others, in the therapist’s past, as well as clients in the immediate counselling context influence the self and the experience of self in therapy. The trans-personal nature of the counsellor’s self is also described by some within the humanistic tradition. Therapists need to be themselves in their encounters with clients, without façade, and honestly experience their feelings and attitudes. Whilst the therapist is not expected to be a perfect person outside of therapy (M. Baldwin, 1987a; Rogers, 1957) he or she strives to be congruent, open and honest during therapy.

Behaviour and cognitive behaviour therapy

Behaviour therapy and cognitive behaviour therapy are commonly practised forms of therapy that tend to focus on the technical skills of the therapist, rather than the personal qualities of the individual therapist.

The ascendance of behaviour theory occurred with the publication of Skinner's (1938) book *The Behavior of Organisms*, in which the self had seemingly little relevance. Accordingly, behavioural therapists have traditionally de-emphasised the role of the therapist, though this varies according to the particular technique employed and the individual therapist (Prochaska & Norcross, 1999). For example, during systematic desensitisation, a standard behavioural technique, treatment might occur between a client and a computer, (Prochaska & Norcross, 1999). On the other hand, social reinforcement may actively involve the therapist's approval and disapproval as reinforcers for the client's desirable behaviour. For example, Greenspoon (1955) showed that therapist 'I' messages significantly increased clients' adaptive behaviours. Modelling is another behaviour therapy technique in which the therapist potentially plays an important role. Through the process of observational learning, the behaviour of the therapist (or some other model) acts as a stimulus for similar thoughts or behaviours on the part of the client (Perry & Furukawa, 1986). In these instances, the role of the therapist is as the provider of reinforcements, modelling and contingencies (Prochaska & Norcross, 1999). It is, however, debatable whether these instances refer to the 'self' or 'person' of the therapist, or instead, a behavioural technique practised and taught within the behavioural school and detached from the personal and individual essence of the therapist. As the therapist is not theoretically necessary for client change, Lambert (1989) suggests that the individual therapist is not generally the focus of behavioural therapy research.

The personal qualities of the therapist are also under-emphasized in the various cognitive therapies. Most forms of cognitive behaviour therapy focus on client's thought patterns and irrational beliefs and the ensuring technical skills the therapist needs to employ to

work effectively with the client. Stressing the instructional role of cognitive behaviour therapists, Dryden (2000, p.329) writes

REBT [a form of cognitive behaviour therapy called Rational Emotive Behaviour Therapy] therapists see themselves as good psychological educators and therefore seek to teach their clients the ABC model of understanding and dealing with their psychological problems.

There are however, notable exceptions in both streams of therapy. Some behaviourists for instance, concede that the person of the therapist is an important part of the therapeutic environment (Horvath, 2000). Eysenck, a committed behaviour therapist acknowledged that ‘the method may be less important than the person in many cases [and] that some people are good therapists and others are not’ (as cited in Feltham, 1996, p. 430). Lazarus (1985) also expressed the importance of therapist empathy and rapport in effective behaviour therapy. Dryden, (1991, p.141) a cognitive behaviour therapist, hints at the importance of personal rapport when he describes sending his client a birthday card: ‘I want to stress that I did not see this purely as technique. If I did not experience the concern, I would not have given him the card’. Others have also described how a therapist’s own irrational beliefs and thoughts might impact on the therapeutic process (Borcherdt, 1996; Dryden, 1990; Walen, DiGiuseppe, & Dryden, 1992; Waring, 1987).

Overall however, the behaviour and cognitive behaviour therapist tends to work in an educational and functional manner. In both forms of therapy, emphasis is on the therapist’s technical skills rather than the personal qualities of the therapist and his or her personal development or self-knowledge. Subsequently, the role and nature of the counsellor’s self has been under-emphasized or omitted in these therapies.

Systems or family therapy

Systems or family therapy extends the previously reviewed approaches by emphasizing the broader social and contextual factors of the counsellor’s self. Systems therapy, which

developed a conceptual base during the second half of the twentieth century, attends to the interactions of family members and views the entire family as a unit or system of interrelated parts (Sharf, 2000)³. Rather than specific techniques, systems therapy is a field of inquiry and a way of considering the individual and/or family (Prosky, 1996). Consequently, there are many divergent methodological approaches in this field, and many different positionings of the counsellor's self ranging from uninvolved to involved, and from passive to active (Bochner, 2000; Prosky, 1996).

Most of the research into the counsellor's self has come from the field of systems therapy, in a variety of forms. One body of research focuses on individual system therapists describing the self that they bring to therapy and the ways their self impacts on, and is a part of the therapeutic system (Carlock, 2000; Duhl, 1987; Haber, 1990, 1994; Hardham, 1996; Keith, 1987; Lum, 2002; Paterson, 1996; Prosky, 1996; Real, 1990; Rober, 1999, 2002; Smith, 2000). Other methodological approaches include interviewing therapists, (Oke, 1994; Shadley, 1986) or the use of surveys (Tester, 1992; Turney, 1991). The emphasis within systems theory on counsellor's self research has been due to the recognition, amongst many, that the therapist is a part of the presenting system. Minuchin and Fishman (1982) claim

Family therapy requires a use of self. A family therapist cannot observe and probe from without. He must be a part of a system of interdependent people (p.2).

Baldwin (1987) concurs.

According to systems theory, the therapist is unavoidably part of the treatment situation, both as therapist (change agent) and as himself. He does not choose to be in or out, he can only choose to be aware or not (p.27).

³ There are different types of systems approaches, including intergenerational, structural, strategic, experiential, solution focused and narrative (Sharf, 2000). As the focus of systems therapy is the interrelationship between systems, the focus of therapy may be on an individual, and the systems impacting on that one individual, and/or all available members of a family and the subsequent systems impacting on and within the family unit (Prosky, 1996).

The counsellor's self, within a systemic framework, is seen through a dialectical process and though originally applied in family and feminist therapy, forms the basis for newer approaches to clinical practice including, solution focused therapy, narrative therapy and dialogic therapy (Laird, 1993).

Contemporary theorists have sought to situate systemic therapy within the terms of postmodernist, and specifically social constructionist, discourses (Anderson & Goolishian, 1992; Cheung, 1997; Gergen, 1985; Gergen & Kaye, 1992; Real, 1990; Weingarten, 1991). Within a systemic, constructionist framework, the therapist and the client are seen as constantly and actively constructing their own realities. The self is considered neither a private possession nor a personal construction but is instead a social construction, embedded within the social environment (Freedman & Combs, 1996; Geertz, 1979, 1983; Gergen, 1971, 1985, 1991; Giddens, 1991; Haber, 1990, 1994; Kondrat, 1999; Real, 1990; Rober, 1999, 2002). The counsellor's self is viewed as a process, and an ongoing fluid construction whose identity is linked to the greater social context and interpersonal interactions. Consequently, the self is defined through dialogue and narrative with other people's understanding of who the self is. Freedman and Combs (1996) point out that this means different selves come forth in different contexts and that no one self is truer than any other. Giddens (1991) extends these arguments by suggesting that the self is inextricably immersed in society's structures as both agent and as product, as both shape and form each other. The notion of the self as bounded, separate and a 'thing' inside an individual is a Western concept bound to traditional psychological methods and is consequently discredited within the systematic framework.

Accordingly, the counsellor's self is intelligible only within a specific time and place, historically and culturally (Cushman, 1990, 1995; Haber, 1990, 1994; Oke, 1994; Real, 1990; Rober, 1999; Shadley, 1986). The self of the therapist may be interpreted in relatively global terms, in terms of the organisation, society and time in which therapy takes place, as well as at a micro-level, such as exists between the therapist and client (Muran, 2001). This means that how the self is interpreted is dependent upon the

meanings constructed between the various participants, their own life histories, and the broader cultural, historical and political context in which therapy occurs.

While previously the therapist's task was to discover some objective reality or underlying problem of the client, the systemic perspective disavows any belief in an objective reality or truth (Gergen, 1985). Instead, according to this epistemology, reality constitutes what participants consensually agree on, through social interaction and conversations (Gergen, 1985; Oke, 1994; Real, 1990). As each person has his or her own interpretation and experience of reality, based on his or her own cultural, historical and local contexts, no one has more claim on objectivity or truth than anyone else (Fine & Turner, 1991). Oke (1994) summarizes these points when she writes 'We are all inevitably involved in the construction of meaning with others and cannot assume to know how other people will see things based on our own experience or knowledge' (p.6).

Therapists do, however, bring to therapy their expertise in the practice of therapeutic conversation and a sensitivity to commonly held social beliefs (Anderson & Goolishian, 1992). As the counsellor's self is socially constructed and related to the context in which it is located, it is not standing apart from and acting upon the system of the client/s but is instead positioned within the system. Consequently, according to this approach, the therapist is not in a privileged or higher position than the client since the therapist is but one part of the context and process in sharing and constructing the meanings that arise from therapy (Anderson & Goolishian, 1992; Weingarten, 1991). Instead of considering the therapist as an expert who acts on or otherwise directs clients, the therapist is seen as a participant-facilitator or participant-observer (Oke, 1994; Real, 1990; Rober, 1999).

Freedman and Combs (1996), in a book on narrative therapy, argue that the counsellor's self exists *only* within the relationship of therapy. They explain this in the following manner:

... ideas of the self, like other constructions, are formed through social interaction with particular social contexts... "Selves" are socially constructed through language and maintained in narrative. We think of a self not as a thing inside an

individual, but as a process or activity that occurs in the space between people (Freedman & Combs, 1996, p.34)

In other words, there is no self other than what is presented to others and as exists between people. However, other researchers and practitioners (Haber, 1990, 1994; Hardham, 1996; Oke, 1994; Paterson, 1996; Real, 1990; Rober, 1999; Shadley, 1986; Tester, 1992) consider the counsellor's self as individual as well as relational. For instance, Hardham (1996) describes the experience of self as individual, pre-reflective and without words, but points out that these felt individual experiences can be located contextually, in the immediate therapeutic environment and the broader cultural context. Both experiences of 'self', or what Hardham (1996) refers to as 'insights' and 'outsights', are important for the practicing therapist. She conceptualizes this duality in this way:

As individuals we experience ourselves as biologically discrete, as contained within our skins. Thus, we experience ourselves as embodied and largely define our selves and our boundaries by our bodied experience. But most importantly, despite the ecological reality of our inextricable embeddedness, we are boundaried, defined, and located by others – and, so, we are also embodied by others (Hardham, 1996, p.75).

Empirical research also supports the dialectical relationship of the counsellor's self as both individual and relational (Oke, 1994; Shadley, 1986). Oke (1994) interviewed six family therapists in order to conceptualise the counsellor's self and to determine how the self is manifested in therapy. As the therapists were working within a systematic framework, Oke (1994) expected therapists to describe a concept of self that was contextual and socially constructed. However, she found that the six therapists described the counsellor's self as internal and separate, as well as being influenced by significant others. Paradoxically, Oke (1994) also found that one of the main ways that therapists engage the self is in linking two worlds, between the counsellor and the client. She tentatively suggests that this might be the means by which the therapist and client make sense of each other's worlds, and from the therapist's perspective, the counsellor's self is the means by which the client's story is ascertained and interpreted.

Using a similar methodology, Shadley (1986) conducted semi-structured interviews, with thirty family therapists. Their response to the question, 'What is the self of the family therapist?' included; 'the essence of who or what I am as a person,' 'integration of total person,' and 'integrity of all self parts' (p.130), all indicative of a localized and central self. However, the same participants also described the counsellor's self as 'all systems interacting' and 'patterns formed by past, present and future' (p.130) suggesting that the counsellor's self is not necessarily fixed and autonomous all the time. Again, these findings, whilst influenced by notions of a contextual and socially constructed view of self, are also indicative of a self experienced and located within the individual therapist. Shadley (1986) also found female therapists to be more personally revealing, in their verbal disclosure patterns, than male therapists.

Other research also supports the notion that the counsellor's self is both relational and individual. Using the Delphi technique, Tester (1992) developed a composite statement regarding the counsellor's self in therapy, from a group of expert and experienced family therapists. Over a series of questionnaires, participants defined the therapist's self as 'the therapist's private experience [including] dreams, fantasies, song fragments, urges, fears, wishes, impulses' (p.165). At the same time this final analysis also acknowledged that the therapist's self is largely co-created by the participant's interactions and from all other contexts in both the client and the therapist's lives.

Support for the view that the counsellor's self is both individual and relational also comes from single case studies. Rober (1999; 2002) described the counsellor's self as the internal world of the therapist, while Haber (1990, p.376) presented the self as consisting of 'the images, kinesthetic reactions, intuitive flashes, past experiences and crazy thoughts of the therapist'. At the same time both Haber (1990; 1994) and Rober (1999; 2002) stressed that the therapist's phenomenological experiences are evoked by the therapeutic context and consequently need to be interpreted within this context. For example, Haber (1994) described working with a female client who presented with various relationship difficulties. The image of a white wolf repeatedly came to his mind, emulating from a movie he had seen several years ago. He subsequently described this

image to the client and together they were able to use this symbol throughout therapy. The imagery experienced by the therapist was initially evoked by the client, but sourced from the therapist's own experiences, and subsequently used by the therapist in ways that were meaningful and healing for the client.

Not all aspects of the counsellor's self should be involved in therapy. Because of the constructing and reconstructing nature of self, therapists need to be aware of their own subjectivity and the assumptions and presuppositions they bring to the process of making meaning with another person (Weingarten, 1991). Therapist self-awareness is vital and the therapist's professional codes and ethics are essential in the utilization of self. The decision as to when and how to use the self of the therapist, including his or her phenomenological processes, needs to be dictated by the therapist's professional knowledge, training and experiences (Haber, 1990, 1994; Keith, 1987; Oke, 1994; Real, 1990; Rober, 1999; Tester, 1992). Rober (1999) for example, argued that while both the professional and the personal aspects of a counsellor are important, the role of the professional is to decide whether to, and how to use their personal reactions, feelings and perceptions. Rather than say whatever is on his or her mind, the therapist needs to reflect on "*if* and *how* he can use the elements of his self to promote a healing conversation" (p.214) with the client.

The (personal) self refers to the experiencing process of the therapist and reflects the therapist as a human being and a participant in the conversation. It refers not only to his observations (what the therapist sees and hears), but also to his imagination (the emotions, images, associations, and so on, that are evoked by his observations). The role of the therapist reflects the therapist as professional whose task it is to facilitate the conversation. The role refers to the therapist's hypotheses and his theoretical knowledge (Rober, 1999, p.214).

Thus, Rober (1999) argued, the personal self of the counsellor, and the therapist's role, or what he sometimes refers to as the 'professional self', each have distinct roles during therapy. The images, observations, moods and emotions of the therapist's personal self provide important information for opening up new interpretations and observations for the client. The role of the therapist's professional training and expertise is to "decide whether and how to use the information" (Haber, 1994, p.279). Similarly, Keith (1987)

writes, “The Self appears by surprise. When it appears, the professional self decides whether to recognise it” (p.64). Haber (1994) makes a similar distinction between the ‘self’ of the therapist, and his or her professional role.

...I use it [the self] as a consultant, not a supervisor. I listen but do not feel a need to act unless my primary process fits within the context of the interview... thus, there needs to be a marriage between the self and the role of the therapist. The self can generate information and images; the role needs to decide whether and how to use the information (Haber, 1994, p.279).

Overall, it is the responsibility of the professional therapist to facilitate the conversation in a way that will assist the client to achieve his or her goals and to keep the focus on the client and his or her meanings and constructions (Oke, 1994; Real, 1990). Real (1990, p.260) explains this responsibility in terms of positioning.

How may I position myself *vis-à-vis* the many contrasting currents in this system, its multiple realities and agenda, in such a way as to promote healing conversation?

As therapists’ stories and meanings about their self influence the therapeutic process, Oke (1996) urges therapists to be aware of their self in order to understand the assumptions they bring to the process of making meaning with another person. Real (1990) concurs and claims that therapists need to take personal responsibility for themselves within the system, as well as demonstrating political awareness in acknowledging that therapy is a form of social discourse, and so is social rather than idiosyncratic.

Consequently, guided by the therapist’s professional ‘self’, or role, and an understanding of the contextual factors in which therapy occurs, the therapist may then decide to use his or her (personal) self, in a variety of ways to further the goals of therapy. For instance, the therapist might disclose phenomenological experiences (including his or her feelings, thoughts, images, dreams and so forth), self disclose generally about his or her own life experiences, use his or her self to build a relationship with a client, express his or her self through humour, integrity and power, apply the self to join and mark boundaries between the therapist and client, give support, and make sense and meaning out of the client’s own experiences (Carlock, 2000; Haber, 1990, 1994; Hardham, 1996; Keith, 1987; Lum,

2002; Prosky, 1996; Satir, 1987; Shadley, 1986; Tester, 1992). Recurring images for example, might help the therapist decide what to do and say to the client, and assist in understanding the experience of the client (Haber, 1994). Lum (2002) describes using her affective reactions with different family members to formulate therapeutic interventions and to better understand clients. These studies have highlighted the various positive ways the counsellor's self might be utilized in therapy and consequently provides important information, education and support for other family therapists and trainees in their own use of self in therapy (Carlock, 2000; Duhl, 1987; Haber, 1990, 1994; Hardham, 1996; Keith, 1987; Lum, 2002; Oke, 1994; Paterson, 1996; Prosky, 1996; Real, 1990; Rober, 1999, 2002; Shadley, 1986; Smith, 2000; Tester, 1992).

The purposeful manner in which the self is used in systems therapy might indicate that systems therapists view the self as a specific tool or technique. However, this is not necessarily the case. For instance, one participant in the Tester (1992) study claimed

Use implies doing. I think the self 'shows up'... we can access it [this self] in our dreams or free associations. If I repeat the experience then it becomes a technique. Use implies manipulation or duplicity - a technique (Tester, 1992 p.145).

Rather than a tool or technique, the counsellor's self is considered a presence, albeit a presence that is accompanied by reflection and self-awareness (Haber, 1990, 1994; Oke, 1994; Real, 1990; Rober, 1999, 2002; Shadley, 1986; Tester, 1992). Accordingly, this presence is usually distinguished from the inadvertent experience of self, during the therapeutic encounter, that may occur, for instance, via the therapist's choice of clothing, furnishings and so forth. Instead, these therapists describe how they conscientiously and carefully involve their self in therapy, not as a planned tool, but as a presence, that is positive, responsible and beneficial for the client. Consequently, counsellor self-awareness and knowledge are inextricably linked to the involvement of self in therapy, for many family therapists. The counsellor's self is a positive and conscientious entity, and while not a specific tool or intervention, is a presence that is neither passive nor inadvertent.

Accordingly, the counsellor's self is seen as a positive rather than a negative entity within the therapeutic process. Bochner (2000) points out that many systemic theorists reject or underemphasize the concept of countertransference. He argues that while many of the founders of family therapy had their initial training in psychoanalysis, they tended to reject many psychoanalytic concepts, such as countertransference. Consequently, the concept of the counsellor's self, within the systemic framework, does not incorporate notions of the therapist's own personal issues or limitations. In comparison with the concept of countertransference that appears to over-emphasize the capacity of the therapist to harm clients, the manner in which the counsellor's self is generally described in the systemic literature appears to over-emphasise the positive presence of self.

In summary, the counsellor's self, as presented within the systems therapy literature, exists as part of the client-therapist relationship, and the broader context of therapy, as well as being localised and experienced by the therapist. To this end, the self of the therapist is described in terms of the therapist's phenomenological processes (thoughts, feelings, images, dreams, and so forth) as evoked by the immediate therapeutic context, situated within a specific cultural and historical backdrop, and finally directed and managed by the professional therapist. Therapist self-awareness is essential in understanding how meanings are constructed, and in interpreting the therapist's phenomenological processes. The involvement of self comes across as a presence rather than a tool or technique and one that is ultimately positive and useful.

The development of self across a therapist's professional career

There are a variety of studies that investigate the various changes to self across a counsellor's professional career (Brightman, 1984; Dreyfus & Dreyfus, 1986; Skovholt & Rønnestad, 1992). A major study in this area comes from Skovholt and Rønnestad (1992) who interviewed 160 counsellors over a ten year period. They differentiate between the personal and professional self, and describe the professional self in terms of the therapist's ethical boundaries, theoretical allegiances and technical skills and

knowledge, while a personal self is composed of the therapist's integrity, personal style, creativity and individuality.

During training and early in their counselling careers, Skovholt and Rønnestad (1992) found that counsellors rely heavily on external cues, such as supervisors, theory and research, for their counselling practices. Beginning therapists primarily use a specific theoretical orientation or a supervisor's style as the template for their work with clients. Consequently, their working style is often characterized by a rigid application of theory to practice. The need for registration and/or passing academic commitments is often the primary motivation for therapists to work this way, though often at the cost of neutralizing or suppressing their own personality (Skovholt & Rønnestad, 1992). For example, some counsellors reported that while their natural use of humour was often suppressed or stifled during their training practicum, it gradually became a part of their counselling practice after training was completed (Skovholt & Rønnestad, 1992).

When training ends and external control is loosened, therapists are thought to develop in one of two ways (Skovholt & Rønnestad, 1992). First, a therapist may develop in a 'pseudo' manner by continuing in an external and rigid mode, usually emulating an acknowledged theorist, a therapy or a series of theoretical techniques. Skovholt and Rønnestad (1992, p.103) suggest that this leads to 'stagnation' and produces a 'growing alienation between the authentic personal self and the evolving professional self'. Rather than integrate training and theoretical principles with their own personal values and beliefs, such counsellors are stuck in a technical and theoretical mode. Similar to the notion of a 'stagnated counsellor', Brightman (1984) describes a process in which some therapists evolve into what he has called the 'grandiose professional self' as a means of coping with the tension between training expectations and their inner fears of inadequacy. Such therapists might assume an image of an all-knowing, all-powerful and all-loving therapist, in what Jones (1951) first called the 'God complex', rather than confronting and dealing with their own inadequacies and vulnerabilities. In this way, the personal limitations of the therapist impede their professional development and they become stuck in a certain way of doing things and 'image' of themselves.

In contrast, the second way therapists might develop demonstrates an 'increasing closeness between the professional and personal selves in terms of being authentic at deeper levels of self' (Skovholt & Rønnestad, 1992, p.104). Because the 'need for compatibility with the self seems more powerful in the choice of professional role,' these therapists choose to 'shed(s) elements of the professional role that are incompatible with one's own personality' (p.109). These mature and experienced counsellors become increasingly at one with self though still work within competent, professional boundaries. Skovholt and Rønnestad (1992) suggest that the conceptual counselling system used by experienced and evolving counsellors, as opposed to stagnated counsellors, is highly individualistic, allowing for greater flexibility and creativity.

The healthy evolution of the Professional Self permits the therapist/counselor to consistently meet one's own needs within an ethical, competent role. There is more flexibility and more creativity in, for example, applying clinical knowledge to unique clinical problems (Skovholt & Rønnestad, 1992, p.105).

These experienced therapists do not abandon theory but instead assimilate theory into their own style; similarly they seek out professional development and adapt it to suit their self. Paradoxically, lay helpers also rely more on personal cues, and their own personal experiences in the same manner as seasoned counsellors, in contrast with counsellors engaged in professional training and at the start of their professional careers (Skovholt & Rønnestad, 1992). This may explain, to some extent, the minimal difference in therapeutic outcomes found between professional and non-professional therapists (Atkins, 2001; Berman & Norton, 1985; Durlak, 1979; Hattie, 1984; Stein, 1995). Little (1951, p.36-37) made a similar observation when she argued that successful therapeutic results may come from both

those experienced analysts who have gone through the stage of over-cautiousness... [and from] beginners who are not afraid to allow their unconscious impulses a considerable degree of freedom because, through lack of experience, like children, they do not know or understand the dangers, and do not recognize them.

Such arguments indicate that the use of self allows therapists the flexibility to work authentically and genuinely with various client groups. Little (1951) also alludes to the potential dangers associated with the use of self in therapy that beginners may not, as yet, be aware of.

The developmental literature reviewed illustrates the potential for the counsellor's self to change and develop over time. Simultaneously, because of the personal limitations of a therapist, his or her self might become stuck and stagnated, yielding an inability to adapt to new ideas, situations and circumstances. Skovholt and Rønnestad (1992) have also shown that the counsellor's self is an important way that some therapists are able to transform and mould theory into their therapeutic practices and to work creatively in unique and challenging situations.

Research gaps and theoretical issues

In previous research, therapists have been asked about their understanding and experience of self from within a specific, theoretical approach. This selectivity in research may have resulted in the perspective that the self is either constructive, or alternatively harmful, rather than potentially both, a point that is raised here as a theoretical issue. A multi-perspective interpretative framework, drawn from previous literature and research is also outlined and the research questions for this project are formed.

Research gaps

Many researchers and practitioners have highlighted the lack of research into the counsellor's self (Bowen, 1987; England, 1986; Goldstein, 1994; Guerin & Hubbard, 1987; Horne, 1999; West, 1982; Wosket, 1999). Others have highlighted the deficits of research into the impact of the counsellor's personhood on counselling behaviour and/or treatment outcomes (Cooklin, 1994; Gaylin, 1994; Guerin & Hubbard, 1987). When considering why the person of the therapist has been under-researched, Lambert (1989,

p.481) argues that in terms of counselling research, 'the individual therapist is far down the list, even a last resort as an object of study'. The counsellor's self is sometimes considered to be an unprofessional area of study (Oke, 1994) with some suggestion that it might be 'unscientific' to consider that the most curative components of therapy are not connected to existing theory or technique (Lambert, 1989). According to Guerin and Hubbard (1987) and Horne (1999), research in this area decreased in the 1980s and 1990s because of an increasing emphasis upon short-term therapy and psychopharmacology.

However, available counsellor's self studies can be classified into three distinct methodologies; system therapy studies, single case studies and finally, studies that focus on specific therapist behaviours or variables. The first type of research methodology focuses exclusively on system therapists as the sample, either as individual therapists describing the self that they bring to therapy (Carlock, 2000; Duhl, 1987; Haber, 1990, 1994; Hardham, 1996; Keith, 1987; Lum, 2002; Paterson, 1996; Prosky, 1996; Real, 1990; Rober, 1999, 2002; Smith, 2000), as interview subjects (Oke, 1994; Shadley, 1986) or as participants in survey research (Tester, 1992; Turney, 1991). Whilst there are some studies from outside of a systems perspective, the majority of counsellor's self research has come from a systems framework, in the recognition that the therapist is a part of the presenting system. Consequently, in available studies on the counsellor's self, a specific theoretical approach is stressed, rather than the perspectives and experiences of therapists working across a range of theoretical frameworks.

The second type of research methodology consists of individual therapists from across a variety of theoretical orientations (including systems therapists). In these studies individual practitioners describe what they bring as people to therapy, and what this means for them in their counselling practice (Basescu, 1990a, 1990b; Carlock, 2000; Duhl, 1987; Elliott, 2000; Haber, 1990, 1994; Hardham, 1996; Keith, 1987; Kottler, 1986, 1995; Lomas, 1981; Lum, 2002; Paterson, 1996; Prosky, 1996; Real, 1990; Rober, 1999, 2002; Smail, 1978; Smith, 2000; Wosket, 1999). While the value of single case studies has sometimes been contentious (Marshall & Rossman, 1999) others (Douglass & Moustakas, 1984; Polanyi, 1983) argue that the personal and subjective knowledge

afforded by the single case is itself legitimate and worthwhile as a means of understanding and exploring the world. Nonetheless, such accounts have provided rich and personal ways of considering the counsellor's self and describe how the self of the counsellor may impact on the therapeutic context, from an individual perspective.

The final area of research has attempted to outline the specific behaviours assumed to exemplify specific aspects of the counsellor's self (as highlighted by Gurman, 1987; Hayes, 2002; Herman, 1993; Kline, 1992; Lambert, 1989; McConaughy, 1987). For example, when discussing congruence, Duehn and Proctor (1977) highlight stimulus-response congruence, that is, whether the therapist's verbal responses acknowledged the content of the client's preceding communication. They also define congruence in terms of the consistency between the therapist's verbal statements and the client's expectations concerning what was to be discussed. The problem with such studies is that they focus on specific therapeutic behaviours rather than on personal aspects of the individual therapist. McConaughy (1987) summarises this concern.

Although some of these behaviours may be the observable representations of deeper therapist personality characteristics, it appears that a majority of studies did not move beyond the surface level. There are therapists, for example, who can perform all of the behavioral components that comprise empathic listening (eg eye contact, forward leaning, head nodding, verbal utterances indicating attunement), and yet unless they actually experience an empathic reaction to the client, the client will not feel heard. The observable behaviours, at least at the macroscopic level, do not always completely describe the therapist's involvement and the affective and perceptive interchanges that take place between therapist and client (p.311).

Similarly, Hayes (2002) and others (Gurman, 1987; Kline, 1992; Lambert, 1989) point out that the bulk of therapist variables studied have been superficial constructs, such as therapist age, social class, or personality type, rather than the internal and personal entity of the individual therapist. Accordingly, studies examining predetermined counsellor behaviours or therapist variables have, on the whole, been shown to be simplistic and meaningless and not specifically related to the concept of the counsellor's self or person.

In summary, previous counsellor's self research has focused on systems therapists, single case studies or specific therapist behaviours and external variables. Research appears to be lacking that captures the individual essence of the counsellor's self, from a trans-theoretical or integrative perspective. The focus on specific epistemologies in much of counsellor's self research may have led to limitations in the way the self is described, a point which is raised next as a theoretical issue.

Theoretical issues regarding the counsellor's self

Various theoretical perspectives on the counsellor's self in therapy have been presented, in the previous literature review. Overall, there appears to be some contention regarding the value of self; on the one hand, many, usually from a psychoanalytic background, describe the influence of self as contaminating and interfering with the goals of therapy (Arlow, 1985; Fenichel, 1945; Fine, 1982; Lane & Hull, 1990; Langs, 1982; Segal, 1993; Strean, 1982), while others from the person centered (Brodley, 2000; Gaylin, 1994; Greenberg & Geller, 2001; Knapp, 2000; Wyatt, 2000) and systemic fields (Baldwin & Satir, 1987b; Brothers, 2000; Carlock, 2000; Duhl, 1987; Lum, 2002; Oke, 1994; Prosky, 1996; Real, 1990; Rober, 1999; Tester, 1992) highlight the many positive uses of self in therapy. Using integrative research it will be argued here that the counsellor's self has the potential to be both.

In the first instance however, even if the therapist has no intention of revealing his or her self, the client will, nonetheless, attribute certain characteristics, based on what he or she sees, and hears (Basescu, 1990a, 1990b; Gelso & Hayes, 1998; Goldstein, 1994; Jackson, 1990; Weiner, 1978). For instance, the therapist's gender, office furniture, age, dress, the manner in which the therapist greets his or her clients, the organisation for which he or she works and the referral process used, are amongst the numerous ways in which the therapist's self inevitably becomes a part of the therapeutic dynamic (Basescu, 1990a, 1990b; Gelso & Hayes, 1998; Weiner, 1978). This phenomenon has been described in the following way:

Analysts show themselves all the time in their dress, in their office surroundings, in their manner of speaking, in the way they establish time and money group rules, and in the myriad of ways of being that are publicly observable... My books have been criticized. My plants have been taken to mean that I'm good at making people grow. My cough meant that I was getting a cold. My eyes showed that I was tired. My car proved that I didn't know much about cars, and the loud voice at the other end of the phone indicated that I was a hen-pecked husband. Not all of such conclusions are accurate, but some are, and some are more accurate than I initially gave them credit for being (Basescu, 1990b, p.159).

Judging and making assumptions about these 'publicly observable' features is an inevitable part of human interaction, both in and outside the counselling environment, and is important in predicting another's behaviour (Sdorow, 1998). Consequently, even therapists who do not purposely reveal their self will inevitably provide information about who they are in a myriad of incidental and observable ways.

However, Wosket (1999) makes a distinction between the 'person of the therapist' and the 'therapist's use of self', arguing that while contextual features will inevitably impact on therapy, it is important to focus on those aspects of self which the therapist is able to purposefully apply for therapeutic purposes. She explains this in the following way:

Because the person of the therapist pervades the therapeutic relationship, some aspects of who the therapist is unavoidably become accessible to the client to a greater or lesser degree... Yet inadvertent self-disclosure is not the same thing as intentional use of self... If the therapist's personhood is a given presence in the therapeutic encounter, their *use* of self is evident in the way that they *extend* aspects of their personality with the intention of influencing the client (original emphasis, p.11).

Thus, according to Wosket (1999) and others (Oke, 1994; Tester, 1992) it is important for therapists to focus on those aspects of self that might be gainfully applied to further the goals of therapy. Accordingly, there are various studies, mostly with a single case or systems focus, which have examined the various ways the person of the therapist might be used effectively, within the therapeutic dynamic (Baldwin & Satir, 1987b; Brothers, 2000; Carlock, 2000; Collier, 1987; Duhl, 1987; Elliott, 2000; Haber, 1990, 1994; Lum, 2002; Oke, 1994; Prosky, 1996; Real, 1990; Rober, 1999, 2002; Satir, 1994; Shadley,

1986; Tester, 1992; Wosket, 1999). As outlined earlier, the use of self generally focuses on the therapeutic alliance and different forms of verbal self-disclosure.

While the negative or harmful nature of self is generally stressed in psychoanalytic literature, the positive uses of self might also be identified in some psychoanalytic literature. Some, for example, have described how the self of therapist, by acting as a container for the projected material of the client, provides useful information the therapist is able to use, (Bouchard et al., 1995; Holmqvist & Armelius, 1996; Lammert, 1986; Lecours et al., 1995) although Aron (2001) points out that this experience is defined in terms of the client's transference, rather than from the therapist's own self. Basescu (1990a; 1990b) and Weiner (1972; 1978) are two psychoanalytically orientated therapists who have described the use of self in terms of self-disclosure⁴. Within the broader psychoanalytic field, there are also relational and Jungian analysts who have stressed the importance of the person of the therapist within the therapeutic relationship. Consequently, common themes might be identified across the various psychotherapies in the positive use of self, in terms of verbal self-disclosure and in the client-therapist relationship. However, therapists across a range of theories have not been asked to describe the self nor their experience of self within therapy.

The positive involvement of self in therapy is generally associated with therapist self-knowledge, well-being and personal maturity (McConaughy, 1987). How therapists become aware of their self differs across the literature (for an outline of the various processes therapists might undertake in order to become self aware, see in particular Jevne, 1978; Kondrat, 1999). For example, some therapists (Basescu, 1990a, 1990b; England, 1986) consider the involvement of self to be intuitive though at the same time point out that the expression of self is not necessarily without scrutiny and conscious

⁴ While some psychoanalytic therapists do verbally self disclose to clients, on the whole, they tend to disclose less often and less intimately than eclectic, humanistic, existential and systemic therapists (Simon, 1987). Other factors such as the therapeutic relationship, the therapist's personality and therapist self-awareness also impact on the type, frequency and content of therapist verbal self-disclosure patterns (Matthews, 1988; Simon, 1987, 1990).

awareness. While he does not detail the process by which this occurs, England (1986, p.39) argues that

Social work is a matter of intuitive understanding but it must be intuition which is unusually sound, unusually fluent and accessible and subject to unusually careful evaluation.

Similarly, Basescu (1990) differentiates between saying whatever comes to mind as the mark of thoughtless impulsivity, and being fully present and available as the hallmark of spontaneity. As has been previously reviewed, the same dynamic between the therapist as a person and a conscientious professional can be found in the systemic literature in which therapist's professional role and identity is important in regulating and deciding when and how to use the [personal] self of the therapist (see in particular, Haber, 1990, 1994; Rober, 1999, 2002). Accordingly, rather than a tool or technique, the use of self in the systems therapy literature is a useful, conscientious presence. Thus it appears that the interactive nature between the professional discipline of counselling and the spontaneous and intuitive character of self are necessary for the experience of self to be therapeutic, within the counselling context.

However, being aware of one's self and in particular, one's personal problems and limitations does not make the therapist any more effective. Nouwen (1972, p. 88) points out, 'Open wounds stink and do not heal'. Therapists must not only acknowledge their personal limitations and inner conflicts, but also attempt to resolve, transform or otherwise manage them in their therapeutic practices. Nonetheless, because the extent and depth of these wounds or unresolved personal issues often remain in the therapists' unconscious, the therapist needs to be open to the possibility that he or she still has issues or personal blocks that may only be flushed out with a particular client or at a certain time. The process of identifying and resolving these flawed and problematic aspects of self is life long and never ending, even for experienced and competent therapists. Thus, Kottler and Blau (1989) claim, 'We are all imperfect. We make mistakes. We learn from these errors... and still continue to find new ways to fail' (p.173).

More recently, Hayes (Gelso & Hayes, 1998; 2002) has argued that it is not possible for therapists to completely resolve all their own personal limitations, issues and inadequacies. Consequently, therapeutic error and failure, directly arising from the person or self of the counsellor, is an inevitable feature of therapeutic practice. Sometimes therapists will be aware of the less than ideal aspects of themselves that they bring to therapy, and sometimes not. Whilst the therapist might engage in his or her own personal analysis, and strive for continual self-development, the therapist is not perfect and this should be reflected also in the notion of self, regardless of the theory within which the therapist works.

Accordingly, while the potentially positive involvement of self is acknowledged, there also exist problems associated with the presence of the counsellor's self in therapy. The counsellor's self as potentially damaging is usually considered in terms of (classical) countertransference, as reported previously within the psychoanalytic literature. However, outside of a psychoanalytic framework, various single case, review and research studies indicate that the person of the therapist has the potential to impede therapy (Ablon & Jones, 1999; Andrews, 2001; Binder & Strupp, 1997; Davis et al., 1987; Elliott, 1985; Gelso & Hayes, 1998; Hayes, 2002; Horvath, 2000; Kottler, 1986; Kottler & Blau, 1989; Lambert, 1989; McLennan, 1996; Mohr, 1995; Wosket, 1999). As Wosket (1999) points out, while most therapists are committed to achieving high standards of therapeutic intervention for their clients, successful outcomes will not always be possible.

Therapists make mistakes for a variety of reasons; some professional (such as therapist inexperience, or lack of professional knowledge) and some owing to personal insecurities and inadequacies (Kottler & Blau, 1989). However, what constitutes as inappropriate therapeutic behaviour is ultimately subjective, with views from the client, the therapist's supervisor, the referral source, the organisation within which the therapist works, and therapists themselves with, at times, competing and differing perspectives as to what might be construed as 'correct' and 'incorrect' therapeutic behaviour. For instance, a therapist's display of anger and frustration with a client might be potentially healing to

the client if managed within the therapeutic relationship and debriefed sufficiently and sensitively. Nonetheless, problems arising from the person of the therapist may be identified, including mistakes of omission (lack of understanding and empathy for instance), inappropriateness (such as domination or initiating a sexual relationship) or one of timing (terminating therapy prematurely).

In reviewing the negative outcomes in therapy, Mohr (1995) identifies various therapist personality styles and values that may be construed as negative or inappropriate when working with clients. For example, Yalom and Lieberman (1971) found that aggressiveness, charisma, impatience and intrusiveness were therapist factors associated with negative outcomes for group therapy (as cited in Mohr, 1995). Similarly, Binder and Strupps' (1997) review of the negative outcome literature found a number of therapist characteristics that proved problematic for therapy, including the therapists' level of hostility toward the client and the inability of the therapist to manage the client's anger.

In the main, however, Binder and Strupp (1997) found that most of the negative effects that occur in therapy arise from problems in the therapeutic alliance. They argue that the interpersonal ability of the therapist to establish a positive therapeutic relationship, to recognise when the relationship is threatened, to deal with ruptures when they arise, and successfully terminate therapy, are all essential for effective outcomes in psychotherapy. These interpersonal skills are however, difficult for therapists to obtain. Binder and Strupp (1997, p.123) suggest

... it is our belief that the ability of therapists to implement these strategies successfully has been greatly overestimated. The reason for this has to do with the enormous difficulty that human beings, even highly trained therapists, have in dealing with interpersonal conflict in which they are participants.

Hill and colleagues (Hill, Nutt-Williams, Heaton, Thompson, & Rhodes, 1996) found that a broad range of therapists (representing analytic, humanistic, and cognitive behavioural approaches) were vulnerable to missing or ignoring problems in the therapeutic

relationship even when they themselves were feeling frustrated with the progress of therapy. Thus, the formation, continual maintenance and termination of the therapeutic alliance is intrinsically associated with the person of the therapist and will invariably be influenced by the therapist's personal limitations, regardless of his or her theoretical allegiances.

Kottler (1986; 1995; Kottler & Blau, 1989) is particularly public in admitting his own imperfections and limitations as a therapist and his subsequent experience of therapeutic failure. For instance,

I know that I have unresolved personal issues that get in the way of my being more effective with my clients... I frequently catch myself saying and doing things in sessions for my own entertainment. I ask questions only to satisfy my curiosity. I let clients dig themselves in holes just to see how they will get out. I inflate my sense of importance so clients will admire me more. I probably see clients longer than is absolutely necessary because I need the money. Oh, I justify all of these actions, convincing myself they are all for the client's good. I do not worry as much about this personal fallout because I am aware of it. [But] I do genuinely worry about those instances when I do not catch myself meeting my own needs (Kottler, 1986, p.41).

Accordingly, based on his experiences as well as interviews with other therapists, Kottler (1995) contends that while therapists are supposed to embody the highest level of personal functioning, the reality is far from the ideal. Kottler repeatedly argues (1986; 1995; Kottler & Blau, 1989) that like their clients, therapists will have their own personal issues, unresolved needs, limitations and inadequacies that will not always be appropriate for all of the clients they meet, all of the time.

Various review articles, examining research across the theoretical spectrum, have examined the various difficulties experienced by therapists stemming from their personal inadequacies (Binder & Strupp, 1997; Davis et al., 1987; Elliott, 1985; McLennan, 1996; Mohr, 1995). Along with the psychoanalytic literature on countertransference, such literature indicates that the personal qualities of the therapist, including his or her interpersonal style, values, beliefs and reactions, will at times be non-facilitative or hinder therapy. Data drawn from various developmental studies provide further support

that the therapist's personal needs and style might impede therapeutic progress (Brightman, 1984; Dreyfus & Dreyfus, 1986; Skovholt & Rønnestad, 1992). However, while these difficulties might be a constant source of discussion for therapists in supervision and between close colleagues (Davis et al., 1987) the problems experienced by therapists are often neglected in research (Davis et al., 1987; Lambert, 1989; McLennan, 1996; Mohr, 1995). More specifically, the personal blocks therapist might experience are generally under-emphasized in the person centered and systemic literature (as highlighted by Bochner, 2000; Lietaer, 2001; Rowan, 1998; Rowan & Jacobs, 2002).

The literature on the counsellors' self, previously reviewed, tends to conceptualise the counsellor's self as including those aspects of self that may be intentionally applied *or* alternatively focus on the negative and generally passive experience of self, stemming from a therapist's personal blocks and issues. Acknowledging *both* the prospective value as well as potential danger in the involvement of self is not usually found in the counsellor's self literature, and instead, the self that therapists bring to their clients is usually described as either helpful *or* unhelpful.

For instance, in systems therapy and some single case studies, the counsellor's self is depicted in terms of the therapists' feelings, thoughts, moods, and insights that may be usefully and conscientiously applied to further therapeutic goals (Elliott, 2000; Haber, 1990, 1994; Keith, 1987; Lum, 2002; Prosky, 1996; Real, 1990; Rober, 1999, 2002; Wosket, 1999). Such data provides much support to the argument that the counsellor's self affords the therapist various options and interventions, predominately in terms of verbal self-disclosure and in the therapeutic alliance. However, inherent in this definition is the constructive and purposeful use of self, rather than the passive experience associated with (classical) countertransference reactions. The therapist's personal blocks and issues are subsequently not addressed in this notion of self.

Similarly, in person centered therapy, whilst Rogers (as interviewed by M. Baldwin, 1987a) has pointed out that the therapist is not expected to be a 'perfect person' outside of therapy, when working with a client, he or she is expected to be psychologically

mature, congruent, open and honest. While the concept of congruence involves therapists' receptivity to all types of internal experiences, including feelings of boredom, dislike and anger, such personal acceptance, self-awareness and honesty is not possible all the time, with all clients. Consequently, even though authenticity, congruence and conscientiousness are all held up as therapeutic ideals, (in both person centered and systems therapy), and emphasize attributes that all therapists aspire to, the therapist's personal limitations are an integral part of any human being and instrumental also in the relationship formed between two people. Whilst the presence and involvement of self in therapy *should* be useful, there will be occasions when this is not the case. The therapist is not perfect and this should also be reflected in the notion of self. While the therapist's professional role and the ability to self reflect are important in the positive experience of self, this is not feasible all the time, throughout a therapist's professional career. It is consequently contented that the self therapists bring to their clients includes more than those aspects they are able to usefully apply. As the therapist's personal limitations and inadequacies are not acknowledged within the person centered and systemic fields, this depiction of the counsellor's self might be considered as the therapist's 'idealised self' or a partial and incomplete self that does not include all aspects of the therapist as a person.

In comparison, the concept of (classical) countertransference, within psychoanalytic discourse, does highlight the potential for the therapist to bring aspects of self that may potentially harm the client or impede therapeutic progress. The emphasis within psychoanalysis is consistently upon the negative or inappropriate aspects of self, particularly as drawn from the therapist's own unresolved personal issues and needs. However, the recognition of the unique, personal features of the therapist that may be meaningfully applied in therapy (and not just a 'container' for the client's psyche) is not emphasized or adequately addressed in this literature.

Accordingly, it appears that the self of the person centered and systems therapist is represented idealistically and predominately positively. In this literature, the counsellor's self represents what therapists aspire to, rather than what they actually are, as a person interacting within the human context of counselling. On the other hand, the self of the

psychoanalytic therapist is depicted as overly negative, and the useful personal qualities he or she has to offer clients, is not adequately addressed. Whilst therapist self-awareness promotes and encourages the positive use of self, this is not possible all the time. Consequently, therapists will bring all aspects of self to therapy, both those that may promote healing, and, at least occasionally, with certain clients, personal qualities that may impede therapy.

In summary, there appears to be three processes in which the impact of self might be identified. In the first instance, because of various publicly observable features associated with the therapist, the impact of self is inevitable. Second, when used with self-awareness the counsellor's self might be usefully applied in the formation of the therapeutic alliance and in various instances of verbal self-disclosure, for therapists from a range of orientations. Finally, because self-awareness is not possible all of the time, therapists' personal limitations and inadequacies will at times also impact on therapy, again for therapists across a spectrum of theories. Accordingly, it is argued here that the personal qualities of the therapist have the potential to be valuable as well as hindering to the overall therapeutic process.

Moving towards⁵ a multi-perspectivist framework

The following constitutes an attempt to 'move towards' a framework of the counsellor's self, rather than provide a definitive or final argument on the issue. The term 'multi-perspective' endeavours to encompass the various theoretical approaches on the counsellor's self, as well as incorporating negative and positive elements of self. Accordingly, this framework represents an attempt to draw together the distinctive and consistent theoretical and empirical data, across a variety of theories, on the counsellor's self. By summarizing the literature in this way, a new and original way of considering the counsellor's self is presented, which conceptualizes the counsellor's self as intra-

⁵ Wosket (1999) includes a section entitled, 'Towards a definition of self' (p.9) and this idea of moving towards, rather than arriving at a set and definite point, is attributable to her.

personal, inter-personal and trans-personal. The framework drawn from this literature will subsequently assist in the choice of an appropriate methodology for a research study into the counsellor's self, and will be employed in the discussion to interpret the findings of the present study.

This multi-perspective framework consists of three different ways the counsellor's self may be described or positioned. In the first instance, the counsellor's self may be conceptualised in terms of the therapist's phenomenological processes. The therapist's thoughts, feelings, physical sensations, images and so forth, are important in this aspect of self, and may be seen in many of the therapies reviewed. Various single case (from therapists practicing a variety of theories) as well as systems therapy studies have shown for instance, that the therapist's phenomenological processes are important when describing the counsellor's self (Basescu, 1990a, 1990b; Duhl, 1987; Elliott, 2000; Haber, 1990, 1994; Hardham, 1996; Keith, 1987; Lum, 2002; Oke, 1994; Prosky, 1996; Real, 1990; Rober, 1999, 2002; Tester, 1992; Weiner, 1972, 1978). The concept of countertransference includes the therapist's emotional, cognitive and physical experiences during therapy (Samuels, 1989). The therapist's inner experiencing is also highlighted in the person centered concepts of genuineness and congruence. Here the counsellor's self is described as *intra-personal* as it is centered chiefly on the person of the therapist and his or her inner processing.

Second, the counsellor's self may be defined by the client-counsellor relationship as well as the broader context of therapy and is consequently considered as an *inter-personal* way of describing and positioning the counsellor's self. In this instance, the counsellor's self is defined through the therapist's relationships, on both a micro (to the client) and macro scale (the broader dynamic in which therapy occurs). While the nature of the therapeutic relationship differs across the different therapies, (for instance, the transference relationship is markedly different from the open and honest relationship endorsed in person centered therapy) there is, nonetheless, an acknowledgement that the therapist's self can only exist in relation to the client. The therapist's subjective experiences for instance, are in reaction to the client, and need to be understood in the therapist-client dynamic. While the notion of countertransference focuses on the

therapist's inner experiences, it is in essence the therapist's reactions *to* the client. Similarly, many within the systemic literature describe the therapist's phenomenological processes as embedded within the therapeutic dynamic. Ultimately, therapy is the forum in which the two selves - that of the client and the therapist – shape, influence and define each other.

On a macro-level, therapists' past experiences as well as academic institutions, professional associations and society in general shapes and moulds a therapist's sense of self and the experience of self in therapy. In both the micro and the macro approach, the self relates to and is formed by others, and subsequently needs to be interpreted through these various relationships, both in and out of therapy. Defining the counsellor's self in terms of the counsellor's relationships, on a micro and macro level, is labeled *inter-personal*.

The bulk of the literature previously reviewed focuses on the counsellor's self as intra-personal and inter-personal. Found less frequently, the final and third position of the counsellor's self is known here as *trans-personal*. Identified in some Jungian, Eastern, humanistic and existential (though not in family therapy) writings, the boundary between the therapist and the client may disappear altogether. Cameron (2001) describes this position of self in terms of being joined at a deeper level, even though at a surface, skin level the therapist and client are different. The notion of self as trans-personal has also been described as a process of engaging in what passes between and beyond the client and therapist (Rowan & Jacobs, 2002). This process of therapy involves a different form of consciousness and the ability of the therapist to transcend separateness to merge with the self of the client.

Overall, the multi-perspective framework presented here, conceptualizes the counsellor's self as intra-personal, inter-personal and trans-personal. These three possibilities or positions may not necessarily be mutually exclusive. For instance, rather than accept the view that the self only exists in relation to others (as previously argued by Freedman & Combs, 1996), there exist much empirical data from systems therapists that the counsellor's self is both intra-personal and inter-personal. Hardham (1996) neatly

describes the interactive nature between the intra and inter-personal self when she describes the counsellor's self as embedded and embodied. Accordingly, therapists' feelings, thoughts, images and so forth, will change in different environments and with different people. Consequently, the self of the therapist is defined by a person's inner or intra-psychic experiences but also as a self that is perceived by, and relates to others, in varying degrees of intimacy. Cameron (2001) acknowledges that it is neither appropriate nor feasible for the counsellor to 'merge' with each client, or 'merge' all the time with the one client. There are therefore a variety of different positions of self the individual therapist might assume when working with the one client, or with different clients and these positions are not necessarily dictated by any one theoretical stance or orientation.

The capacity for change, over time, and in different environments and people, is consequently another key feature of the counsellor's self ascertained from previous literature. Rogers (1961; 1980) emphasized the view that the self is in process and full of possibilities, rather than being stuck or rigid, while more recent person centered theorists (Gaylin, 1994; Mearns, 2002; Mearns & Thorne, 2000) have stressed the configurations of self, across different environments. The inter-subjective view within psychoanalysis highlights the fluid nature of self and the systems approach is also consistent with the multiplicity notion of the counsellor's self.

A key finding from the developmental literature is that a therapist's experience and sense of self will change over his or her career (Brightman, 1984; Dreyfus & Dreyfus, 1986; Skovholt & Rønnestad, 1992). It has been shown the therapists during training and at the start of their professional career, might experience a constrained sense of self, and assume a 'professional' persona. Thereafter, therapists might develop in either of two ways, by integrating their own personal style into their professional role, or alternatively, because of their own personal limitations and needs, may become stuck or 'stagnated' in a certain theory or technique. Thus, it could be expected that therapists' sense of self, and their experience of self in therapy, will vary across their career spans and may differ according to their personal limitations or blocks.

It has also been demonstrated, from integrative research, that the counsellor's self may be involved in the therapeutic alliance and in various types of therapist self-disclosure. While the frequency and nature of these activities might differ according to the theoretical allegiance of the individual therapist (for instance, the psychoanalytic therapist might verbally self-disclosure less than a person centered therapist) nonetheless, the use of self has been identified in these two, positive ways. The manifestation of self might also be related to the three positions outlined here. For example, therapists might disclose their feelings and thoughts (intra-personal self) and/or involve the self in the therapeutic alliance (inter-personal self). The impact of self due to various publicly observable features, such as the therapist's furniture, clothing, the organisation for which he or she works, and so forth, is also implicated in the inter-personal position of self. Found less often, the counsellor's self might also move through and beyond the direct and immediate experience of the therapist and 'open up' to experiences both within and outside of the therapist and client (trans-personal).

Furthermore, the involvement of the counsellor's self is inherently neither good nor bad, regardless of the theory of the individual therapist; it can be well understood, suited to the needs of the client and subsequently, highly constructive; it can also be indicative of the personal inadequacies and limitations of the therapist, geared to his or her personal needs and subsequently deleterious to the therapeutic process. For instance, while the counsellor's self seems to be important when forming a relationship with clients, a therapist's personal qualities are also associated when ruptures in the alliance arise, such as being able to deal with client frustration and hostility.

Rather than one aspect of self as primary, all three positions, of intra, inter and trans-personal, are equally important and represent different ways the counsellor's self may be described and in turn, manifested, in the therapeutic environment. Consequently, this framework provides a tentative and new way of summarizing and organising the available empirical and theoretical data, across a variety of diverse theories and investigations. This multi-perspective approach is also consonant with the view that many valid ways of describing and knowing the 'self' exist and that no single perspective

on the self should dominate another (Hattie, 1992; Kondrat, 1999; Luft, 1984; Rosenbery, 1986).

Describing the counsellor's self as intra-personal, inter-personal and trans-personal provides a consistent basis from which to interpret the data. Through this selective, multi-perspective approach, drawn from the major elements of the research and theoretical literature, the data interpretation of this study is facilitated. Such a framework serves as a tool from which to interpret and discuss the data collected. In addition, using this multi-perspective approach to the counsellor's self, a methodology is sought, which is capable of capturing the individualist nature of the counsellor's self at any given moment in time, and at the same time allowing for the flexible and relational nature of the therapist's self. First however, the research questions are presented.

Research questions

Much of what represents the counsellor's self defies being captured because it can be manifested in so many varied and individual forms. Nonetheless, in the literature reviewed so far, across several theoretical orientations, there appears to be an acknowledgement that counsellors bring to therapy more than their professional skills and knowledge. However, based on research gaps and theoretical issues identified in the literature, there are various questions that remain, related to defining the counsellor's self in therapy.

As has been previously established, most of the studies into the counsellor's self are drawn from a single case or single theory (usually systems) perspective, or have focused on superficial therapist variables and behaviours. Therapists from a range of theories have not apparently been asked to describe the self that they bring to therapy, nor how their self influences the therapeutic environment. Thus, the two main research questions of this thesis concern defining the counsellor's self and articulating how the counsellor's self is manifested in therapy, for counsellors across a variety of theoretical orientations.

Furthermore, differences are apparent across the major psychotherapies in the representation of the counsellor's self in therapy. Generally, within the psychoanalytic literature, the personal qualities of the therapist are regarded as a hindrance to the overall aims of therapy. On the other hand, the self described by family and person centered therapists, is generally positive and useful. It has been previously argued that the counsellor's self has the potential to be both constructive and harmful, in different situations and with different clients. My various case studies, originally outlined in the prologue, provide further support for this view. Again, specific questions concerning the positive and/or negative nature of self and the subsequent contribution of self to the therapeutic environment has not apparently been asked of practicing therapists across a variety of theories.

The first research issue centers on the self that therapists bring to therapy and may be articulated in the following way:

How do counsellors, from a range of theoretical orientations, describe the self that they bring to counselling?

The second issue relates to the manifestation of self in therapy.

How is the counsellor's self manifested in therapy, if at all, for counsellors from a range of orientations?

An investigation into the counsellor's self in therapy, across a variety of theories, provides potentially useful information in a number of ways. First, it has been shown that self-development programs for counsellors have, on the whole, been deficit based, narrow, culturally biased and ill-formed (Cook, 1999; Prosky, 1996; West, 1982). It has been difficult to develop and evaluate such programs without first defining the 'self' that counsellor's need to develop. Thus, describing the involvement of the counsellor's self in therapy, across theoretical lines, provides potentially useful information for the

selection, training and supervision of therapists. In addition, as definitions and concepts are the building blocks of theories (Denzin, 1978) a comprehensive definition of the counsellor's self may enhance and focus future research and theory development regarding therapist variables. Similarly, descriptions detailing the involvement of self in therapy may also demonstrate how the self is related to relationship building, from a trans-theoretical perspective.

The following chapter is an exploration of the research methodology employed in this study which focuses upon the description and experience of the counsellor's self in the therapeutic context.

Chapter three: Methodology

This chapter involves a description of and a rationale for the interpretative research framework and methodology employed in this thesis. Data are collected and interpreted according to a predominately qualitative approach. While traditionally much counselling research has favoured quantitative approaches, the inadequacy of such an approach will be discussed, and the subsequent rationale for an interpretative, qualitative focus will be highlighted. In-depth, semi-structured interviews are the primary method of data collection. The benefits and limitations of interviewing counsellors, as well as using my own thoughts and insights as the researcher, are also presented.

Traditional counselling research

Previously, the dominant research paradigm in psychotherapy research has been empiricism and positivism, an approach that traditionally uses scientific operations such as ‘separating, ordering, quantifying, manipulating [and] controlling’ (Bakan, 1966, p.20). This view established the experiment as the appropriate forum from which generalisations may be made to human behaviour and the therapeutic context (John, 1986). While contemporary training for students still invests heavily in this kind of research paradigm (Aiken, West, Sechrest, & Reno, 1990; O’Gorman, 2001), concurrently there exists growing discord and debate about its appropriateness and validity, particularly within the counselling forum (Blampied, 2001; Cotton, 1998; John, 1998; John, 1997; Karasu, 1996; Larner, 2001; O’Gorman, 2001; Seligman, 1995; Soldz, 2000).

The traditional clinical trial calls for considerable experimental control wherein, for instance, clients are randomly assigned to control and treatment groups, with efforts made to standardise the treatment offered and minimise differences in other variables, such as may be apparent across individual therapists. Criticism focuses on whether standardised, controlled treatment research may be generalised to what therapists and clients actually

do (Bergin & Garfield, 1994; Goldfried, 2000; John, 1998; John, 1986; Lambert, Masters, & Ogles, 1991; Lerner, 2001; Seligman, 1995; Soldz, 2000). For example, Goldfried and Wolfe (1998) query whether standardised treatments that compare various 'pure' therapies, such as cognitive behaviour therapy versus person centered therapy, generalise to actual therapeutic practice.

While significant group differences are the primary focus of much scientific work (Erwin, 1999; O'Gorman, 2001), the therapist's priority is the individual client and the treatment of his or her presenting problem. An understanding of the client and the context from which the problem originates is paramount. For example, while much 'scientific' evidence demonstrates that cognitive behaviour therapy is most effective for behaviourally disturbed children (Sanders & Dadds, 1993), the treatment of possible concurrent family problems such as alcoholism, marital discord, violence and parental psychiatric illnesses, is both morally ethical and professionally effective for therapists working in the field (Seligman, 1995). Goldstein (2000, p.20) states, rather than "going by the book... a certain amount of art is involved in the practice of therapy". Accordingly, the number of psychotherapy variables in natural settings requires a flexible approach that needs to incorporate a variety of research as well as treatment approaches (Miranda & Borkovec, 1999).

In addition, while the potentially reductionist approach to much counselling research has aimed to quantify or measure the various components of the therapeutic encounter, it has in many ways failed to deliver information and knowledge that is applicable to practising clinicians (Howard, 1996; John, 1986). Generally, in terms of counselling, there appears to be a considerable gap between research and practice. Orlinsky and colleagues (2001) found that for more than 4000 psychotherapists the experience of working directly with clients, rather than academic learning or undertaking research, was the primary influence on professional development. Furthermore, Watkins and Schneider (1991) reported that counsellors rarely engage in research in their work lives and hold negative views about its importance. Concurrently, researchers rarely engage in clinical practice (Garfield & Kurtz, 1976, as cited in Kazdin, 1986). While not referring specifically to psychotherapy

research, Schön (1983, p.26) summarizes the respective value positions between practitioners and researchers.

Researchers are supposed to provide the basic and applied science from which to derive techniques for diagnosing and solving the problems of practice. Practitioners are supposed to furnish researchers with problems for study and with tests of the utility of research results. The researcher's role is distinct from, and usually considered superior to, the role of the practitioner.

The difficulty for much empirical research is the very humanness or 'messiness' of the therapeutic encounter that is not readily amenable to isolation and experimental control (Larner, 2001). Larner (2001) argued, 'it is not always what can be measured and predicted by science that is relevant to therapeutic outcome' (p.39). Counselling is essentially a relationship between a counsellor and the client (or groups of clients) and while the therapist may employ a variety of theoretical techniques and interventions, it is primarily a human activity that often defies measurement and control.

The lack of generalisability and the subsequent artificial nature of the results as well as the failure to recognise the multitude of realities and influences on both the client and the counsellor, reflect the core weaknesses of the traditional trial approach to counselling research.

An interpretative approach to counselling research

The principal aim of this study is to identify how therapists, across a variety of theoretical orientations, describe their person or self as a therapist and their experience of self in therapy. An interpretative approach is employed, which means that the multi-perspective framework (previously presented at the end of Chapter two) is used as a basis for interpreting the data collected. Within an interpretative research paradigm, a qualitative approach to data collection was employed in this study as a means to tap therapists' personal and subjective meanings regarding the 'self'. To this end, interviews were conducted to allow for the negotiation of meaning between the interviewee and researcher.

As this was an exploratory study, constructs emerged directly from the data, and were subsequently interpreted in light of relevant theory, as represented in the theoretical framework. Mahrer (1988) labeled such an approach 'discovery orientated' as opposed to 'hypothesis-testing' which is employed within the traditional scientific model, and compared the two paradigms as follows.

The whole basis for designing hypothesis-testing studies revolves around some predetermined, formulated idea or expectation or prediction or hypothesis that one then proceeds to test... in contrast, the whole basis for designing discovery-orientated studies is the intention to learn more... to answer a question whose answer proves something one wants to know but might not have expected, predicted, or hypothesized (Mahrer, 1988, p. 697).

Whilst patterns emerging from the data provided the basis for the present set of findings and their reporting, a theoretical interpretative framework was nonetheless employed as a means to consistently interpret the data. This multi-perspective, theoretical framework, which was presented at the end of the previous chapter, is a distillation of the major concepts and common research threads in the area of the counsellor's self. The framework was not employed to predict hypotheses, but was instead employed as a basis from which to interpret the data and as way of comparing previous research with the current project. In this way existing literature may be added to, challenged or elaborated.

Instead of producing definitive theories from such data, the aim of such research is towards modest localised explanations, based on immediate evidence (Denscombe, 1998; Strauss & Corbin, 1990). Lincoln and Guba (1985) claim,

...this [is] not an attempt to make ultimately true (and modern) pronouncements, but an effort to take our place along the path of understanding (Lincoln & Guba, 1985, p.16).

Consequently, the current study was not aimed at a definitive and conclusive theory regarding the self of the therapist, but instead aimed to consider what the counsellor's personhood meant for a group of rural counsellors, and how their personal presence was

involved in the therapeutic environment, if at all. This was seen as providing potentially useful information for future research into therapist variables associated with effective outcomes, as well as addressing some of the training and supervision needs of therapists.

The present study began with the researcher's phenomenological perspective (in the case studies outlined originally in the prologue) and aimed to extend and explore these experiences with other counsellors. The participants' viewpoints were explored in their own terms rather than immediately fitting their words and ideals into some preconceived framework. While previous literature on the counsellor's self was not used to generate hypotheses, it was employed to ground and compare emerging concepts elicited from participants in the present study. To this end, the interpretative, multi-perspective framework formed the basis for interpreting the data gathered in this study and comparing the results of the present study with previous research.

Interviewing as a methodology

In-depth, semi-structured interviews were employed in this thesis as the primary method of data collection. Interviewing is valuable for obtaining information that is sensitive and personal (Adams & Schvaneveldt, 1991). As a methodology, interviewing provides the forum for respondents to discuss sensitive and emotive issues about themselves and, when conducted in a respectful and sensitive manner, may be enlightening for the participant (Minichiello, 1990). Through the process of interviewing, participants have the opportunity to consider aspects of themselves that they may not previously have considered.

Interviews were employed in this study as they have the potential to generate ideas that emerge from and are grounded in the data (Strauss, 1987; Strauss & Corbin, 1990). Interviewing has also been regarded as an appropriate methodology for gaining insights into nebulous and individual concepts such as the 'self'. Patton (1990, p. 278) asserted

We interview people to find out from them those things we cannot directly observe. The issue is not whether observational data are more desirable, valid, or meaningful than self-report data. The fact of the matter is that we cannot observe everything. We cannot observe feelings, thoughts, and intentions... We cannot observe how people have organized the world and the meanings they attach to what goes on in the world. We have to ask people questions about those things. The purpose of interviewing, then, is to allow us to enter into the other person's perspective.

The major dilemma or problem associated with an interview methodology is whether the respondent is telling the interviewer the 'truth' about him or her self. Keith (1987), highlighted the possibility that 'The Self which may be spoken of, is not the true Self' (p.64). How an individual presents him or herself, and how others see the individual may be markedly different, suggesting self deception, lack of self-awareness, or both (Jopling, 1997; Luft, 1984; Smith, 1998). Mackay (as interviewed in Wilson, 2000), however, refutes the concept of having to verify self-statements with either behavioural checks or otherwise.

Behavioural checks are interesting - not that that denies the validity of what people are saying, because when people report their feelings I regard that as, in a sense, the truth. Even if they are not very clear themselves and even if they contradict themselves a lot, that's all part of a completely valid exploration of their values, their attitudes, their motivations or their aspirations - many of which will, inevitably, be self-contradictory... (p.242). Let anyone talk about anything for long enough and they'll contradict themselves. That's part of the human condition. We don't have neat rational frameworks of attitudes and beliefs. They're very messy (Mackay, as interviewed by Wilson, 2000, p.247).

Consequently, how the individual represents him or herself in an interview may not be 'true', in an objective or measurable sense. An individual may become a different 'person' or 'self' in different social situations, one of which is an interview, and either consciously or unconsciously distort his or her 'self'. Kondrat (1999) has pointed out that the knowledge people have of themselves, no matter how objective, is always to some extent, flawed and partial. In relation to interview-based research, the only thing that can be accessed is what participants have understood their experience to be, and what they want to represent about themselves.

Reality however, is not a single external entity. Polkington (1992, p.149) argues, 'Reality is not a static system underlying the flux of experience, but is itself a process of continuous change'. There are many different realities, and the one that is accessed through an interview is only one of many. The self that is experienced and understood by the therapist may be a different self that is seen by the client. The self may never be fully disclosed in its entirety, since others will never have complete knowledge of an individual's inner experience, and an individual cannot observe some manifestations of themselves that are readily perceived by others (Luft, 1984). On the basis of such arguments, Hattie (1992) contends that no one perspective on the self, should dominate another. Consequently, the notion of objective truth or self-knowledge is rejected, and instead replaced by the notion that there exist many, valid ways of knowing and identifying the self (Hattie, 1992; Kondrat, 1999; Luft, 1984; Rosenbery, 1986).

The process of talking about the self may help the individual understand him or herself better. Fivush and Buckner (1997) make the point that talking about the self allows the individual to interpret and evaluate oneself with others. Jopling (1993) supports this view, "Dialogue not only opens one person to another; it is by means of face-to-face dialogic encounter that we are "talked into" selfhood through elucidative speech acts" (p.297). Interviewing may provide an opportunity for participants to become clearer about who they are, and why they do what they do. However, asking people questions about themselves implies a certain order and logic that may not exist in the self perception of an individual. Bruner (1997) argues that when asked questions about the self, individuals impose meta-structures on the experience of life, in order to be coherent to others. This is a form of 'self making' that makes us coherent and intelligible to others, that may or may not reflect the self as experienced by the individual (Bruner, 1997). The process of interviewing encourages this presentation of a logical and coherent self and, in this thesis, may also encourage the use of meta structures to explain counselling experiences.

Frost (1980) argues that it is unreasonable to assume that people's knowledge of themselves, and the world they live in will be one-dimensional and 'all-in-one-piece' or

that people have only one clear and coherent picture of themselves, which is unchanging. Based on her research with women, and women's self representations, she suggests that people have different ways of seeing themselves in different contexts and may see themselves in contradictory ways at one and the same time. Arguing that 'self-discovery and self-creation are inextricably entangled' (1980, p.79) Frost contends that activities that encourage participants to talk about and be aware of themselves may have as much to do with the *creation* of self as they have to do with the *discovery* of a pre-existing entity that may be called the 'self'.

Thus, the context of the social interaction influences what is said about the self, and how the self is understood and experienced. Hirst, Manier and Apetroaia (1997) have shown that the nature of the social interaction influences how we remember events in our lives. Another study has shown that the order of questions influences what respondents remember and feel (Maybery et al., 2002). People have difficulty knowing why they acted as they did; their responses are often based on *a priori* theories rather than on their cognitive processes (Nisbett & Wilson, 1977). Furthermore, the dialectical relationship that exists within the interview context assumes that the interviewee and the interviewer are changed and being changed throughout the interview, much like the process between the therapist and the client, during the therapeutic encounter.

A major research challenge of this thesis is to determine how counsellors describe and experience their person or self, when counselling. The ordering, logic and memory of the 'self' or 'person' is, however, not only dependent upon the context in which an interaction occurs, such as an interview. Therapists are likely to impose a structure and make sense of their own 'self' or 'person' at other times, for example, during moments of self-reflection, during supervision, peer debriefing or when writing up case notes. Imposing order and coherence is a part of understanding ourselves, and an interview is one way, amongst many, that may facilitate self-knowledge and self-expression. Consequently, while the difficulty in capturing the inner experience of participants in words is acknowledged, the importance of trying to distill meaning regarding the experience of the counsellor's self is considered potentially valuable, for the future training, supervision

and research. Accordingly, in-depth, semi structured interviews were employed to access participants' subjective experience of self in therapy.

In summary, compared with the positivist approach to counselling research, the potential depth of response made available by employing the interpretative approach using interviews to collect qualitative data, is consonant with the humanness of the counselling encounter. This study was not concerned with an objective and measurable 'truth' (if there is any such thing) but instead with the perceived and experienced 'truth' as participants reported it.

The interview guide

Glesne and Peshkin (1992) consider various attributes of a successful interviewer, such as being non-reactive, non-directive and therapeutic. The interviewer used these skills plus other micro skills such as clarifying, paraphrasing, probing and encouraging during the interviews with participants. A conversational tone was used, rather than a question-answer approach.

The interviews were open and semi-structured, and provided an opportunity for 'rumination, contradiction, resolution, revelation' (Mackay, as interviewed by Wilson, 2000, p.242). Minichiello, Aroni, Timewell and Alexander (1995) describe semi-structured interviews as essentially a process that allows the researcher to ask questions about a central theme without being restricted by fixed wording or ordering of questions. Accordingly, questions asked were open-ended and allowed the participant to initiate topics and issues relevant to the area of the counsellor's person or self. Data were then comparable between subjects because they are 'sampled by representativeness of concepts' (Strauss & Corbin, 1990, p.191), with the same sort of information being sought from each participant, even though the same questions were not asked in each interview.

The interview commenced with a clarification of the main terms of the phenomena under investigation. It was considered important to commence the interview with some discussion about this, to ensure a shared understanding between the interviewer and interviewee. Baumeister (1999) claims, "Most people use 'I' and 'self' many times each day, and so most people have a secure understanding of what the self is - but articulating that understanding is not easy" (p.1). Whilst most people have an understanding of what the 'self' is, explaining, describing and articulating their perception and experiences of self, as pertains to the counselling context, may be more difficult.

Tester (1992) also explored the issue of terminology and, as part of a Delphic study, polled a group of expert family therapists, the term they most preferred to use, when discussing the self or person of the therapist. She found that most of the family therapists she polled preferred, 'the counsellor's self' rather than person or personhood of the therapist. Therapists from other theoretical orientations have not apparently been asked this question and may not have been exposed to the concept of self or person in their training or practice. I sought to ask counsellors what they understand by these terms, but some participants may have little reflective knowledge regarding the term 'self', or 'person' even though the experience of self during therapy is real and important.

Overall, I wanted therapists to consider what it was that they brought with them, as people to the therapeutic environment. As well as explicitly saying this I also referred to other terms found in the general literature. For instance, in addition to the terms 'person' and 'self', the phrase, 'who you are', was also used at the beginning of the interview. The phrase 'who you are' or 'who I am' refers to the 'I' William James first described when referring to the self that is known by the individual (Hattie, 1992). Furthermore, 'I', and 'who you are' and 'what I am' are phrases used linguistically, in everyday discourse, when individuals want to describe themselves (Lakoff, 1997). The phrase, 'who you are, as a counsellor' was considered to be generally inviting for participants to elaborate about themselves and their personal experience as therapists. Consequently, in order to be clear about the purpose of the research, the interview opened with the following:

This is a study about what you bring as a person to therapy. This involves who you are, as a therapist. The literature sometimes calls this concept the ‘self’ or ‘person’ of the counsellor. What do you think is the best term or phrase to describe this concept?

In the next part of the interview each participant was invited to describe the ‘self’ or ‘person’ of the counsellor (or whatever phrase or term they nominated). Information was also sought to determine whether the qualities they brought to therapy were positive and/or negative. Accordingly, various questions were developed to obtain a sense of the self that therapists bring to their clients. Sample questions included,

How do you describe the self or person that you bring to counselling?

What aspects of the self (or person) that you bring to therapy are positive, if any?

What aspects of the self (or person) that you bring to therapy are negative, if any?

The next major theme of this thesis explores how, if at all, the counsellor’s self, or person, is manifested in the therapeutic environment. Therapists were also asked in what ways the contribution of self might be considered helpful or not. Accordingly, sample questions included

How is your self or person manifested in counselling? If your self or person is not manifested in therapy, how is this so?

How does your self (or person) contribute helpfully to therapy, if at all?

How does your self (or person) contribute in ways that are not so helpful, if at all?

Further sample questions for the interview may be found in Appendix A.

At the end of the interview, participants were provided with a list of professional counsellors available for debriefing if the interview was in any way distressing or upsetting for them, both at the present time or at a later stage. Participants were also asked whether they had any concerns or queries that they wanted to address with the researcher. Interviewees were then thanked for their support.

Sample

Small samples are sufficient for research designed to develop the start of theory, based on immediate evidence, rather than for the purposes of generalizing findings to a wider population (Mackey & Mackey, 1994; Strauss, 1987; Strauss & Corbin, 1990). A small sample group also provides an opportunity for an in-depth and intensive investigation on the issues in question. The aim of the current study is not to generalise to a larger population of counsellors, but instead to investigate the term 'counsellor's self' in depth.

In terms of making generalizations to a larger population, we are not attempting to generalize as such but to specify. We specify the conditions under which our phenomena exist, the action/interaction that pertains to them, and the associated outcomes or consequences. This means that our theoretical formulation applies to these situations or circumstances but to no others (Strauss & Corbin, 1990, p.191).

No claim is made that the counsellors who speak in this study are representative of all counsellors or all counsellors from the same theoretical orientation. The counsellors speak with their own voice of their own specific experiences. However, from these perspectives, the researcher was able to map out the 'grounded structures' which underlie each participant's experience, and then determined whether there are common elements between them (Lemon & Taylor, 1997). Twelve interviewees are normally considered a sufficient sample size from which to identify themes and issues (Strauss & Corbin, 1990), though 16 were used here, in order to get an adequate spread over several different theoretical counselling orientations.

Subjects were identified initially by their respective professional affiliations including the local branch of the Australian Psychological Society (APS) and the local Social Work Interest Group (SWIG) (see Appendix B for a sample letter requesting this information). The respective presidents or facilitators of these associations were asked to supply the names and addresses of local psychologists and social workers, and then the researcher contacted individual counsellors inviting them to participate in the study (see Appendix C). These introductory letters also posed several key questions that were used in the interview. This served two purposes: first, potential interviewees knew more about the

topic area and could make an informed decision about whether to participate or not; and second, potential interviewees had the opportunity to think and reflect about the issues before the interview.

The researcher contacted participants following receipt of their permission forms to arrange a suitable interview time and place. At the interview, participants were asked to complete the informed consent forms required for ethics purposes (see Appendix D) and then invited to participate in a semi-structured interview.

Demographic information

The demographic information collected in this study includes gender, years of counselling experience, profession, current work focus and theoretical orientation.

Gender has been found to impact on participant's conception and manifestation of self (Shadley, 1986) as has participant's years of experience (Brightman, 1984; Dreyfus & Dreyfus, 1986; Skovholt & Rønnestad, 1992). Both social workers and psychologists were invited to partake in the study. As practicing therapists are the focus of the present study, participants were asked a question regarding their primary work focus. Perspectives on the counsellor's self from therapists across a range of orientations is sought, and so another important demographic was therapists' nominated theoretical background.

Poznanski and McLennan (1995) defined the theoretical orientation of the counsellor as the conceptual framework he or she uses to understand the therapeutic needs of the client. This conceptual framework includes generating hypotheses about a client's experience and history, formulating a rationale for specific treatment interventions and evaluating the therapeutic process (Poznanski & McLennan, 1995). There are various ways to identify a counsellor's theoretical orientation, including the use of questionnaires, asking a series of questions, or by asking respondents to state, or write down the theory with which they most identify (Garfield, 1977; Norcross, 1983; Poznanski & McLennan, 1995; Steiner,

1978; Wilson, 1993). As the counsellor's person or self has been a largely untested concept across a variety of theories, it was considered important not only to identify each participant's salient or primary theoretical orientation, but also other, less dominant theoretical influences. An individual therapist's approach to his or her self may be attributed to a gamut of theories, and may not be solely attributable to any one salient, dominant theory. Consequently participants were asked

What theoretical orientation or orientations, if any, most closely aligns with the way you counsel?

Participants' theoretical orientation/s was then identified collaboratively between the interviewer and participant, at the commencement of the interview.

Data organisation and analysis

In order to identify both unique and shared meanings, data analysis was undertaken in two parts: intra-interview analysis and then subsequent across-interview analysis.

In the first stage of data organisation, intra-interview analysis, I read through each individual transcript several times and identified various themes for each individual participant. After specific themes were identified, I then looked for internal validation of themes by referring back to the original statements to judge their adequacy (Colaizzi, 1978; Lemon & Taylor, 1997). Each interview was read in this way, with each transcript forming an individual set of categories. This method of theme analysis aimed to broaden and elaborate discourse around the research questions, and to prevent the decontextualization of the themes from the interview process and the broader sociological context (Oke, 1994). Consequently, separate lists of themes were developed for each participant.

Given that specific theoretical differences were found in the literature review, particularly in terms of the negative or inappropriate aspects of self, it was not assumed that common broad categories would be found across participants. Nonetheless, after categories were

formed from each individual transcript, shared and unique themes were then considered across the 16 individual representations of self. For ideas shared across more than one participant, categories were identified and grouped into a specific theme. These categories had internal convergence as well as external divergence (Guba, 1978; Marshall & Rossman, 1999; Patton, 1990). This meant that each category needed to be internally consistent so that similar responses are grouped together, but also that each category was distinctly different from other categories, so that significant overlap did not occur (Guba, 1978).

Differences across participants were also identified and unique themes noted. In this way, shared and unique themes were grouped into broader categories for presentation in the report. The number of participants grouped under each theme was noted as well as other demographic information, including theoretical orientation.

In both the intra-interview analysis and the subsequent across-interview analysis, data was initially sorted in two discrete areas, namely, 'What is the counsellor's self?' and secondly, 'How is the counsellor's self manifested in therapy, if at all?'. While there might be a number of possible ways of organising the data, this initial division of results is considered appropriate for a number of reasons. First, separating the results in this way mirrors the process of the interview, staying as close as possible to the original context in which responses were provided. Second, while ideas as a whole may not be reported as per individual participant, trans-theoretical or integrative themes may instead be identified, representing perspectives from a diverse group of counsellors. Subsequently, themes were further identified within each of these two, discrete areas.

Analyst-constructed typologies were applied to the data. These are category labels that are created by the researcher and are grounded in the data, but are not necessarily used explicitly by the interviewees themselves (Patton, 1990). However, while the researcher developed each category label, the concepts underlying each category were nonetheless predominately drawn from the language of the interviewee, so that examples and themes came from participants, rather than from the researcher. Finally, when the various

categories were developed and presented, the researcher then went over the transcripts again, to ascertain whether the categories assigned were appropriate, and whether there was any information missing in the first group of readings. These findings are not intended to be a definitive, final interpretation, but rather to be viewed as part of an ongoing process. The views expressed in this thesis are those endorsed and confirmed by the participants and the researcher; other researchers and counsellors may extend, modify or change these perceptions. Throughout this process the principle of effective research was kept in mind, namely that it should

... not reduce the complexities of human interaction and learning to simple formulas but rather should elaborate and accentuate their richness (Krall, 1988, p.474).

Simple formulas were not sought. In addition, it was recognised that the methodology used in this study had parameters and limitations, and other methodologies might show different and/or conflicting results. Qualitative research does not concern itself with only one interpretation of data; there are always other possibilities, strategies and outcomes, which future research and/or interpretations might discover (Giorgi, 1985).

Ethics

The Human Ethics Committee at La Trobe University, Faculty for Regional Development, gave ethics approval for the study. Risk assessment is an important part of research (Sieber, 1992) and the present study had the potential, however small, to psychologically harm participants; for example, a respondent might give more personal information than he or she initially intended to give. Participants might find themselves unwittingly discussing their own personal problems and issues, past and present, and how these impacted on their counselling behaviour. Participants were also asked to discuss therapeutic errors attributable to self, another potentially volatile issue.

Various measures were undertaken to minimize potential psychological risk. Informed consent was considered essential so participants could be informed about the interview in

the initial letter of invitation and cautioned about the possible risks of being involved in the project. The option to withdraw from the study at any time, guaranteed confidentiality and security of participant responses was emphasized to all concerned. Permission for the use of audio tape recording was also requested from participants, in the initial letter sent out to potential participants (Appendix C), and in the participant agreement form given to participants at the start of the interview (Appendix D). After each interview, participants were provided with the contact details of various counselling personnel across the region, in the eventuality that the interview was upsetting in any way for the interviewee (see Appendix F). It was important that these counselling supports covered a wide geographical area, as a participant might not feel comfortable seeing another counsellor from his or her own local area. In addition, providing participants with the opportunity to review and discuss their original interviews was important as a validity check for research purposes, and a means of allowing participants to further clarify and/or retract information about themselves. This was subsequently also built into the methodological process of the study.

Researcher subjectivity

As researcher subjectivity is an inevitable part of research, it is generally acknowledged that a process is required to recognise and deal with the researcher's potential personal biases, selective perception, experiences and theoretical predispositions (Denscombe, 1998; Lemon & Taylor, 1997; Marshall & Rossman, 1999; Patton, 1990; Talbot, 1996; Walker & Nias, 1995). Denscombe (1998) suggests that there are two options for dealing with issue of researcher subjectivity during the course of research and analysis. The first option is for researchers to consciously distance themselves from their normal everyday beliefs and to suspend or 'bracket' judgments for the duration of their research. Alternatively, researchers may 'come clean' about the way their subjectivity impacts on research and use these insights and perceptions as a part of the research methodology and subsequent analysis (Denscombe, 1998, p.209). It seemed a more honest approach in this

study to acknowledge my own insights and biases as the researcher, given that the impact and influence of these elements on research was inevitable.

While my subjectivity as the researcher might prove potentially problematic and contaminating, this same subjectivity may, on the other hand, provide useful data for generating and understanding the various issues involved in the counsellor's self. In other words, the personal insights of the researcher can be used in addition to the actual information generated from the participants. In an audio tape recording, Walker and Nias (1995) suggest, 'Your truth [as the researcher] is part of the story as well as the participants' truths'. My perceptions and my own understanding, reactions and experiences regarding the interviews and the information generated all include potentially valuable information for understanding the thesis topic. Consequently, the data pool for this study includes the participants' responses as well as my insights as the researcher.

Being a part of the research does not, however, mean that as the researcher I am then at the center of the research (Elliott, Lather, Schratz, & Walker, 1992). Not discounting the usefulness of my own insights, the information from participants needs to stand alone, and be presented in such a way as to minimise my biases and expectations. As well as being engaged and immersed in the data, the researcher also needs to be able to stand back and to reflect on what participants say, without misconstruing or changing the basic essence of their responses. At the same time, Patton (1990) contends that while researcher neutrality and credibility are important, the researcher need not, and should not, be detached. The researcher's dual positions of neutrality and empathy are not easily attainable, and consequently, various measures may be employed to ensure that the data generated are 'credible, accurate and true to the phenomenon under study' (Patton, 1990, p.56).

Highlighting researcher insights and potential biases was attempted here in a number of ways. In the first instance, the prologue was used to alert the reader, and myself, as the researcher, to my own experiences and the context in which the research is placed. As

the researcher I also maintained a reflective journal and held regular discussions with a peer debriefer during the course of the current project.

Reflective journal

Maintaining a reflective journal is one process through which researcher subjectivity may be highlighted as well as accounted for. Holly (1992) and others (Fulwiler, 1987; Green, 1993; Lincoln & Guba, 1985; Maykut, 1994; Progoff, 1975; Taylor & Bogdan, 1984) maintained a journal to record their thoughts and feelings during the course of their study. Sometimes called a methodological file (Browne & Sullivan, 1999) a journal or file entries usually contain

... the researcher's personal record of insights, beginning understandings, working hunches, recurring words or phrases, ideas, questions, thoughts, concerns and decisions made during the research process (Maykut, 1994, p.68).

There are two levels on which a journal may be both written and read. The first level is like a stream of consciousness or a 'flow of impressions' (Holly, 1992, p.4). At this level the journal reflects the immediate and usually uncensored personal thoughts, feelings and meanings of the researcher (Fulwiler, 1987). It is usually written informally, without consideration of academic form.

The internal censor or critic is more suppressed than is the case in more formal writing, both from the point of view of 'form' and 'content'; one allows oneself to get away with more in either of these respects, because the emphasis here is on letting go and finding out what happens: standing back, as it were, and allowing what emerges from the writing to reveal itself (Green, 1993, p.5).

However, what is then done with this 'stream of consciousness' is what potentially makes the journal 'professional' (Holly, 1992) or 'more directed' (Green, 1993). This second level of journal writing is more critical, reflective and analytically orientated. The researcher reads over the previous journal entry and reflects about what has happened and why. This second level of journal entry may thus provide an opportunity for perspective

and reflection, as the researcher questions what happened during the interviews and how the data were organised.

Accordingly, the reflective journal was kept in the present study as a means to collect data in two ways; in the first instance, my thoughts and feelings were recorded in the journal, immediately after each interview. Then, after several hours and/or days, I read through the previous journal entry and reflected on what had occurred, and what was previously written. These two stages in journal writing provided a means for both capturing my initial impressions as well as time related reflection and perspective (Holly, 1992; Progoff, 1975). Consequently, the reflective journal became a cycle of reflection, building on earlier entries, and a testament to my changing and developing ideas and positions (Holly, 1992). The reflective journal in the present study was maintained in this manner during the interviews, data analyses and discussion phases.

The reflective journal provided a vehicle that made my thoughts and assumptions tangible and concrete. In addition, a peer debriefer was used to look for, challenge and highlight potential subjectivity and provide other important insights about the data.

Peer debriefer

A peer debriefer was employed in this study, in order to read and critique the reflective journal, as well as to debrief the researcher, after the interviews. The role of a debriefer during research is to probe, question, explore, challenge, clarify and deepen the researcher's thoughts and ideas about the data collected (Lincoln & Guba, 1985). Furthermore, the debriefer may also assist in minimising unintentional self-deception on the researcher's behalf and provides an opportunity to discuss working hypotheses and clarify and substantiate ideas (Lincoln & Guba, 1985). Finally, emotions that may have been generated by the interview are debriefed and managed so that subsequent data analysis and interpretation are not clouded by the researcher's own personal issues and biases (Lincoln & Guba, 1985).

Lincoln and Guba (1985) suggest that the peer debriefer is a peer, and is neither ‘junior’ nor ‘senior’ to the researcher. A peer debriefer also needs to understand both the content and methodological issues of the study (Lincoln & Guba, 1985). Based on these criteria, a peer debriefer was selected. The peer debriefer was another university lecturer, with extensive experience in qualitative research as well as teaching and work experience in the field of counselling. He was also undertaking postgraduate research.

As the researcher in this study, I took on multiple roles, as the primary researcher, interviewer and the data analyzer; consequently, it was inevitable and necessary that I would be involved. At the same time, the ability to step back and consider the overall picture of what others had said was paramount. This was a rigorous exercise that called for critical self-awareness and was assisted through the journal and peer debriefer.

Credibility

Credibility refers to the rigor, validity and reliability of the research process and specifically focuses on the techniques and methods for gathering and analyzing data, as well as establishing the credibility of the researcher (Patton, 1990).

The use of the peer debriefer and researcher’s journal provided the potential to enhance my credibility and subsequent ‘trustworthiness’. Credibility of the interview transcripts and subsequent data analysis were also enhanced in other ways. Initially, a copy of the transcribed audio interview was sent to each participant after the interview. Participants were encouraged to check whether there were any modifications, corrections or clarifications they would like to make to these transcriptions (see Appendix F). They were also encouraged to add more information, in response to the two central questions of this thesis in the form of a short questionnaire (see Appendix G). These written statements also provided another avenue for collecting research information that may not have been accessible during the interview part of the data collection. The questionnaire also allowed participants to reflect on the main issues of the interview and to respond in a

different manner, after the interview time. Involving participants as much as possible in the understanding of the interview transcripts adds trustworthiness to the data (Lincoln & Guba, 1985), and thus provides a validity check (Borg, Gall, & Gall, 1999).

Overall, there were a number of data sources for the present study, including the interview transcripts, written questionnaires from participants, the researcher's reflective journal and peer debriefer comments (as recorded on the researcher's reflective journal and via email communication). Using a variety of data sources is a form of data triangulation, and subsequently provides the opportunity to check the overall credibility of one's data set (Denzin, 1978; Patton, 1990).

Chapter four: Findings

Participant demographics and the findings from the interviews and questionnaires are presented in this chapter. The three sets of findings begin with the preferred terminology nominated by participants to describe the counsellor's self or person. Second, participants' descriptions of the counsellor's self are provided. The third part of the findings is an outline of the issues highlighted by participants regarding the manifestation of the counsellor's self in therapy.

On the whole, participants appeared interested and responsive about the subject matter. On several occasions, participants requested a second interview in order to discuss the topic further. Some participants commented upon 'how hard' the questions were, and welcomed the opportunity to think through the issues first, and then comment again at a later stage, write on the transcriptions of their interviews and complete the questionnaires. Several participants (F1, F2, F6, and F8) said that they rarely were given the opportunity to talk about themselves in their work lives and so welcomed the opportunity to do so, in the interviews. As one participant said, 'Therapy is normally about them [clients] and not us, isn't it?' (F6, p.12).

Overall, participants said less about the concept of the counsellor's self than they did about the ways in which the self was present in therapy. Most participants found describing the counsellor's self difficult, though generally provided more information on the returned questionnaire or in the second interview. Furthermore, in the data analysis of interview transcripts it was difficult at times, to differentiate between responses regarding 'what is the counsellor's self?' and 'how is the counsellor's self manifested in therapy?'. For instance, when describing the self as useful and positive, participants sometimes also described how the self was positively involved in therapy. In other words, what the counsellor's self *is*, and what the counsellor's self *does*, overlapped on numerous occasions. While themes do overlap, for clarity and ease of reading, the results are presented in two sections; how therapists describe the self is outlined in part b, and participants' responses regarding the manifestation of self is presented in part c. This

separation of the results also mirrors the interview process and the way in which the questions were asked and consequently retains as much as possible, the context in which original responses were given. While it is acknowledged that the two issues, ‘what is the counsellor’s self?’ and ‘how the self is manifested in therapy’, overlap and are intimately related, because participants were not directly asked to make these connections themselves, a synthesis and connection between the two sets of responses will be tentatively presented in the discussion.

Every interviewee who participated in the study permitted the use of audiotaping. Participants were sent transcripts of their interviews, and encouraged to add, delete or modify these. They were also sent a short questionnaire (see Appendix G), regarding the central questions of this thesis, in order to provide additional information in a different format. Nine of the 16 participants returned their transcripts and completed the questionnaire, all of which added to the information of their original interviews. One participant deleted some of the interview from his transcript, for the purposes of what he considered to be greater clarity. When responses are recorded in this report, italic print denotes the interviewer, while plain text denotes the participant. Participants are represented according to gender and the number of the interviewee, for example, F2 is the second female respondent interviewed, while M5 is the fifth male respondent interviewed. The page number of the transcript is also presented. Besides the exclusion of participant ‘ums’, ‘yeahs’ and ‘ers’ in order to provide greater fluency, there has been no further editing of participant responses.

This section begins with a description of participant demographics.

Participant demographics

Sixteen participants were interviewed in this study, of which 11 were female and five were male therapists. All participants were practicing counsellors, whose major work focus was therapy, even if they did not counsel clients for the whole of their work time, for example,

I'm basically a counsellor but there are other things that I do, but of my day, I spend the majority of my day counselling and I guess with things around counselling but I am still involved in organisational activities, team meetings, that sort of thing and I do group things, and am involved in community reference groups but it is still related to counselling or counselling issues, so really my core business, my core role is counselling (F9, p.1).

Of the 16 participants, there were seven social workers and nine psychologists. See Table 1 for a summary of participant profession as well as gender.

Table 1: Profession, gender and participant number.

	Social workers		Psychologists	
Gender	Male	Female	Male	Female
Participant number	M4, M5	F4, F5, F9, F10, F11	M1, M2, M3	F1, F2, F3, F6, F7, F8
Totals	2	5	3	6

Therapeutic experience was also sought from participants. The categories used for participants' years of experience were based on the previous work by Skovholt and Rønnestad (1992). Two participants were first year counsellors (having just graduated), five participants had been practicing counsellors from between one and five years, four participants from between five and ten years, four participants from ten to twenty years, and two participants had been practicing counsellors for over twenty years. The male participants tended to have more experience as therapists than the women participants. Participants' number in relation to counselling experience is shown in Table 2.

Table 2: Participant number, in relation to counselling experience.

Participant	Years of experience	Total
F6, F11	First year after training	2
F2, F4, F8, F9, M5	2-5 years of counselling experience	5
F1, F3, F10	6-10 years of counselling experience	3
F5, F7, M3, M4	11-20 years of counselling experience	4
M1, M2	Over 20 years of counselling experience	2

Other information sought from participants was their theoretical orientation. Some of the participants were clearly able to nominate the one theoretical perspective that influenced their work. These include F2 and F6 (cognitive behaviour therapy), F4, M4 and M5 (systems therapy) and F10 and F11 (person centered therapy). The following quote demonstrates the ease with which some participants nominated their theoretical orientation.

Well, it's really a systemic approach, I very rarely would consider any person in front of me as being the person who entirely owns the problem, but it's linked to everything else that that person has lived, experienced and even historic experience has brought to them. So I am constantly thinking in a systemic way, linking them to their environment if you like, in terms of therapeutic style (M4, p.2).

Others found it difficult to nominate one, 'pure' theoretical orientation. When listing more than one theoretical influence, some participants were able to nominate the strongest theoretical influence in their counselling practice. For example, F3 said that for her, 'it would be a toss up between Rogers and Jung I suppose' (F3, p.1) and further refined this when she then nominated Rogers as the primary influence for her counselling work. M1 said that while the psychoanalytic model was most appealing, the humanistic model was 'safer'⁶. However, in the follow-up written questionnaire, M1 wrote that his work was most closely aligned to psychoanalytic theory and subsequently he preferred to be aligned there. While these participants were subsequently categorized as having nominated person centered and psychoanalytic therapy respectively, the other influences were noted as important information that may impact on the results. The participants that listed several influences but were able to identify one dominant theory included F1, F3, F5, F7, F8, F9, as well as M1. Table 3 lists the theoretical influences of the 16 participants, including their primary or dominant theoretical influence as well as other secondary influences.

⁶ To provide more detail regarding the reasons for this response would jeopardize the anonymity of this participant.

Table 3: Participant number and their dominant and secondary theoretical influences.

Participant No.	Dominant theoretical orientation	Other, secondary theoretical influences
F1, M1	Psychoanalytic Psychoanalytic	Gestalt Person centered therapy
F2, F6 F7 F8	Cognitive behaviour therapy Cognitive behaviour therapy Cognitive behaviour therapy	None Solution focused therapy and person centered therapy Solution focused therapy
F3, F10, F11	Person centered therapy Person centered therapy	Psychoanalytic None
F4, M4, M5 F9,	Systems therapy Systems therapy Systems therapy Systems therapy	None None None Buddhism
M2 M3	Eclectic Eclectic	Consisting of: psychoanalytic therapy, solution focused therapy, neuro-linguistic therapy, person centered therapy, behaviour modification, and cognitive behaviour therapy Consisting of: systems, cognitive behaviour therapy, and psychoanalytic therapy.
F5	Buddhism	Systems

Other participants were unable to settle on a single category. M2 reported

I will use different techniques from a variety of orientations, depending on who is sitting in front of me (M2, p.1).

These participants included, M2 (who nominated psychoanalytic therapy, solution focused therapy, neuro-linguistic processing, person centered therapy, behaviour modification, and cognitive behaviour therapy) and M3 (who nominated family therapy, cognitive behaviour therapy, and psychoanalytic therapy). Both participants identified themselves as eclectic counsellors.

While theoretical influences varied, the dominant influences for participants in the present study included two participants who nominated psychoanalytic therapy, three who nominated person centered therapy, four who nominated cognitive behaviour therapy, four who nominated systems or family therapy, two who were eclectic, and finally one participant who nominated Buddhism.

The following findings are organised in three parts, namely:

Part a: participants' preferred terminology,

Part b: participants' description of the counsellor's self, and finally,

Part c: participants' reporting of the issues regarding the manifestation of self in therapy.

Part a: Participant's preferred terminology

Participants were asked what term they most preferred when referring to what it was they brought to therapy as people. They were also informed that sometimes in the literature this was referred to as the counsellor's 'self' or 'person'. Fifteen participants nominated the term, 'the counsellor's self', while the one remaining participant preferred 'person'. Overall however, all participants regularly used the term, 'the counsellor's self' throughout the interviews.

One participant, (F1) said that her counselling work was primarily directed at examining and changing the self of the client, and so 'the self of the counsellor', fitted comfortably within her therapeutic focus and interest. F3, F8, F11, M4 and M5 had seen the phrase 'self of the counsellor' previously, in the counselling literature and so preferred this term. Two participants focused on the more 'intimate' appeal of the word 'self' as opposed to 'person'. For example, M2 said,

I like counsellors' self... It's a bit more personal... and that's how it ought to be if you are talking about the counsellors' self then you are talking about yourself. Rather than your person which is a bit impersonal, so I think it just has a greater impact... so if I were talking about myself I ought to be able to say 'self' and not

thinking about me as my 'person'... if I talk about myself as a person it's like I'm sitting out there on the wall, I'm observing me and being quite analytical about it (M2, p.1).

F5 agreed saying,

I think the self is more, intimate... person seems more formal and distant (F5, p.1, 2).

For two participants, M3 and F7, the terms 'person' and 'self' were not important distinctions, 'I don't think it matters particularly' (M3, p.3) and again, 'I mean I don't ever try to think of the distinction, why would you use person as opposed to self, it's not a particular issue...' (M3, p.4).

The two psychoanalytic counsellors both used the word countertransference when discussing the self of the counsellor, for example, 'I guess I'm thinking of what's often talked about in transference and countertransference' (M1, p.3). However, these two psychoanalytic counsellors continued to use the term 'self' rather than countertransference in the interview. While the notion of countertransference was important when describing the counsellor's self for these two therapists, the self that they brought to therapy also included more (as will be presented later).

One participant, F9, preferred the term 'person of the counsellor' because of her interest and commitment to Buddhism, even though she considered systems therapy to be the dominant theoretical influence in her therapeutic work.

Well probably at this stage in my life, I would say the person of the counsellor, given that from a Buddhism perspective there is no self, so in the past I would have said self, but I would be more comfortable these days saying the person of the counsellor... (F9, p.1).

However, this participant used both 'self' and 'person' throughout the interview. The other counsellor who identified strongly with Buddhism (F5) preferred the term 'counsellor's self', (see above quote) as it was more intimate, while the term 'person of

the counsellor' was formal and distant.

Overall, participants in general, preferred to use the term, 'the counsellor's self' rather than the person of the therapist, or any other term, when describing what they brought to therapy as people.

Part b: Participants' description of the counsellor's self

Participants were asked, first during the interview and then in the follow-up questionnaire, 'what is the counsellor's self?'. They were also asked what aspects of self were positive or negative, if any. For the participants interviewed, the counsellor's self was primarily a localized, individual entity that defined each therapist's uniqueness as people and professionals. When asked to further identify what this individual entity was,

Table 4: Descriptions of the counsellor's self, according to participants and key demographic information.

Descriptions of the counsellor's self:	Participants	Key demographic information
<i>Self as a defining and multifaceted center</i>	All participants	Includes all demographic groups
<i>Intra-personal: consisting of the therapist's inner experiences.</i>	All therapists	Includes all demographic groups
<i>Inter-personal: the self as defined by various micro and macro relationships</i>	F3, F4, F5, F6, F7, F9, F10, M3, M5.	Predominately systems therapists but also including some therapists from other theoretical orientations.
<i>The counsellor's self as positive rather than negative</i>	All participants	Includes all demographic groups
<i>Including the counsellor's professional role</i>	All therapists	Includes all demographic groups
<i>Flexible with a sense of consistency</i>	F1, F2, F3, F5, F7, F8, F10, F11, M1, M3, M5.	Includes all demographic groups, but not all the therapists interviewed.

the 16 participants described the self in various ways; as intra-personal, somewhat inter-personal, positive rather than negative, including the therapist's professional role and knowledge, and finally with the capacity to change though at the same time conveying a sense of stability. Participants' description of the counsellor's self is summarized in Table 4. Key demographic information is highlighted if one particular demographic group is predominately represented or under-represented, including gender, profession, years of experience and theoretical orientation.

The counsellor's self as a defining, multifaceted center

All 16 participants said that the self was a defining entity, which characterized their personal presence, uniqueness and included what it 'was to be me', as a therapist working with clients. Representative comments include:

... your core motivating sense of who you believe you are and that's where you operate from... all of that is motivated by how you define your sense of self or what is made up of your self (F1, p.1).

... my core, my ethical stance of who I am (F10, p.11).

Many participants referred specifically to a core sense of self (F1, F2, F3, F5, F7, F9, F10, F11, M1, M3, M4) while others simply emphasized the self as a defining entity that expressed their uniqueness and individuality as therapists and people. For instance,

The self is that which makes me an individual, so it's me the individual who is also a therapist (F2, p.1).

Participants referred to this defining sense of self in different ways including, the 'I', 'you,' 'real self,' 'me,' 'the individual,' 'core,' 'who I am,' as well as 'not trying to be something that I am not,' 'no façade'. These statements suggest that participants considered their self as a counsellor in terms of a defining core that is authentic and genuine.

Whilst participants presented the counsellor's self in terms of an individually defining entity, as the interviewer, I wanted to then know what it was that defined them, as therapists. This became a somewhat interactive conversation between the interviewee and interviewer, with the interviewer then asking such questions as *'So, what is this core sense of you, as a therapist?'* or, *'What are the things that make up you, as an individual therapist?'* Participants then attempted to delineate or otherwise describe what constituted their core and defining sense of self.

Consequently, participants then identified various 'parts' or 'aspects' of self, which together made up the self of the counsellor. One participant (M1), in the written questionnaire that accompanied his transcript, drew a figure (see Figure 1) that to him characterized the counsellor's self. This representation is indicative of what the other participants had to say about the counsellor's self, that is, a self consisting of several parts. For M1, the large circle in Figure 1 represents the counsellor's self, within which there are many 'parts', some in his consciousness, some in his unconsciousness. These parts, as represented by the smaller circles, are composed of different components, and, in M1's view, consist of the different roles, emotions, thoughts, goals and intentions of the therapist.

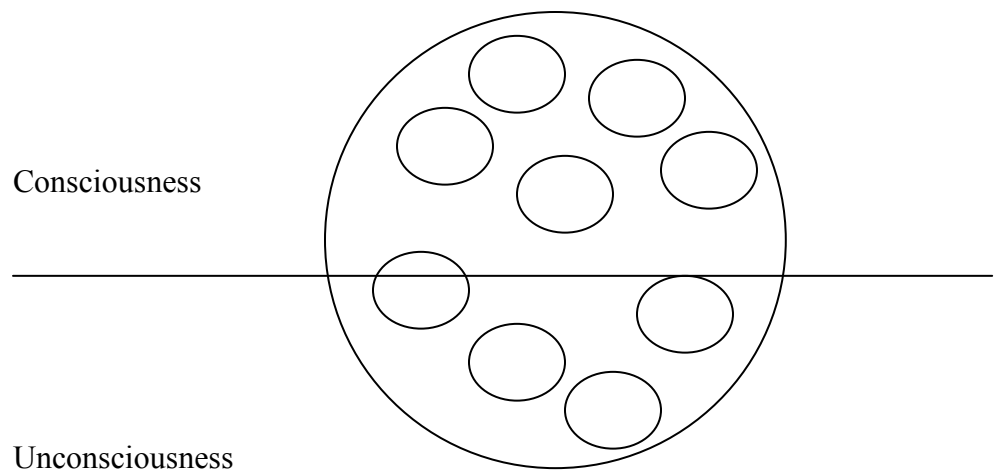


Figure 1: The counsellor's self as represented by M1 (questionnaire, 16th November, 2001). The large circle represents the counsellor's self, and the smaller circles represent the various aspects of self, such as a counsellor's emotions, thoughts, roles, intentions, some of which reside in his consciousness, others in his unconsciousness.

While common or shared self aspects may be identified, each participant presented with a different conglomerate of self facets, so that no one self is identical to another, in the present study. For participants, the self is complex and is not composed of one single entity but is instead the sum total of several parts that differed across the 16 participants. Thereafter, the various ways the counsellor's self was described by participants includes, as an intra-personal phenomena (including the therapist's inner experiences), somewhat inter-personal (that is, defined by the therapist's various relationships), as positive rather than negative, including the counsellor's role, knowledge and expertise, and finally, flexible though at the same time conveying a sense of stability and consistency.

Intra-personal

All 16 participants described the counsellor's self in terms of their inner processing and experiences. These inner processes were reported in terms of participants' affective experiences, thoughts and perceptions, beliefs and values, a personal style or personality, and an unknown, instinctive or unconscious component of self.

Most therapists referred to their feelings as an important aspect of self (F1, F2, F3, F4, F5, F6, F7, F8, F9, F10, F11, M1, M2, M3 and M5). For instance,

How I feel on any given day is an important part of the self that I bring to therapy (F4, p.3).

My feelings, my emotional and affective life are an essential part of the self that I take to my clients (F1, p. 6).

The therapist's emotional experiences included feelings such as anger, curiosity, boredom, satisfaction, sadness, frustration and joy. Sometimes these feeling were in reaction to the client, but not always.

The counsellor's thoughts and perceptions were another facet of self that some participants (F1, F2, F5, F6, F11, and M4) included when describing the self as a therapist. The therapist's thoughts were regarded as a way of cognitively and actively interpreting situations and experiences, particularly as they pertain to the client. For instance, F5 said that her self included how she would

... see a particular situation and how I've interpreted it (F5, p.1).

Some therapists (F2, F4, F5 F6, F9, M2, M3 and M4) also said that their beliefs and values made up the counsellor's self, though they did not specify what these beliefs and values were. Participants also did not articulate how these beliefs and values might have been formed or shaped. Nonetheless, participants' beliefs and values filtered the way they saw the world, their clients, and the presenting issues they might be faced with, when working as therapists. Whilst not strictly phenomenological, therapists' beliefs and values are included here, because they encapsulated how therapists understood the world and viewed their clients.

Similarly, the therapist's personality or 'nature' was also included in the counsellor's self, as a certain style or way of doing things. For example,

I think who I am as a person as in my nature is another part of my self... this constitutes the way I personally do things, and see things... (M5, p.2).

F2 also talked about her 'nature' (F2, p.1) and how this (along with other components) describes her self. She later elaborated by saying that this 'nature' is her personality. Similarly, F10 said

... the counsellor's self includes my unique personality, maybe it's my or others quirky sense of humour... [my self includes] the person that I am, I might be a touching type person, maybe it's not appropriate, maybe it's appropriate, however if that is genuine and that is who I am and it comes from a sense of good faith or genuine compassion I guess I do it subconsciously (F10, p.3).

However, the counsellor's self was more than the individual's personality. For example, one participant said

The self [of the therapist] and personality is to me, pretty much the same, but to me personality is a little bit more external... it's what other people see whereas when I think of self I think of both what other people see but also what you don't really express... and it may not be that you are trying to conceal it but there is just parts of you that other people don't know about but still a part of who I am as a therapist (F8, p.3).

Many participants, from a variety of theoretical orientations (F1, F2, F4, F5, F6, F8, F9, F10, F11, M1, M2 M3 and M5) acknowledged that the self included parts that they were not aware of. Participants had different ways of describing this, including, the unconscious, instinct, intuition, hunches or gut reaction. This aspect of the self seemed to exist on the edge of their awareness and so was difficult to describe. The different ways participants described this aspect of self included

... gut reaction... intuition, that is there in my concept of self... I mean you can't stand next to somebody without having some sort of reaction, and being at least partially conscious of that, that there is something going on, I suppose it's your sub-conscious as much as unconscious, there is something going on at a, not a clearly conscious level (M3, p.9).

...my self also includes that part of you that reacts very instinctively...I guess I'm thinking of what's often talked about in transference and countertransference and, so, the automatic emotional reactions [which exist along with] this is what I'll ask and this is what I'll do (M1, p.3).

Participants were, however, able to talk about this part of the self, suggesting that, at times, this unconscious part of the self entered into their awareness. Overall, all participants referred to their inner experiences when describing the counsellor's self, referring to their emotions, thoughts, perceptions, beliefs and values, personal style or personality, and an unknown or unconscious part of self.

Inter-personal

The counsellor's self, for some participants (F3, F4, F5, F6, F7, F9, F10, M3, M5), was described as inter-personal in that the self they brought to therapy was influenced by others, and the social context in which it is placed. Many of these therapists work within

a systems framework (either as their primary or second theoretical influence) but also included some therapists from other theories. Participants' personal history was an important way in which the self was formed for some therapists. Some therapists acknowledge that various contextual features, such as social class, age, and gender, defined the self. Some therapists also recognised that other people's perception of the self, including their clients, is important in their descriptions of self. There were, however, limitations to this feature of the self, for rather than being constructed by others, many therapists argued that they defined who they were, and that others, including clients, often misinterpreted the self.

In the first instance, some participants said that the self was shaped by past family influences and relationships with significant others. For example, F4 spoke at length about her childhood and how her relationships as a child have shaped the way she works as a therapist with children in an education setting. Another respondent (F3) also spoke about her self and her past experiences,

... my self has been influenced by the family that I was part of, [and] the other families I've been part of, where I am now, places I've been to, that I feel like I've brought bits, away with me... (F3, p.3).

Rather than passively taking on aspects of her past, this therapist emphasizes the 'bits' she has actively taken on from her personal history that are current in her definition of self.

Some participants (F6, F7, F10 and M3) acknowledged that the counsellor's age, gender, culture, organisation, and social status were a part of their description of the counsellor's self. These contextual features were mentioned alongside other features of self, and participants generally did not elaborate or dwell on how these contextual variables inform or describe the self. Some participants felt that such variables should be important, from an academic rather than personal point of view, for instance,

After reading this [the transcript of the interview] I was aware that there had been no mention of either gender or age. I do think this is important from my readings

on how therapy works and so I am trying to be conscious of both these aspects of myself... so I can use both quite deliberately – particularly gender, especially when I am working with other men (M3, questionnaire, October, 2002).

While age, gender and class were noted, such features were not central or marked features of self, according to participants.

Three participants (F6, F7, and F10) suggested that the self is defined, in part, through the eyes of others. In the following quote, for example, F10 explains how her self is constructed as having ‘more power’ than she believes she actually has, which influences the self that she presents to the client.

... the context they [clients] see you in, is important, I mean, it amazes me that they see you as having more power sometimes than what you actually have, just because you work here and you happen to have an office and they conjure up all these different ways of being here, whereas if they had seen me, you know, down the street somewhere I wouldn't have the same amount of power... (F10, p.13).

However, these participants pointed out that other people's perceptions may or may not reflect their own perception of themselves. For example, F6 said that sometimes her clients assume certain things (inaccurately) because of her age (she is in her early 20's); similarly, F7 described how her husband's occupation also set up expectations from others that were not necessarily correct. While these participants considered other peoples' perceptions important in describing self, they strongly contested their accuracy, saying several times, and in different ways, ‘but that is not me’.

Three therapists (M3, F5 and F9) describe how the counsellor's self and the self of a client may become intertwined. These therapists describe a process whereby the counsellor's self was used as a means of holding or receiving emotions that did not belong to them, but came from and belonged to the client. For instance,

The first time [the participant felt sad when listening to a client] that happened to me I was extremely worried because I thought ‘Oh goodness me, am I tapping into my own stuff, does this mean I am not going to be able work anymore?’ because it happened to me twice in one week. And [the sadness] had been the

first time I had experienced it, and it had really been so overwhelming, I felt like I was going to cry. I felt like not only crying, I felt like I was going to burst into, you know, a big display of sobbing. I was able to contain that, thankfully, but when it happened twice in one week, I thought, what is going on, you know, what is happening to me? [And I found] I was like being a receptor to the energy of the emotion that the other person is detached, totally detached from... So they [the clients] were disconnected from their emotion but I was, because I was open, I was picking it up... So [I realised that it was important for me] to be able to recognize, to check in with myself and say, 'is this my sadness'? And then putting it back, when I'm thinking I don't know that this is my sadness, [so I need to] put it back where it belongs... it doesn't belong to me, it's not mine, it's not a part of me... (F9, p.4).

Here, the participant describes instances in which the counsellor's self 'contained' or 'received' clients emotions, which she subsequently 'gave back' to her clients. Similarly, M3 and F5 also described how they might feel the client's emotions though simultaneously know that these emotions are not their own. The self whilst influenced by the client, was at the same time, separate from the client.

Positive rather than negative

When asked 'what is the counsellor's self?' participants described the self in a neutral manner, giving neither positive nor negative descriptions of the self. When participants were specifically asked what aspects of self might be positive and/or negative, overall, they described the counsellor's self as a positive rather than a negative entity (and from their perspective, the counsellor's self contributed positively in various ways in therapy, as will be outlined in part c). While some therapists did identify some inappropriate personality traits and their own unresolved needs in their description of self these were generally in the past and consequently managed or moderated by the therapist and no longer in their current description of self.

Some counsellors, (F6, F11, M1 and M4), from a range of theoretical orientations, were able to identify negative parts of self that they felt were inappropriate or ineffective in their role as a counsellor, though were carefully managed and subsequently not featured

in their description of the counsellor's self. This included inappropriate personality characteristics or traits. For instance, one first year therapist said

I have to be very careful because I know I have certain traits that don't turn off when I am working that perhaps wouldn't be bad if they did (F11, p. 4).

These inappropriate personality traits were however 'turned off' by the therapist whilst working with clients.

Three female social workers with a predominately family therapy background (F4, F5, F9) were able to describe how their own personal problems and issues, sourced from their own early experiences, formed a part of the therapist's self.

I became very aware that I had really sold the woman [a former client] out. I allowed the male partner off the hook in taking any responsibility in what was happening. And I did that when he would be asked a question and he would say 'oh, I don't know' or he wouldn't give an answer, I would go back to her and get the answers from her... I felt I let her [the female client] down. I felt I betrayed her. I felt I sold her out and from her body language it was very clear that that was what I had done too... When I took that to supervision and a very skilled supervisor in her questioning, you know, was asking me about what, in talking about that couple in general... What was it that was informing me, where, how did I know what was going on in the dynamics of that relationship?... Where did I learn that? What theory is that? And really what had informed me was my parent's relationship and my hesitation in, I guess how I acted with that couple, was really about my resistance of looking at my parent's relationship differently... because if I was to look at my parents relationship differently the anger that I had always felt towards my mother would shift markedly and that I would have to look at my father and I was quite comfortable with blaming my mother and being angry with her (F9, p.5).

However, while F9's own personal issues were once important in defining her self as a therapist, with supervision and therapy she had been able to resolve these otherwise problematic aspects of self. Consequently, these previous personal limitations and inadequacies no longer featured in her current representations of self.

Similarly, another counsellor described how her own needs sometimes impact on therapy, but how she manages this so that her therapeutic work with clients is not impeded.

What I find is every now and then when I have been really busy and I haven't really had a lot of contact with my friends, is that, I just feel like I want to talk more, you know, sometimes during a session and I suppose I am pretty aware of myself and I am sort of constantly checking myself but typically that wouldn't happen but it's just a feeling I have, it's like I'm sitting there and I'm feeling like I want to talk more and it's because I haven't been talking enough in my personal life... So what I typically do is make sure, when I realise I do that, well I'll ring a friend that night or just organise something, so that doesn't typically last for very long (F8, p.12).

One therapist described how she becomes aware that her own issues might be impacting on therapy and what she subsequently does to ensure that they are no longer present whilst working with the client.

... if I feel like I am getting some sort of negative reaction within me, then, I become conscious of it and I try and contain it, and try not to let it escalate, 'cause I would only feel what I feel and they [the client] would be picking up on something, tension... discomfort, they may not be able to interpret it... and I would try and even steer it in another direction, create a red herring, you know a distraction of some sort, but afterwards I would certainly, sit and try and even defuse it with my own mind or talk to somebody about it. I've been trying to do it through supervision though it is still early days (F5, p.4).

While this therapist manages to suppress or otherwise manage a 'negative reaction' she does however allow herself the opportunity to explore and experience these feelings, outside of therapy.

Some therapists (F7, F8, F11 and M3) described aspects of the counsellor's self that could be construed as either positive or negative depending on the client. For instance, here one therapist (F7) describes how she might be considered as being either flippant or optimistic.

I am aware of sometimes being a bit flippant, or I fear that I may be interpreted as being a bit flippant because I will sort of crack a funny which is, perhaps only funny to me, and I don't realise it, or perhaps it's not that funny to other people but I don't like that gloom and doom stuff you know, they come in here and their world has fallen apart... if I could find something funny and I usually do, even if it is only in my head, and that is not always conscious, I mean I don't set out to do that, it just happens I suppose, and so that I will try and feed that into them, you

know, like ‘goodness, you’ve had a rotten time’ or you know, or, ‘what awful thing is going to happen to you next’ or I try to sort of turn it so they can see things a bit more objective[ly], look at themselves from outside, instead of being stuck in that... but sometimes this can be a negative part of my therapeutic work, but may also be positive... (F7, p.3).

Similarly, another therapist described a type of style that might not suit all clients, for example,

... sometimes I walk away from a session and I feel I could have been more confrontational but that style thing that was just in my family, people weren’t directly confrontational so that again is I suppose a personality thing... [it could be that] because of who I am I might then take a little bit longer than if I was more confrontational, in some situations... having said that there have been a couple of clients, one in particular who was extremely shy, reserved, who basically said to me ‘if [it] wasn’t for your manner, there’s no way I would have been here’, and that’s when I really need to value my self and my own style more (F8, p.19).

Two other participants (F1, M1) alluded to the possibility that negative self elements might be brought to the therapeutic context. For example, one participant said, ‘that stuff [her own personal issues] wouldn’t come up’ during counselling, but instead would be ‘*almost* on the shelf’ (F1, p.8, researcher’s italics). Another counsellor said his own personal issues ‘don’t shape my reactions *that much*’ (M5, p.5, researcher’s italics). Both counsellors appear to suggest that their own personal limitations and inadequacies may form a part of the self they bring to therapy, but are unsure about the extent to which this occurs.

Many participants, however, found the issue of whether the counsellor’s self included negative or otherwise inappropriate aspects difficult to answer. Most were reluctant to rule out this possibility that the self they brought to therapy might ever be negative or inappropriate, though they considered that at present it did not. Representative comments include

No, I can’t say it [the self] does [include negative aspects]... I haven’t come across it. That’s not to say negative parts of my self as a therapist might not come up in the future... (F11, p.10).

I mean I wouldn't say that my self is at all negative though I should hesitate to say this... no, I'm finding it hard to think of a time, but that's not to say my self does not contain any negative aspects... (F3, p.11).

... well there probably has been clients that don't come back or don't do particularly well, whether you actually get a chance to identify it, I'm not sure... But I know there have been clients that I haven't done very well with, I know there have been clients who, haven't wanted to come back, that happens, but I don't know whether it's about the way I've been or the way I've used myself, I'm not quite sure whether that's the case... (M3, p.11, 12).

The therapists were not saying that they were 'perfect people' who did not have their own personal issues, or inappropriate attributes. For the most part, therapists said that they were less rushed, critical, and judgmental, and more patient and caring with clients than with most other people in their life. For example,

I know too that sometimes I feel that I give the best bits of my self to my clients... I can be kind and caring and patient... and then go home and tell my kids that I don't have time or I am too tired to help them with their reading... it's pretty crazy really... (F9, p.10).

Similarly, one therapist (F10) described how her self has had to become stronger, and overall more robust to deal with the pain and grief of clients. Her tolerance for pain, anxiety and grief has developed over time, after working with clients, who, for example, might have just found out that they have an incurable illness, or that someone close to them has been in a fatal accident.

For participants, the counsellor's self was a predominately positive rather than negative entity. This meant that the personal qualities that they brought to therapy were considered to be overwhelming useful and beneficial to therapy. While there were some past occasions in which some therapists identified bringing their own personal needs, issues or inappropriate traits into therapy, therapists were able to manage, suppress or otherwise moderate these negative aspects of self in their work with clients (this section is closely linked with manifestation of self in therapy in part c, and more information is provided there).

The counsellor's role, knowledge and training

All participants considered their professional experiences, abilities and professional training a part of their self as a counsellor. For example

Part of the self that I bring to counselling includes a understanding of the issues and of the nature of development, the nature of the personality, the nature of psychopathology, an understanding of personality dynamics and the difficulties that people get into and the things that can actually be helpful... so part of my self includes my expertise, that you make available to clients during therapy (M3, p.3).

However, all participants also said that the self was more than their professional identity and role as a therapist.

It [the counsellor' self] is all of the counsellor including those parts, which respond when out of role (M1, questionnaire, 16th November, 2001).

The counsellor's self includes my knowledge and theoretical basis as a professional therapist as well as my personality, history, philosophical beliefs, practice wisdom and baggage (and bias) (M4, questionnaire, 2nd February, 2002).

Participants generally recognised that therapy is about two humans meeting in a room, even though the therapist also brings his or her professional knowledge and expertise. The counsellor's self includes though is not limited to, the counsellor's professional training, knowledge base and therapeutic skills.

Flexible as well as consistent

Paradoxically, a sense of continuity and consistency across time, as well as notions of flexibility and the potential to change, was a feature of the counsellor's self for most of the therapists in the study, across all the sampled demographic groups.

Various changes to the counsellor's self were identified and included daily mood changes, personal and professional maturity, professional flexibility and the ability to

work differently with various clients. Two therapists articulated the constant and ongoing fluidity of self when they claimed

... your sense of self, it changes all the time, it alters, I mean your sense of self alters all the time, it grows and it develops and matures, you know every minute of the day (F1, p.7).

[my self includes] how I'm feeling that particular day... It impacts greatly I think, you know what has happened at home and when I get to work... (F4, p.2).

Some therapists described how they have changed over their professional careers by becoming progressively more relaxed rather than professional and formal.

I'm developing as a professional and a person, I think, when I first started I was a lot more formal and a lot more controlled, because I had all those ideas in my mind about well this is what you are supposed to do and this is what you are not supposed to do and you are not supposed to be friends with your client. I suppose I think that I have become a bit more realistic and I don't see myself as being a friend in a sense that it's not the same as a friendship but I have learnt that there will be certain clients that I naturally like in a sense, more than other clients, and again it's still not a friend but there are elements of human nature, which make it more friend like than other clients (F8, p. 13).

... I'm more able to take more risks because I went through a stage of just sort of listening, reframing, reflective listening, all that sort of stuff but now I feel that I'm getting to another stage where I can actually start, I can actually start interpreting very quickly about what's going on and it's surprising how spot on I am... So on one level I guess I find that I can connect quicker with clients the more experienced you get but it's still having to constantly self reflect and look on with who you are (F1, p.4).

Professional experience and maturity also allowed one experienced therapist to trust her 'self' during therapy.

... as you get older I think you become more yourself, it's a sort of funny thing isn't it, but I think you, as a professional, you learn how to do things the right way, and you do it the right way and then you think, oh stuff this, you know, you've got more confidence, so, I suppose I'm talking about myself, I've got more confidence so, I know I can relax and I think I am more effective that way. I used to try very hard, with things like hypnosis to do right, [but now] if I stuff up, I laugh and, you know, generally I think, that it works much better (F7, p.2).

Several participants noted changes in self, over their career. One respondent, F5, stressed the importance of becoming and developing her 'self', as opposed to modelling herself on her supervisor,

I was then [during training] wanting to develop a counselling style or an intervention that I thought I could learn from her [the participant's supervisor] and [I] didn't really appreciate what I had already gathered in my years of work and my own life experiences... I really wanted to learn how to be a therapist from my supervisor and model her skills and her interventions... But she [my supervisor] insisted that no, you have to develop your own individual style... Oh, it was really uncomfortable initially (F5, p.7, 8).

Some counsellors will also involve themselves differently with different clients (for example, disclosing to some and not to other clients; F1, F5, F8). Change also occurs during the course of therapy with a client (F1, F3, F5, F7, F8, M1, M5), for example using their sense of humour at the later stages of counselling, rather than at the initial interview with a client (M5). One cognitive behaviour therapist described how her self changes whilst working with the one client,

... With the first session with somebody, there is perhaps, more of the professional me that comes across, than the real me (F7, p.3).

Moreover, many of the participants' ideas about self changed throughout the process of data collection. For some of the participants their ideas about self became more in-depth and extended as the interview progressed, later when filling out the written questionnaire and, for those participants who requested it, during the second interview. These changes tended to add more on to their original ideas of self, rather than change them substantially. Talking about and thinking about the self as a therapist brought forth more ideas that also form the above responses.

Along with the notion of change, there also existed a sense of continuity and genuineness that for participants existed with each encounter, both in and out of therapy. For example, some participants said that while they behave differently in different social situations there existed a basic level of integrity or authenticity across each context.

I know the external things like how I speak, how much I disclose, how I present myself, they're certainly different, those external things are different in different situations and with different people, but at a deep down kind of psychological or spiritual level in the way I respond to people, I think that it is pretty much the same (F2, p.3).

One participant described this in terms of different roles, or 'hats', emphasizing the multifaceted approach to self.

I'm quite aware that I have to put on a professional hat in professional circumstances and I'm not acting or being the way I would be in purely social circumstances... so you take on the counsellor persona, in some sense... [but] you've got to be consistent with your own personality and your limitations and your style and so on otherwise it would become too stressful I think (M3, p.6).

This meant for some participants their personal and professional identities were interwoven.

I think the difference between me the person and me the professional is only superficial, I would say probably there is some difference... [but] what I bring is exactly the same, my knowledge, my experience, my ideas, is exactly the same... (F9, p.9, 10).

While therapists said that the self that they bring to therapy is flexible and has the ability to change, the self is essentially consistent and stable, across different environments.

Summary

The counsellor's self is a localized and central entity that consists of various, integrated parts. Therapists described the counsellor's self as intra-personal, referring to their thoughts, feelings, values, beliefs, personal style and an unknown aspect of self. Whilst somewhat defined by others and the context in which therapy occurs, the self that therapists bring to counselling is seen as primarily an autonomous entity, defined and experienced by the individual therapist. For participants, the counsellor's self is predominately positive rather than negative. While some therapists were able to identify past situations in which the self that they brought to therapy might be construed as

negative, therapists are able to manage, suppress or otherwise moderate their inappropriate personality traits or personal needs whilst working with clients. The counsellor's self includes, but is not limited to, the therapist's professional role, theoretical knowledge and therapeutic expertise. While the counsellor's self is flexible and has the potential to change in a multitude of environments and across time, there essentially exists a sense of continuity and authenticity.

Part c: Manifestation of the counsellor's self in therapy

While the first part of the interview primarily concerned participants' understanding of self, the second part of the interview explored issues regarding the manifestation of self in therapy. In the first instance, most participants acknowledged that the counsellor's self was inevitably revealed in therapy, through various publicly observable features. However, most participants preferred to focus on the ways in which they might constructively 'use' their self within the therapeutic context. The positive contribution of self to therapy was due to various interrelated factors, including therapist self-awareness and objectivity, the extent to which each participant involved the self and the personal and professional constraints on the use of self. Not everyone used the self in therapy and instead preferred to suppress personal aspects of themselves in therapy and present, as much as possible, their professional role only. A summary of the issues regarding the manifestation of self in therapy is presented in Table 5.

All 16 participants said that who they are as people influenced their therapeutic work, in varying degrees. When counsellors described how the self was present in therapy they described a variety of instances, techniques, and styles. At times the self came through in *how* they implemented a therapeutic technique, that is, patiently, sensitively or carefully. At other times the technique itself was as a direct result of self, such as the use of humour or verbally disclosing something about themselves to the client. The distinction between the professional and personal was blurred and it was sometimes difficult to ascertain whether participants were describing the involvement of self, an intervention, or a combination of the two. Nonetheless, there were specific instances and processes in

which the involvement of self can be found, as well as other issues related to the manifestation of self, and these are presented here.

Table 5: A summary of the findings regarding the manifestation of the counsellor's self in therapy.

The inevitable presence of self.	<ul style="list-style-type: none"> • Most participants referred to various publicly observable features of self.
The uses of the counsellor's self in therapy include:	<ul style="list-style-type: none"> • Relationship building, • Interpreting the client, • The application of theory and training to practice, • Self-disclosure, • Providing a focus to therapy, • Humour, • Assuming a position of power, • Providing a role model, • Influencing mood, • Through metaphors.
The involvement of self was positive and useful due to:	<ul style="list-style-type: none"> • Therapist self-awareness and reflectivity. • The extent to which the self was involved in therapy, from little or no involvement of self, to a selective involvement of self and finally to an all-pervasive influence of self in every aspect of therapy. • Personal and professional constraints on self.

The inevitable presence of self

In the first instance, most therapists said that the counsellor's self was inevitably revealed in therapy, because of various publicly observable features such as furniture, what they looked like, and so forth. One therapist, for instance, said

Well, obviously, as soon as a person claps eyes on another human being there are unconscious things happening, the person's physical presence, their voice, even

their odour, whatever, it's all happening, so you can't minimize that (M4, p.8, 9).

However, rather than focus on these inevitable contextual features, participants tended to explore the ways in which the self might be intentionally and purposefully used or alternatively not used at all. Accordingly, most participants seemed to distinguish between the inadvertent manifestation of self and the conscientious application of self as a positive instrument or presence in therapy. One participant made this distinction in the following way.

I think that who I am is revealed in many ways to my clients... they get to see the pictures of my kids, their drawings on the wall, the various things on my desk, the mess on my untidy desk...all those things let them know something about me, without me telling them anything...

And how does this influence therapy?

Well it does... of course it does... but there is really nothing I can do about it... though it must influence how the client sees me and what she thinks of me... [However] I suppose what I work on is how to use my self in ways that I know will be useful... I try to think about what it is about me that I can best offer my clients and work from there (F4, p.17).

Accordingly, participants described different ways that they might intentionally use (or not use) the self in therapy. The following constitutes an exploration of the ways in which some therapists used the self in therapy and the issues involved in using and not using the self in therapy then follows.

The uses of the counsellor's self in therapy

As a consequence of being asked how their self might be used in therapy, most participants identified specific strategies as well as general perspectives and stances. The various ways of using the self were framed as being concerned with relationship building, interpreting the client, in the application of theory and training to practice, through verbal self-disclosure, providing a therapeutic focus, in humour, by assuming a position of

power, providing a role model, influencing the mood of the client, and finally through metaphors.

Relationship building

Building a relationship with clients was, for some participants (F1, F4, F5, F9, F10 and M1) intrinsically intertwined with how the self is a part of therapy, though difficult to articulate in specific behavioural terms. Rather than describe a particular technique or strategy, these participants instead described a presence of self that they felt whilst working with a client, for example

... my level of empathy and compassion, I believe it comes out like through my body, through my gestures, through my face, through my voice, I think who I am comes out in many ways... however, I think that my empathy and compassion and my knowing comes out without me having to say or do anything...(F9, p.2).

This presence came through in three, interrelated ways: first, when respecting clients; second, in how therapists understood and empathized with clients; and finally in the way therapists connected with clients.

Conveying respect as a part of building a relationship with a client was an instance in which the counsellor's self was important (F1, F10).

... I have an enormous amount of respect... I feel incredibly privileged to be in the position that I'm in (F1, p.3)... [and again, later in the interview] My self is important in demonstrating deep reverence, really respecting why the client is sitting here, you know, I really can't say enough about that (F1, p.6).

Respect for the client and his or her pain and having the strength to stay with the client, was shown in a variety of ways for instance,

... it's about being able to feel other people's pain, I guess as well [as] being brave enough to be able to sit with other people's pain and not wanting to fix it, so in other words, if you don't have that capability to be able to just sit there and contain it, you will want to do things quickly to make it better for them, whereas just sitting with someone in absolute pain or crying or being upset and not taking it away from them, not hijacking by changing the subject or talking about your

own experience is actually a skill, really as well as an ability... To sit there with them, with that raw, raw, gut wrenching pain and allow them to have that without taking that away from them... it's about respecting where they are at, and for me to allow that to happen (F10, p.3, 4).

As well as respecting clients, the counsellor's self was an important point of reference for understanding and empathizing with clients. M1 explained this in the following way:

Even, say with a pedophile, I need to be able to acknowledge and interpret his feelings of lust and drive, and I do this by acknowledging the times in the past when I too have had similar feelings... Not in relation to, say sexual deviances, but past times [when] I too have had feelings of really wanting something that I know I shouldn't... I need to use these experiences and feelings as a point of reference so that I am able to connect and work powerfully and deeply with the client (M1, p.14).

In a similar way, F5 used her own experiences and relationships as a point of reference for understanding what the client might be experiencing.

I suppose that you are hearing what they are saying and your self and your interpretations of your own personal experiences will then provide an aid to you to interpret or to hear another person's story (F5, p.10).

Similarly, F10 talked about how the self is involved in understanding and then connecting with clients. While she rarely discloses personal information about herself, her own experience of being a woman and a mother helps to understand what is happening for her client.

I think lots of it comes from who you are and having said that, I just mean that, it's just a connection that you have with people, on what they actually tell you, you might actually say, 'oh that must be so painful for you', that would actually mean enabling them to know that I can actually really feel their pain... we have that common connection about being mothers and about being women... (F10, p.12).

Some participants (F1, F4, F9 and F10) described how important it was for them to connect, person to person, for example,

[I need to] absorb all the theories, then throw the books away and encounter

people, as they are... it's just about being with a human being, my self and the client's self (F9, p.9).

For some counsellors (F1, F10) connecting with clients meant being open to their own humanness, understanding their own past experiences, and using these to connect wholeheartedly with the client who sat before them.

You've got to look at your sense of self. And you actually, that's how you actually connect with the client too, it's a bit of a funny thing, I don't know what it is, but it's almost like they [the client] know that you are human and you can connect and you can feel a deep connection... [say, for example] someone is describing the loss of their mother, never really acknowledging them in a way that they wanted... Of course it connects with me 'cause I had that, I mean most of us had that sort of stuff, so I've got to have those feelings too in a way (F1, p.3).

The three interrelated ways the counsellor's self was involved in the therapeutic alliance was when respecting clients, as a point of reference for understanding, and for connecting. Relationship building was a difficult process for these participants to describe but a process in which the self was fundamentally important.

Interpreting the client's affective state

Related to the concept of connecting with clients, some therapists (F4, F5, F9 and M3) talked about identifying and understanding their own emotional reactions, in order to interpret the client's own emotions and moods. Rather than specifically use the self to connect or build a relationship with clients, these therapists describe using their own emotional reactions, whilst working with a client, to tentatively interpret the client's own affective state. F9 talked about this in terms of feeling a client's pain, or sorrow, and of not owning them herself, but using this to help her understand what the client might be facing and experiencing. Similarly, M3 described how he might feel something whilst working with a client, and rather than disclose how he is feeling, use his own emotional reaction to decide how best to assist the client.

In these instances therapists describe a tentative, rather than a definite or absolute understanding of the client, and point out that they still need to work with the client to confirm these tentative ideas. The counsellor's self, and in particular the therapist's current affective response, was an important way in which to understand and interpret the client's own affective state and experience. These therapists might then use this information to develop specific questions, to self disclose or to identify other possible interventions.

The application of theory and training into practice

F1, F9, M1 and M5 described how the self was instrumental in the transformation of theory into practice. For instance, while F1 said psychoanalysis was the dominant theoretical influence on her work she also said,

Well, I am probably influenced by psychoanalytic theory, but my self is a large part in the interpretation and application of this... I don't honestly read anything very much about counselling techniques or anything, I just don't have the time... you just do, and I think a lot of it is to do about just trusting yourself...(F1, p.1)

While influenced by psychoanalytic theory, F1 preferred to 'trust herself' and 'just do'. This was further elaborated a little later in the interview when she said, 'my own style' (F1, p.1), rather than any specific orientation dictates a lot of what she does and does not do.

Another participant, F9, also suggests the influence of her 'self' in how she applies theory. She says that even though her focus is clearly systems orientated her own sense of adventure and curiosity is combined in this approach.

I probably put my own stamp on it [my nominated theory]. In applying a systems perspective I guess the more informal I can do that... [the better it is]. I am really working quite strategically and bringing in a definite theory and perspective but doing it in a playful way... [For instance] often in doing the genogram, I am like, let's have a bit of a look, let's go on a bit of an adventure and see what's happening. So I will bring in [all those] sort of things, really [that] are reflective of me... I think that I do have a sense of adventure so the whole idea of

uncovering parts of a person and where they are coming from, what's impacting on, what motivates them, it's like a bit of a journey of discovery, and let's make it fun and amusing and how does that work... so while it's a systems approach I use it in my way and combined with my own sense of curiosity and wonder... (F9, p.6, 7).

While she is clearly informed and shaped by her nominated theoretical orientation, *how* F9 goes about applying a systems theory is indicative of who she is and her own sense of self. Similarly, while M5 is systems orientated he said that, over time, his theoretical orientation has become modified to suit himself.

I think that you end up developing your own sort of framework and whether it is planned or it just happens by accident, I think for me it's more by accident, this is the way I work, that has developed over time and developed along with me... (M5, p.8).

M2, who was eclectic in his theoretical approach, said that at times theory played no obvious role in his therapeutic work.

Sometimes [when I am working with a client] something comes out of my mouth, and I think, 'I wonder where that came from'? Certainly not from any theory... but more from me... I think that theory is important but certainly does not totally dictate everything that I do and say... sometimes I say something [to a client] that really says more about me, than any theory or strategy... (M2, p.12).

Some participants (F8, F10) described how training outcomes are different for various therapists because of self.

... ten people went to the exact same course and they were using pretty much those same techniques, or even exactly those same techniques in their therapy, there would still be differences and that, I think, is very much connected with who they are (F8, p.2).

... we have all done the same similar training, 'cause we are all social workers if you like, so we are all coming, hopefully from a theoretical base of what we actually learn in social work, but we are all different in the way that we operate because we use our self, so how I might go around and build rapport, or how I might operate with someone might be completely different to my colleague but that doesn't mean to say that that is any less effective or more effective... (F10, p.3).

The involvement of self seemed important for these therapists in the transformation of training and theory to various applied settings.

Therapist self-disclosure

Eleven of the 16 participants described different types of self-disclosure, that is, instances whereby the therapist verbally disclosed information about him or herself to the client. While all had self disclosed at times, some of the participants in the study argued strongly that the therapeutic context was no place for therapist self-disclosure (in particular, M4 and F6, and to a lesser extent F1, F2, and F11). Other counsellors were flexible in their approach and identified a variety of ways in they might verbally share something about themselves.

Some therapists disclosed how they managed past experiences, similar to that faced by their client.

Sometimes I will talk about what has happened for me in my past life, how I left school and things like that, how I didn't feel like I had a connection with my father... so I'll let them know a little bit about myself and where I am coming from... (F4, p.3).

Others described how they might disclose how they are feeling at the moment, toward the client and/or the therapeutic situation.

You know [I might say] 'I just felt quite uncomfortable about what we have been talking about', it sort of opens it up for them, you can say to them, 'I feel uncomfortable, don't you'? (F5, p.5, 6).

I will definitely convey feeling very sad, particularly when the person sitting across from me is telling me an extremely sad story about their lives and they are showing absolutely no emotion that it is just conveying a story and I say to them, 'when I hear that, I feel so deeply sad, yet I am not seeing that in you, where is your sadness?' (F9, p.3).

Another type of self-disclosure was identified in which some therapists (F8, M2 and M3) might choose to disclose something that happened to them, but not explicitly own these experiences, for instance

... there is a sense of self by the third degree, so I might say that something that really happened to me happened to a client or friend... for example, I might say that I've had somebody else who has had a similar experience and I might use it in that context, not my own personal experience but an experience that I know of...(M3, p.6).

Some therapists also described letting the client know some factual information about him or herself, such as whether they had been divorced, or how many children they had.

I might say, I know what you mean, I've got a brother and sister [and] they can be annoying sometimes, can't they...? (F8, p.8).

While M4 argued that self-disclosure was counterproductive for counselling, if a client repeatedly asked him for personal and factual information about himself he reflected

... for me to remain coldly neutral to those questions would have been really counterproductive in that highly challenging environment. So I would acknowledge but I would always add the rider that we are not here to discuss my marriage or my children. If I need to do that I'll go to someone else (M4, p.5).

For some counsellors self-disclosure was a developmental issue, and something they may do at different stages of the therapeutic relationship.

... probably near the end I might [self-disclose] (F8, p.6).

Rationale for self-disclosure included normalising (showing that others also have been through the same situation), credibility (providing the therapist with some authority or expertise, for example, they too have been through a divorce or brought up teenagers), rapport building (wanting to connect and establish a therapeutic relationship) and education (for example, the therapist describing how he or she relaxes after a hard days work).

Providing a focus in therapy

Some therapists (F2, F3, F5 and F9) used the self by directing the focus of therapy and initiating a specific topic or issue that they felt personally important. For instance, F5 had completed a diploma of leisure studies and was also involved in numerous leisure activities, consequently,

I think I am very much into the leisure sort of activities so I like to encourage people to look at their leisure time and value their leisure time 'cause it can have such a very positive impact (F5, p.6).

The counsellor's self was used purposefully by the therapist to focus the type of questions asked, interventions suggested and advice given. The counsellor's self was used to direct therapy in a certain way, by following a lead or topic that the therapist considered important, even if not a presenting feature of the client.

Humour

Some counsellors (M5, F4, F7 and F10) said that they used the counsellor's self through humour.

I think part of my self is that I like to be able to have some humour as part of that process, providing that it's appropriate at the time and I think that it helps some individuals relax and feel comfortable with that interaction. Not for everybody, but I have certainly found it to be useful (M5, p.5).

... we have one of the social workers who uses humour, you will never hear a session that she will have without laughter coming from it which is really quite good... I do use humour, hopefully appropriately... I suppose to relieve tension... I am very aware that it can seem disrespectful as well so I have had the odd experience you know, where it hasn't gone down [well], I'm just aware of it, so I probably am more cautious than what I might be, so... I consciously use it (F10, p.11).

Humour was used as a tool with clients, to relieve the tension, build relationships and help the client relax. Participants stressed that as the therapist's sense of humour was not considered useful for all clients, or at all times, it was used judiciously.

Assuming power

M2 and F10 described how, as therapists, they may choose to use power (or chose to not use it) within the therapeutic context. The self of the counsellor was involved by assuming this power, and telling the client exactly what to do and when, for instance,

Sometimes you have to take over, because people are so stuck and they are so refusing to move that you need to say and I will sometimes do this deliberately, I will get up and I will stand up and I'll say, 'look I don't know what you are doing here and you don't know what you are doing here, but it seems to me that if you don't get out off your bum and go and do this then nothing is going to change for you, now that is all that I can think of, and if you don't want to do that then that is alright, you come back and tell that me [that] next week, but if you think that's alright come back and tell me why you've done it and how, no not why you've done it, but how you've done it and what's happened in fact I'm going to write that down on your card for your next appointment'... this is the sort of power that I will deliberately use as an therapist that I consider part of me and my role (M2, p.9).

Alternatively, F10 talked about the power she feels that she has in directing sessions, and whether she should focus on the client's pain or not.

... you almost have a bit of power over the situation, and you [could] quite easily start to talk to them and, you know, when they are starting, take them away from that, their pain and distract them or somehow not focus on that [their pain] (F10, p.4).

She continued by saying that she is usually able to withstand her own anxiety and discomfort when listening to a client's story, and instead 'allow' clients to stay with their pain. While she acknowledges the power she has over that situation, she chooses not to use this power to distance or distract the client from their suffering. The use of power within the therapeutic context was something these two therapists were aware of, and so used in the interests of the client, rather than to satisfy their own needs.

Providing a role model

F5 and F7 describe how the self of the therapist might provide a potential role model for clients. For example,

... I mean, particularly with young people, you are modelling a particular style of adulthood, which they may or may not, wish to respond to, and you are also modelling a type of interpersonal relationship that they may form later on... Because they may not have those opportunities with their own family... (F5, p.12).

The counsellor's self, according to these participants, provides a useful way in which to demonstrate and model interpersonal skills, problem-solving abilities, conflict resolution and relaxation techniques.

Influencing mood

One therapist (F5) described how her own emotions might influence the client's affective state or mood. She reported this in the following way.

If two people get together and one is happy and one is sad, at the end of the hour, the mood between the two will be either happy or sad. And I reckon it is the responsibility of the therapist to make sure that they are the one that is happy and that the mood between the two goes that way...

And how does that happen?

Well... I don't really know... I don't think I consciously plan for it... but I know that if I talk to depressed people all day I am in constant danger of being sucked into being depressed and low as well... I learnt that very early on... so now I work at making sure that I am reasonably balanced and positive and work to stay that way... and I find that I work better too, and feel better and that it sort of rubs off onto the client, well some clients at least... (F5, p.12).

While she seemed unsure how this occurs, F5 described how the counsellor's self might influence the mood or affective state of the client, a process that was beneficial to both herself and the client.

Use of metaphors

One counsellor (F9) said that she used metaphors with clients because 'I'm a story teller and I talk, I love to talk to people...[the use of metaphors] fits with who I am' (F9, p.7), while another counsellor (M2) described how he might disclose a personal experience through metaphors. These therapists used metaphors as an indirect way of providing client education. Both therapists chose to present stories and metaphors in therapy because it was something they considered part of their personal style; their stories and metaphors were also drawn from their own lives and experiences and so represents another way the self may be involved in therapy.

Summary

For the therapists interviewed, the counsellor's self was used in a variety of interventions and stances. However, the rationale behind many of these processes was to build a relationship with the client, either explicitly or indirectly. For instance, whilst therapists talked explicitly about the involvement of self when relationship building, other interventions, such as the use of humour and therapist self-disclosure, were utilized primarily to build rapport and connect with clients. Thus, one of the key functions of the counsellor's self is relationship building with clients.

'Managing' the involvement of self in therapy

The contribution of self was considered positive because of the various ways therapists 'managed' the involvement of self. On the whole, participants did not identify problems associated with the involvement of self in therapy. While some of the experienced counsellors did describe the various 'mistakes' they had made whilst working with clients generally these 'mistakes' were the result of inexperience or lack of knowledge, rather

than their own personal issues, though there was some discussion as to why these occurred. One counsellor resolved this issue in the following way.

And sometimes well you just can't do therapy right, you give up, or you're just not always going to do it right. It's just about being human. The important thing for me is not to be hard on myself and [instead] say you could have done that better and next time you know not to do that, but I'm not going to beat myself up about that (F1, p.12).

The positive contribution of self was due to a number of interrelated factors, including therapist self-awareness, the extent to which therapists involved the self in therapy and various personal and professional constraints on self.

Therapist self-awareness and objectivity

Therapist's capacity to reflect on and be aware of their self ensured that the counsellor's self was positive and useful in therapy. At some point, all therapists described the importance of self-awareness and self-knowledge in their therapeutic work with clients. Representative comments include

... [it is important] that you do constantly reflect on what's occurring and own it.

Own it?

Own what is happening for you, rather than saying that the client is either inadequate in this, you know it's the fact that they have a problem 'cause they are dysfunctional and they are being seen as dysfunctional or not coping or a failure in the sight of his eyes. That is quite easy to do... I think that it is very important that you own what is happening for you and understand I suppose why that person [is] reacting in a particular way, [and] why that reaction is causing you grief (F5, p.5).

Well you might come to [the] realisation that there is a part of you that needs to be looked at or you need to explore that a bit, or sometimes you know you get a, what they call, 'aha experience' it's 'a aha oh that's what that [is all about]', 'that relates to that', or 'aha that is the same theme as what I was experiencing with my last client'... So it's another little bit of evidence to support something else that I might be learning about my sense of self (F1, p.7).

Some therapists were able to identify past situations in which the counsellor's self impacted negatively on therapy, but with subsequent self-awareness were able to resolve or otherwise manage these same negative self aspects. For instance, one therapist (F9) describes how her own relationship problems initially impeded her therapeutic work,

... I remember going through a time when I was worried that most people, most women that came to me with relationship issues ended up leaving their relationship and I wondered how much that was influenced by me and where I was at in my life... you know there are problems in this relationship, oh well you know just get up and get out of it, the way that I worked with people, this is very embarrassing actually... (F9, p. 10).

However, when she was aware of it, and started to reflect on why these women were also leaving their partners, she changed her behaviour.

I got a bit worried about that, and it's interesting that when I started to get a bit worried about that and really started considering how was I working and what influence I was having... I did start to work a bit differently... the way that I worked with people has changed in that I am probably, I think I'm less influential, I think I'm more neutral, not neutral full stop, but I think I'm more neutral and not influencing one way or the other with couples now whether you stay together or separate... [I am] much more about assisting them [the clients] to look at what is [happening for them]... what they [the clients] do is really up to them, because I think that I am guilty of influencing sometimes in the past... [and saying things like] it's not going to work out, it's too hard to work it out so, and he is not going to change... and I'm sure that was coming from my stuff (F9, p.10).

Another therapist (F2) described how with self-awareness she was able to transform a potentially negative part of her self into a positive force in therapy.

[My self is] kinda positive and kinda negative Andrea, and I'll tell you why I think it is. I think it could be negative if I wasn't aware of what I was doing, but [for instance], part way through the process with a client I realised that I did have a value position and [this] experience was impacting upon my work, and so I think it can be a positive thing if I'm aware of what I'm doing, if I'm aware of my own values and experience and then I can think about it and use it in my work with clients... (F2, p.2).

Not only did the therapists emphasize the importance of self-awareness in their work, but this same objectivity and awareness was reflected in the manner in which participants described the self, during the interview and on the questionnaire. At times the

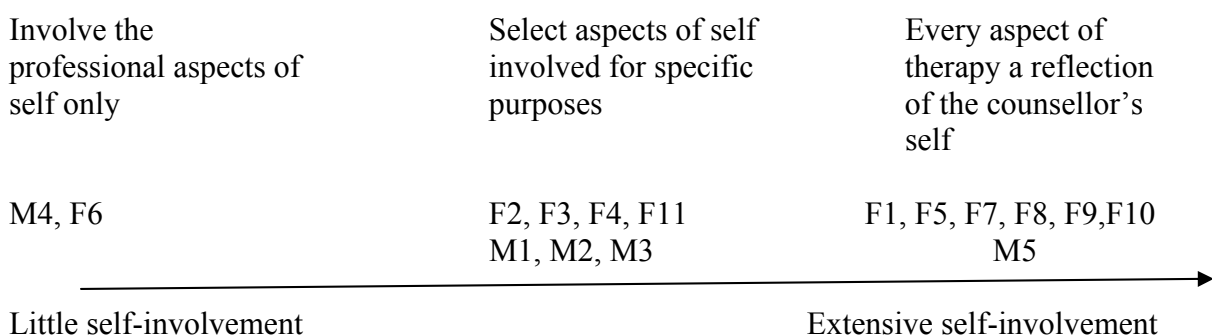
counsellor's self was referred to as 'the self' or 'a self', while at other times, the same participants referred to the self as 'my self', 'me' and 'I'. Consequently, the counsellor's self was both object and subject in the way participants described and articulated their understanding of self.

While the counsellor's self might have contributed harmfully in the past, with self-awareness these negative aspects were not longer current in participant's descriptions of self. The self was positive and useful in therapy because the therapist's personal issues and/or inadequacies were resolved, transformed or otherwise managed during therapy.

Continuum of involvement in therapy

Participants not only articulated *how* the self was involved but also *how much* the self was involved. When intentionally using the self, differences were identified and may be placed on a continuum (see Figure 2). Three points were identified on this continuum; first, two participants (F6 and M4) argued that ideally only the professional, rather than personal aspects of self, should be involved in therapy; some therapists (F2, F3, F4, F11, M1, M2 and M3) described how they selectively involved certain aspects of self in therapy; while the final group of predominately female therapists (F1, F5, F7, F8, F9, F10 and M5) contended that every therapeutic interaction was a reflection of self.

Figure 2: A continuum of the involvement of the counsellor's self in therapy.



M4, a systems therapist, and F6, a therapist who nominated cognitive behaviour therapy as her primary theoretical influence, argued that ideally there should be little personal involvement in therapy. While M4 and F6 said that the counsellor's self included other aspects besides their professional knowledge and expertise, both contended that in order to be useful and positive, the therapist should involve only professional aspects of self, and suppress or neutralise all other aspects of self. F6, a first year probationary psychologist who worked in child protection, said the self she involved in therapy had to be 'unbiased and neutral' (F6, p.4). Similarly, M4 said on two occasions

In most professional counselling circumstances it is the use of technical skill and the ability to avoid contaminating the client's issues with personal ones, which leads to the best, self-generated outcomes (M4, questionnaire, 2nd July, 2002).

It conflicts with good therapy if I am involved as myself, I am of course involved as the professional, skilled counsellor and that's the difference (M4, p.5).

The rationale given by these two therapists for the involvement only of the professional aspects of self was twofold. First, they both considered that it was important for their own self care, for instance

... there is no sense of using up my personal being, I use up my professional energy but not my personal being [in counselling]... Now again, some people would argue that that is false or that that is stressful or dishonest even, but for me that has been the most comfortable way to work.

In what way comfortable?

As in looking after myself... (M4, p.6).

Similarly, F6 described how it is 'safer' to remove her self and any references to her own family whilst working with clients in a child protection agency, in order to protect herself from clients who might harm or threaten her.

The second reason for the involvement of only the professional aspects of self was for what both therapists considered to be effective therapy. For example,

... I think the essence of good counselling, from my point of view anyway, is that the process is as close to being purely to do with the client as possible (M4, p.3).

M4 talked more about the process of removing or 'controlling' his self in therapy,

... my struggle is to control the self, to minimise the impact of the self, to remove any unconscious barriers.

Is that possible?

No, I said it was a struggle [laughs]...

So what then makes your role? Like what do you then do?

Well I'll make an analogy here between a chemical catalyst. As you know in chemistry, you can have two chemicals which independently will not react but when you add a catalyst they do react but the catalyst does not participate in the reaction... It stays the same but some how or other it facilitates the reaction. In the absence of it the reaction doesn't occur. So in a counselling situation ideally the client will leave the counselling room with some kind of sense that they have discovered something about themselves or that somehow or other they have seen some kind of opportunity or insight, or that some things become clear. If the client leaves the room thinking what a wonderful counsellor that counsellor is, I think that I have done bad work, because some how or other my personality, my wisdom, my experience, my skills are now participating in that person's life. And I believe that that is intrinsically weakening for that person (M4, p.3).

F6 stressed meeting the professional obligations for the organisation she worked for.

I'm supposed to represent what society views as correct... (F6, p.10)... My job is to implement certain values and beliefs from my organisation, I am not supposed to have my own values and beliefs about that... of course I do, but I try very hard not to involve them... that is what I have to do, for my clients and for my organisation... (F6, p.14).

Both F6 and M4 said the counsellor's self was a positive entity in therapy, by using only their professional knowledge and skills, and ensuring all other aspects of self were neutralised, or otherwise controlled and suppressed.

Other therapists (F2, F3, F4, F11, M1, M2 and M3) were also selective about what aspects of self were considered appropriate to therapy, though 'allowed' more than their

professional skills and knowledge to be involved in their therapeutic practice. Consequently, the involvement of self for these therapists was selective and deliberate. For instance

...I become aware of it [the self] and, and then I can use it in a deliberate sense or choose not to use it or maybe try to distance myself (F2, p.1).

... I suppose it's a consciousness of using yourself in a particular way, of actually being able to, not just being yourself but actually using yourself with a person in a way which is helpful to the other person (M3, p.3).

In a similar way one participant said that she needed to decide what part and how much of herself to give.

... [I need to] assess it at how much, from me, they [clients] need. I guess sometimes people come in and they want you to go bang, bang, bang and that's it, sort of thing, and they don't want any of you, and they just want to work out what's happening for them. Sometimes people may come in, and they do want a little bit of you, they do want to know a little bit about you, they do want to have a connection and work from there. So sometimes that will depend on how much I open up, and what I give of myself to the client (F4, p.8).

The emphasis for these therapists was on the conscious enactment of self in therapy. M1 described this conscious awareness in the following way,

... I'll imagine that there is a visual mentor there watching me behind a one way screen, and I'll image him saying [counsellor's name] stop smiling so much, 'cause the self that is doing that is the pleaser... you're actually imagining what it would be like to be the consulted in that way... I have the sense of looking over there and listening... it's almost a tennis volley back... (M1, p.3, 4).

The self was a tool, amongst several, which these therapists chose to employ, or not, during therapy. For example, F2 said that she would only occasionally involve herself deliberately in therapy, preferring instead to focus on a client's irrational beliefs and thoughts. She might direct the focus of therapy to areas that she felt personally relevant, but on the whole said that she would not use her self in therapy. These therapists identified a range of theoretical influences, including person centered therapy, cognitive behaviour therapy, psychoanalysis and systems therapy.

The final group identified on the continuum were several, predominately female, therapists (F1, F5, F7, F8, F9, F10 and M5), drawn from the range of theories. These therapists saw the counsellor's self as being extensively involved in all aspects of therapy. For instance, F9 involved her life experiences, sense of being, and her thoughts and feelings, throughout her therapeutic work with clients and in particular when building relationships with clients, interpreting a client's affective state, applying theory to practice, focusing therapy, disclosing her affective reactions, and through metaphors.

However, these therapists were not placed here because the number of self-enactments in therapy was necessarily high. F1, for instance, identified only two ways in which her self was involved in therapy, that is, when establishing a therapeutic alliance and in the application of theory to practice. While F1 said she very rarely verbally disclosed to clients, the involvement of self came through to the client regardless of what she directly said.

... rarely do I need to self disclose it's more about, it's just who I am... and that comes through without me having to self disclose to a client... (F1, p.3).

For F1 the involvement of self in therapy was intimately connected with her therapeutic work, even if the actual number of identified self enactments were comparatively low. The involvement of self was pervasive in every aspect of F1's therapeutic work, indirectly if not directly.

For this final group of therapists, every intervention and interaction in therapy was a reflection of the self that they brought to therapy.

I'm always, you are always using the self, 'cause that's human and the way you work is you (F5, p.4).

I suppose when it comes down to it, the person of the therapist... everything [including] our professional knowledge, has got to come through... (F9, p.9, 10).

[When I was younger and inexperienced] you didn't actually reveal yourself but I have given up on that because it is too much of a strain. It happens, so now I just acknowledge that it happens, rather than pretend or say that my self is not a part of the therapy that I offer to clients (F7, p.1).

My self is part of every therapeutic action I undertake, it comes through in the way I move, the way I talk, the way I see the client, the way I understand her, the total way I am as a therapist, I suppose...(F1, p.7).

Rather than describe the self as a deliberate tool, these therapists depict the self in terms of a spontaneous and all pervasive presence. One therapist describes the fluidity of this process when she reported that

When working with clients and particularly if I am relaxed and comfortable, I generally find that I have thoughts that aren't at first logical to me, like you have your intellectual thoughts where you think, well I know this order, this technique, so let's do some of that, this is my rationale behind it, but then generally you just get these [other types of] thoughts and at first you might even think oh, that's a bit left field, it's not the traditional way of dealing with this particular problem.... like it's above my intellect, [it's] like something else, like my intellect is still in there but it's part of my unconscious... and usually I don't even realise these thoughts or ideas are there... [or] that I have used my self till afterwards when I get a chance to stop and think about it... (F8, p.4,5).

While spontaneous, this use of self was nonetheless purposeful. One therapist, for instance, said that

I use my sense of humour, and it does, sort of, just come out, but I am aware of it, and I use it well, as opposed to it coming out of me without me having thought about it (F7, p12).

Stressing again the interactive nature of self as both spontaneous and intentional this same therapist reported that 'I know it works, so I let it work...' (F7, p.12). Similarly, another therapist said that because she is aware of her self and has had several positive experiences in her previous work, she does not have to consider her self at every moment during therapy, but instead, 'trust in it' (F1, p.2).

The extent to which therapists used the self in therapy included participants describing

the involvement only of their professional role and subsequently suppressing all other aspects of self, others who reported selectively using certain aspects of self, and finally, predominately female therapists, who described every interaction in therapy as a reflection of the counsellor's self.

Constraints on the involvement of self in therapy

All therapists, to some extent, described the constraints, both personal and professional, on the involvement of self in therapy. Again, therapist self-awareness was stressed and considered important to ensure that only aspects of self that were appropriate and useful in therapy would be involved.

All therapists described the importance of their professional role and the context of therapy as exists between a therapist and a client, as opposed to that between friends, when describing the involvement of self in therapy. One therapist (M1) described how the Australian Psychological Society code of ethics was useful in delineating boundaries, in deciding how much to help clients and when it might be appropriate to refer on and/or terminate therapy.

All therapists regarded the relationship between therapist and client as different from the relationship that might exist between friends, even though a core, consistent sense of self was apparent. For example,

I'm different here [outside of counselling] than when I'm with a client, it's different, it's a different environment and you are different. It's a different set of rules because counselling is a very unreal situation... but who I am as a person and a professional can't be separated... both come from the same place... but you know there is a clear distinction about what you do with clients and what you do with your friends... (F1, p.3).

One therapist said that to a friend, as opposed to a client, she would be able to say

... what I really think [rather than] ...pussy foot around in a polite and professional way that her partner is a loser or whatever... Now I would never be like that of course with a client... (F11, p.11).

Similarly, therapists said that there would be aspects of self that they would not show or involve in therapy. For instance, some therapists (F9 and M2) said that they would not be as 'grumpy or cranky' or 'complaining' with clients, than they might be with colleagues, friends and family.

I probably complain a lot more to my work colleagues than I ever would with my clients. I need to load off this stuff too, but I know not to do it with clients and in many ways that part of my self has nothing to do with the client and what I am trying to do in therapy (M2, p.11).

In the same way, some therapists (F4, F5 and F9) said that they would not involve their own personal issues and problematic attributes in therapy, and while these same issues might have proved problematic in the past or in other circumstances, did not currently influence their therapeutic work.

The decision regarding how much to involve themselves in therapy depended on the client, the stage of therapy, the therapist's own needs and the overall goals of therapy. For instance, M1 and F2 described how they might limit the involvement of self if they considered the boundary between themselves and the client poor and ill defined. When working with such clients, these therapists preferred to maintain a boundary between themselves and the client and rely instead on techniques and theory. Other potential problems identified by participants in the use of self included worrying and thinking about clients outside of session times, and having clients excessively depend on them.

Another reason for the limited involvement of self in therapy was out of concern for the client. M3 and F3, for example, said that they would not involve the self or 'get too close' to a client, if they felt the client would worry about them. F3 also said that she would limit the involvement of self if her credibility as a therapist was jeopardized.

I would not use my self in either a specific self-disclosure or otherwise, if in the eyes of that person I lose my expertise or my professionalism and they think, “well she's as bad as me, what am I doing here?” (F3, p.4).

One therapist described other potential problems in the involvement of self,

I think that I only occasionally involve my self in therapy... because the session should be about the client and not about me, and it's very easy to take the focus off the client, both in terms of me verbalizing or self disclosing and me thinking about myself or focusing on myself... I think that I focus on the client... and the cognitive behaviour skills and techniques that I use, are directed towards the client, rather than the focus being on me... (F2, p.7).

Personal constraints on self involved therapist self care and prioritizing professional and personal demands and needs. One therapist described the changes her self has undergone since she has become a mother,

Before I had kids, I don't know, but I think perhaps that I gave much more of myself to clients... but now... I just don't have the energy to spread myself around to all those needy people... my priority is my children... and I want this to be that way... I actually feel myself holding back sometimes with clients, and feel tired... and my kids have got to come first... I don't think that I am any less of a therapist for it... in some ways I work quicker and don't deliberate as much and trust myself more (F1, p.12, 13).

Even though some therapists saw the counsellor's self as an inevitable presence in therapy, (see the continuum in figure 2) these therapists still acknowledged that the 'rules' of therapy meant that they needed to also abide by certain professional constraints. Consequently, these therapists recognized the presence of self as all-pervasive, and while not while deliberate in its use, worked at making the presence of self useful and positive.

Summary

Therapists agreed that the counsellor's self influenced their therapeutic work, to greater or lesser degrees. Participants described involving the counsellor's self as a therapeutic stance and as an intervention in numerous ways including relationship building, client interpretation, applying theory to practice, therapist self-disclosure, providing focus,

through humour and metaphors, in assuming power, providing a role model and influencing mood. The positive contribution of self was due to a number of interrelated factors, including the therapist's ability to be objective, the extent to which the self was involved in therapy and personal and professional constraints on self. Some therapists considered every therapeutic interaction as a reflection of self, while others reported being less personally involved in their therapeutic work and either used the self selectively or chose not to involve personal aspects of self at all. These findings do not seem to be based on theoretical grounds, though female therapists tended to regard the self as intrinsic to their therapeutic work, more so than male therapists.

The concept of the counsellor's self involves acknowledging the therapist is a person as well as a professional. Each counsellor in the present study acknowledged that aspects of the self impacted on therapy. When used with self-awareness, the counsellor's self provided the therapist with a multitude of interventions and processes. A major way the counsellor's self was involved in therapy, for therapists from a range of orientations, was in connecting with clients. However, not all therapists said that they used personal aspects of self in therapy and preferred instead to present their professional role, knowledge and skills only. As a hindrance the counsellor's self might take the focus off the client, and be harmful for the therapist's own emotional well-being, though each of the therapists worked hard to ensure that this did not occur.

Chapter five: Discussion

Reflecting the previous chapter, the preferred terminology nominated by participants is discussed first. Second, participants' perception of the counsellor's self is discussed in relation to the multi-perspective framework previously drawn from the literature and presented at the end of Chapter two. Finally, the various issues regarding the manifestation of self in therapy is discussed and parallels are again made to previous literature. An attempt is made at the end of this chapter to connect therapists' conceptualizations of self and their practice of therapy.

Part a: Terminology

The term the 'counsellor's self' was preferred by most of the counsellors in the present study, and although one participant identified the 'person of the counsellor' she alternated with both 'person' and 'self' of the counsellor, throughout the interview, suggesting that either is appropriate. This may be attributable to the amount of times 'the counsellor's self' was used by the researcher in the initial letters sent out to participants. Nonetheless, when asked directly to consider the terms 'person' or 'self' of the counsellor, 15 of the 16 participants nominated 'the counsellor's self'. This confirms Tester's (1992) findings from a group of expert systems therapists, who also preferred to use the term 'counsellor's self', rather than person or personhood of the therapist.

The preferred use of the term, 'the counsellor's self', suggests two things. First, participants in this study had a common understanding of the terminology employed. Second, participants in this study, ranging in experience, profession and employing a range of theories, agreed with Tester's select group of experienced, systems therapists. While not able to extrapolate this finding to the general therapist population, 'the counsellor's self' is a term employed by therapists from a range of theories, years of experience and professions in the present study.

Part b: Conceptualisations of the counsellor's self.

Emerging concepts elicited from participants will be discussed and compared with the multi-perspective framework presented in Chapter two, which established the counsellor's self as potentially intra-personal, inter-personal and trans-personal. Participant responses demonstrate support for an intra-personal notion of the counsellor's self, though less for the counsellor's self as inter-personal and no support for a self that is trans-personal. Other key features were also found, not related to this framework.

Participants described the counsellors' self in terms of therapists' inner processing, referring to their thoughts, perceptions, feelings, beliefs and values, personal style or personality and an unknown aspect of self that some referred to as their unconsciousness. Previously, depicting the self in this way was referred to as intra-personal and is confirmed by the data collected in this study. Others studies, working with a single case and systems therapy focus, have also described the counsellor's self as an intra-personal phenomena (Basescu, 1990a, 1990b; Duhl, 1987; Elliott, 2000; Haber, 1990, 1994; Hardham, 1996; Keith, 1987; Lum, 2002; Oke, 1994; Prosky, 1996; Real, 1990; Rober, 1999, 2002; Tester, 1992; Weiner, 1972, 1978). This study extends previous research by demonstrating that a wide range of therapists consider their thoughts, feelings and the way they saw and interpreted the world and their clients as essential qualities in therapy. This has implications for psychotherapy research and training and will be discussed later.

Another position of the counsellor's self, previously established in the multi-perspective framework, was the counsellor's self as inter-personal, on both a micro (self in relation to the client) as well as macro level (self in relation to the broader context of therapy). In the present study, however, participants varied in the extent to which they considered the self to be related to others and in the main, generally described an individual and autonomous self. Contextual features, such as gender, age, social status and culture were part of the self but not central in therapist's depictions of self, for some therapists. While allowing for the influence of others, in particular family influences and the perceptions of clients, therapists generally describe a self that is individual and primarily defined by the

individual therapist. Therapists tend to describe the self in terms of their thoughts and feelings, values and beliefs, rather than subscribe to a culturally contextual view of self, which is framed within the broader social context, or a relational notion of self, as might exist between two people in therapy.

At times, therapists contested client's interpretations of self, implying that the client did not know who they really are. The participants in the present study distinguished between the self of the therapist and the self of the client as two distinct entities so that the counsellor's self was an active and individual self that was interpreted and defined by the individual therapist. For example, one therapist (F3) said that while her personal history was important in shaping her self, she nonetheless 'chooses' to take 'bits' from her past relationships, rather than having these past relationships shape her.

In addition, whilst some therapists recognized that the self might act as a 'container' for the client's own affective reactions, primarily their thoughts and feelings were their own. For instance, whilst some therapists reported experiencing an affective response that seemed to be projected from the client, they distinguished between their self and that of the client and as one therapist said, 'gave back' those emotions that did not belong to her. Furthermore, whilst therapist's phenomenological experiences were an important aspect of self, not all participants recognized how these might occur in reaction to the client, but instead indicated that these processes were localized within themselves. For example, one participant described how her self included her feelings on any given day, without explicitly referring how these might be in reaction to a client.

It was predominately systems therapists in the present study who viewed the self as an inter-personal phenomenon, though not all the systems therapists interviewed saw it in this way. It might be expected that systems therapists would place greater importance on the role of relationships and systems in their reporting on the counsellor's self, though this is not a clearly defined conclusion in this study. Overall, the 16 participants did not describe the dialectical relationship between the therapist and client, as highlighted by systems therapists, in their descriptions of self (Freedman & Combs, 1996; Haber, 1990,

1994; Hardham, 1996; Oke, 1994; Paterson, 1996; Real, 1990; Rober, 1999; Shadley, 1986; Tester, 1992).

There are several, possible explanations for the lack of participant responses supporting the notion of an inter-personal self. One possibility is that the idea of self in western traditions has become increasingly individualized, with Western cultures promoting ideals of personal uniqueness and self fulfillment (Baumeister, 1987; Cushman, 1990). Paradoxically, whilst participants did not acknowledge the influences of culture on their perspectives of self, their descriptions of self as individual and localized may be reflecting the culture in which they work and live. Consequently, participants may have found it difficult to consider self and relationship simultaneously.

Similarly, Muran (2001) argues that individuals are often not aware of how much they are thoroughly embedded in the world around them. This is a result of both unconscious influences and various social filters, some of which people take for granted, and others of which they are no longer aware. Muran (2001) claims that ultimately people are unaware of how much their values, beliefs and identities are influenced by the society in which they live and instead consider that their values and beliefs are somehow determined by themselves alone. Consequently, while the inter-personal concept of self may be important, participants may not be aware of the influence of others, on both a micro and macro scale, in their descriptions of the counsellor's self.

The context of the interview and the type of questions posed may inadvertently have focused on each individual therapist, rather than the processes existing between the therapist and client. The interview context invited each participant to step outside of the context in which they usually functioned as a therapist, and through the relationship with the researcher, engage in a personal exploration about the counsellor's self. Therefore, it is possible that these discussions encouraged participants to develop an overall structure of self, or 'omnibus self' (Bruner & Kalmar, 1998, p.323) that may not exist when working with clients. The interview transcripts and returned questionnaires are responses constructed from within the mind of the single individual and demonstrate what Gergen

(1992, p.179) describes as a 'single formulation of self-understanding'. Accordingly, the context of the interview and the questions asked may result in greater coherence and consistency in the presentation of self and in particular a localized, individual self, than exists when interacting with a client.

Some therapists commented that they do not get the opportunity to talk about themselves very much, in therapy, or in the broader context of their workplaces and consequently may have used the interview to make up for this omission. The interview was a reasonably focused time for each therapist and most of the participants preferred to meet outside their workplace. Rather than the focus being on the client, the central purpose of the interview was on the counsellor and his or her self, and so, in this way, the interview process may have encouraged responses that focused solely on the counsellor and not the client or the broader context of therapy. Consequently, participants may have taken the opportunity in the interview to compensate for the absence of 'self' in their work lives. In this way, the relationship between therapist and client may actually be important in how they define themselves, but not categorized in participants descriptions of self in the present interview format.

The counsellor's self as individualist may also be a reflection of participants' view of the self as isolated and disengaged generally from their workplaces. Corey, Corey and Callanan (1998) observed that managers or administrators of welfare institutions are usually far removed from the practical and daily demands of providing direct services to clients. Communication between managers and workers is often inadequate and tension in these circumstances, is often inevitable (Corey et al., 1998). Counsellors usually have little say in the formulation of agency policies, yet are limited in what they can do by the agency's rules and regulations (Corey et al., 1998). Thus, general workplace disengagement may be reflected in the stance of the counsellor's self as singular.

Alternatively, the therapists in the present study may consider the counsellor's self an important part of therapy, as important as the client, or other aspects of therapy. Specific therapist variables have generally been minimized in research studies or alternatively

localized into specific external variables such as age, gender or orientation, so that the personal qualities of the therapist are either discarded or overlooked (Gurman, 1987; Hayes, 2002; Kline, 1992; Lambert, 1989; McConaughy, 1987). The view that the counsellor's self is generally autonomous and defined by the therapist is perhaps a reaction against some of these established empirical views on the counsellor's self.

None of the 16 participants described the counsellor's self as trans-personal. The trans-personal notion of self, drawn from existential, humanistic, Jungian and psychoanalytic literature, established the counsellor's self as a merging between the self of the client and the counsellor. There were no references or descriptions of the self in this way, from any of the 16 participants. Cameron (2001) points out that there is no commonly accepted English word for the part of the person that can extend beyond the skin, inherent in the concept of a trans-personal self. Consequently, the interview methodology used in this study may have impeded descriptions of the self in this way. Rowan and Jacobs (2002) contend that the trans-personal self in therapy is not without its risks, including over-identification, and consequently many therapists might be reluctant to work in this way. Mearns (1996) argues that it takes courage to merge with another, and that therapists are often too afraid of others, and/or of themselves, when working at this intense depth. Thus, there are a variety of possible reasons that practicing therapists in this study did not consider the counsellor's self in terms of being trans-personal.

Overall, a major finding of this study was that all participants, across a range of theories, described the counsellor's self as a defining center that encapsulated each therapist's individuality. Rather than relate to the notion of the self as intra, inter and transpersonal, the therapists in this study described the self in terms of a centralized, localized entity that was unique and made up of various, integrated parts. Subsequently, the counsellor's self included those aspects that each therapist considered important in defining who he or she was as a person and a therapist. Neither the client nor the broader context of therapy defined the self of the counsellor; nor was the counsellor's self merged with the client, or otherwise arising from outside of themselves. Instead, the counsellor's self, for participants here, was owned by the therapist; it came from them, and belonged to them.

The self of the counsellor expressed each participant's experience and impression of his or her 'me-ness'. In comparison, previous research, and in particularly studies with a systems focus, incorporated both intra and inter-personal elements when describing the counsellor's self (Haber, 1990, 1994; Hardham, 1996; Oke, 1994; Paterson, 1996; Real, 1990; Rober, 1999; Shadley, 1986; Tester, 1992). The notion of countertransference within the psychoanalytic literature and the focus on relationships in person centered therapy also provided further support for the concept of an inter-personal position of self. Consequently, for participants in this study to describe the counsellor's self solely in terms of the individual therapist's inner experiences and subjective sense of 'me-ness' appears to be a new way of considering the self of the therapist.

Nonetheless, links between this finding and the general literature on the self may be drawn, in particular, from Rogers' early theory on the self (Rogers, 1951; 1959; 1961; 1971). While Rogers does not refer explicitly to therapists in this definition of self, his early writings on self fit most closely with the counsellor's self described by participants here. The basic premise of Rogers (1951) self theory is that of the organism, which is the locus of all experience and potentially includes everything available to awareness that is going on within the organism at any given moment. This and Rogers's subsequent focus (1971) on the 'experiencing organism' resonates to participants' description of the self as intra-personal and localized within the individual therapist.

Rogers also claims that there exists an inner, core self that can be distinguished from the outer façade or 'public face', which strives for acceptance (Kirschenbaum & Henderson, 1989). Rogers (1961) argued that the goal of each individual was to achieve authenticity, so he or she would follow one's own directives rather than those of others. Each person has a 'true self', that is his or her 'inner core' and the goal for all individuals was to reclaim or uncover this self. Similarly, Maslow (1971) emphasized the importance of self-fulfillment, or what he called 'self-actualization'. The expression of this true self is authenticity and genuineness, and for person centred therapists, relates to being congruent to the client and the therapist's inner experiences.

Participants did not specifically refer to being congruent when working with clients. They did, however, describe the self that they bring to therapy as a true or real self, and a self without façade, which defined their personal identity, as people and therapists. Similarly, they describe being genuine and authentic across a variety of environments, both in and out of therapy. Rather than develop, uncover or reclaim ‘a true self’, each therapist seems to describe the self that he or she presented in therapy as the true self. They were not, however, saying that they were self-actualized, or that their self was perfect. Nonetheless, within the therapeutic context at least, participants did say that the counsellor’s self was predominately useful, positive and true to their personal identity and sense of individuality.

A theoretical issue previously identified was whether the counsellor’s self included aspects that were both positive and negative. While some participants identified negative aspects of self, such as inappropriate personality attributes, unresolved personal issues or a certain style that might not suit all clients, the self was generally described as a positive and useful entity. On the whole, participants did not bring their own unmet needs or personal limitations to therapeutic environment and said little about the existence of a ‘troubled’ or ‘inadequate’ professional self.

Perhaps it was naïve of me to ask participants whether the self that they brought to therapy was negative. Such questions may have constituted a threat to the ‘reputation, morale and even the livelihood of the practitioner’ (Lambert, 1989, p.482). The therapists in this study hardly knew me, and though seemingly open and relaxed, may not have wanted to acknowledge and discuss parts of themselves that they felt were inappropriate in their role as counsellor. An interview format methodology may have impeded the self-disclosure of participants, with many participants opting to say nothing about this aspect of the self and their work.

Furthermore, there was a lack of a prior, established context between each participant and the researcher, which meant that participants might have constructed the kind of self they would like, as opposed to how they actually present and experience the self during

therapy. The social constructionist view of self allows that individuals may re-orient themselves and alter or dispose of earlier versions and narratives of self, not because they are inaccurate, but because they are not consistent with the presentation they are currently making. Thus, different contexts invite different ‘selves’ or narrative patterns based on self. This suggests that participants might choose to present themselves during the interviews in a particular manner, which may or may not be based on their experience of self in therapy. However, the approach taken in this thesis is to accept what each participant had to say, rather than search for a ‘true self’.

Nonetheless, both Luft (1984) and Jopling (1997) have pointed out that there will be aspects of self to which the individual is blind and/or deceives him or herself about. Subsequently, therapist self-deception, conscious or otherwise, might be a factor in positive descriptions of self. Moreover, participants may not be consciously aware of their own personal issues or needs that may be impacting on their work as therapists. As many therapists describe an unknown or unconscious aspect of self, the possibility exists that therapists’ own unresolved issues or personal inadequacies may be present, but are not currently in their awareness. This may explain the initial hesitation of many participants to definitely rule out the possibility that their own needs and limitations might form a part of the self that they bring to clients. The implication is that once in his or her conscious awareness the therapist is compelled to address or otherwise manage these dysfunctions. Conversely, if the therapist’s personal limitations are not in his or her awareness, these dysfunctions still exist and potentially may impede therapeutic goals. This is speculation however, and cannot be surmised from participant responses.

Rogers (1957) acknowledges that while it is neither possible nor necessary for a therapist to be ‘a paragon’ of wholeness in every aspect of his or her life, it was nonetheless important that during therapy the therapist demonstrates a sense of congruency and genuineness. In a similar way, one therapist described how she has had to develop her self, to make it stronger and robust, to ensure that she is able to deal with her own discomfort and anxiety, when dealing with clients who are facing raw and gut wrenching pain. It may have been that therapists worked hard at ensuring that the self shown in

therapy was helpful and positive, even if the self that exists, outside of therapy and in the past, is not always positive, robust or functional.

The multi-perspective framework also established the counsellor's self as changing and in process. The self, depicted by participants in this study, changed over the course of their professional careers, but rather than change substantially, became more relaxed, and less formal. It seemed that participants were saying that their 'true nature' came through in their counselling work and they developed a style that suited them. This is similar to the phase described by Skovholt and Rønnestad (1992), in which (some) experienced therapists developed an authentic professional self, consonant with their values, beliefs and personal style.

While therapists stress a core sense of self, they also describe the self as continually developing. Rather than being inflexible and resistant to change, therapists talk instead about being different with a range of clients, and taking on new ideas and approaches, which best serve the needs of the client, though still suited to their sense of self. Accordingly, the self was expressed differently in various relationships and environments. For instance, counsellors talked about being different, or wearing different 'hats', whilst supporting a friend and a client. While a core sense of self is articulated, there appear to be different aspects of self to which therapists might access, throughout their careers, with different clients, and during therapy with the one client. While not specifically referring to configurations (Mearns, 2002) or subselves (Gaylin, 1994) participants present similar notions when describing different aspects of self that are available at different times and with different clients, though with an underlying and consistent sense of self.

The self of the counsellor, as described in this study, includes both professional and personal aspects of each individual therapist. The distinction between a counsellor's personal self and a counsellor's professional role, knowledge and skills is sometimes made (see in particular, Haber, 1994; Wilkins, 1997). In comparison, the counsellor's self identified in this study includes both professional and personal aspects. Thus,

regardless of gender, years of experience and theoretical orientation, all the therapists acknowledge that they bring various aspects of the ‘self’ to counselling, and not only what they have been taught as counsellors. Both personal and professional aspects of the therapist need to be considered when describing the self that therapists bring to their clients. This has implications for the training and supervision of therapists and will be explored further in Chapter seven.

Many participants described a self that was in their consciousness, but also acknowledged there were aspects of self in their unconscious, or an unknown aspect of self, of which they were not completely aware. Therefore, rather than concur totally with Gergen’s (1992) view that the self cannot be articulated, described or explained, the participants in the present study seem to be saying that the self cannot be *fully* articulated, described and explained. Overall, participants are able to describe, at least partially, the counsellor’s self.

In summary, therapists described the counsellor’s self as a positive, multifaceted and integrated entity that includes participants’ professional skills, knowledge and experiences, but also their beliefs, values, personality, thoughts and feelings and an unknown aspect of self, which some therapists referred to as existing in their unconsciousness. Whilst common themes can be identified, each therapist described an individual self. The counsellor’s self is primarily autonomous though somewhat influenced by others, in the therapist’s past, and the immediate therapeutic context. Overall, the counsellor’s self is a defining, localized entity.

Part c: Manifestation of the counsellor’s self in therapy

The counsellor’s self is a part of therapy in many, idiosyncratic ways, consonant with participant’s conception of an individual and unique self. Responses varied, from counsellor to counsellor, and depended also on the client and stage of therapy. The counsellor’s self provided many therapists with a range of additional interventions and options, and a process and a style of doing things. These findings are discussed and

compared with the multi-perspective framework presented in Chapter two, which established the self as instrumental in verbal self-disclosure and the client-therapist relationship, as well as having the potential to merge and join with the client, at a deep level. Other issues regarding the manifestation of self in therapy, not related to this framework are also discussed.

In the first instance, most participants acknowledged the inevitable influence of self due to various publicly observable variables, such as their clothing and office furniture. For instance, many participants referred to clients knowing something about them, from what was on their desks, their physical presence, their voice and so forth. On the whole however, participants seemed unclear how this might influence therapy or whether this might be helpful or not. Minimizing the influence of contextual variables in therapy is also consonant with participants' reluctance to describe the self as a socially constructed and contextual entity. Instead, most therapists preferred to concentrate on the self they could purposefully and intentionally use, in much the same way Wosket (1999) also urged therapists to focus on the 'intentional use of self' rather than 'inadvertent self-disclosure' (p.11). Accordingly, participants did not consider the inadvertent presence of self as important but instead focused on the conscious and purposeful use, or non-use of self when working with clients.

The use of self in therapy provided many therapists in the present study with a range of options and approaches, including but not limited to self-disclosure and the therapeutic relationship. While connecting with clients was important, none of the 16 participants described merging or joining with clients as outlined previously in the concept of a trans-personal self. Instead, different parts of the counsellor's self were used in various ways; the therapist's thoughts and affect were helpful in interpreting the affective state of the client; contextual cues were used in assuming power; the therapist's lifestyle, problem solving abilities and interpersonal skills provided a role model to clients; the therapist's mood influenced the affective state of the client; and the therapist's life experiences were used to focus therapy, and in helping to understand the client. In addition, the intention and rationale for the use of self varied, from therapist to therapist, and the therapist-client

dyad, and included normalising, enhancing credibility, applying theory and training to practice, educating the client, and relieving tension. Another key function of self was the building of relationships with clients.

Many, predominately female therapists, involved the self in the therapeutic alliance. Instead of a tool that was employed 'on' a client, the self was 'with' the client. Rather than an intervention or technique, for some therapists the involvement of self was represented as an internalized attitude or stance that came through the therapist's presence. Respecting, understanding and connecting were key personal stances in the enhancement of the therapeutic alliance. The counsellor's self was important in acknowledging respect and reverence for the client, without taking over or dictating the process of therapy. Therapists also described using the self as a point of reference in which to listen and understand, a process that then enabled them to connect and work intimately with a client, as another human being. Accordingly, many therapists stressed a relationship between two people, person to person, rather than the therapist assuming a position of authority or distance.

As well as a stance or internal attitude directed at building a relationship with a client, some therapists described using specific techniques and interventions directly aimed at enhancing the therapeutic alliance. For instance, some participants described how they might disclose something about themselves, or use humour, for the explicit purposes of establishing or maintaining the alliance. Thus, the counsellor's self was used both implicitly and explicitly when enhancing the therapeutic alliance for therapists across different psychotherapies. The finding regarding the importance of self in the therapeutic alliance extends previous literature in two ways. While previous studies focused only on single cases or systems therapists (Oke, 1994; Shadley, 1986; Smail, 1978; Wosket, 1999), this integrative study interviewed a range of different therapists. In addition, an articulation of the inner processes of some therapists as they go about the process of establishing and maintaining a relationship with clients was highlighted in this study. Describing the intricate process of relationship building is important information, and has implications for the training of counsellors, as will be discussed in Chapter seven.

As well as building relationships with clients, the counsellor's self was also used when interpreting the client's affective state by acting as a 'container' for emotions of the client. While the 'container' concept is usually presented in the analytic literature as a form of countertransference *vis-à-vis* projective identification, (Miller, 1990; Ogden, 1979, 1982) the therapists who described this did not align themselves with psychoanalysis. Nonetheless, participants talk about the importance of understanding that the emotions they are experiencing are not their own, though serve as potentially useful data in better understanding the client. The process of involving the self in this way involved a mutual collaboration with the client, in the search for meaning and understanding. Therapist self-awareness was important in being able to use these emotions in a productive and meaningful way, in therapy.

Verbal self-disclosure was another major way in which some therapists used the counsellor's self in therapy, again confirming previous counsellor's self research (Basescu, 1990a, 1990b; Oke, 1994; Shadley, 1986; Weiner, 1972, 1978). In this study, some self-disclosure statements and styles were removed and distant from the counsellor, for instance, some therapists described disclosing past experiences, without 'owning' them, and instead, referred these experiences to someone else. Other self-disclosure statements were intimate and involved the therapist disclosing how he or she felt toward the client at the present moment. Different types of self-disclosure have been found elsewhere (Dowd & Boroto, 1982; Hendrick, 1987; McCarthy, 1979; Nilsson, Strassberg, & Bannon, 1979; Remer, Roffey, & Buckholtz, 1983; Robitschek & McCarthy, 1991) and the types of statements described by participants here, confirm what has previously been found.

Another use of self identified by some participants was the way in which the counsellor's self transforms theory and training into practice. Others (Atwood & Stolorow, 1993; Collin, 1998; Lindner, 1978; Skovholt & Rønnestad, 1992; Strupp, 1978; Wilson, 1993) have also explored how the personal characteristics and style of the individual therapist are important in the delivery of theory, a finding confirmed here for a wide variety of

therapists. On the whole, therapists do not dismiss or discredit the place of theory in their therapeutic work, but instead describe how they transform theory in their own personal way. Rather than stay rigid within the boundaries and constraints of a certain theory or method, they explore ways in which they adapt and transform theory to suit themselves, their work environment and clients. Similar to Collin's (1998) idea of 'scaffolding', therapists describe using theory as a basis upon which their own 'self' can then be utilized within the therapeutic context.

Other enactments of self, have also been described elsewhere in relation to family therapists and include humour (Keith, 1987), the use of power (Satir, 1987), influencing the client's mood (Prosky, 1996), providing a role model (Duhl, 1987) and through the use of metaphors (Haber, 1990). This study extends previous research by demonstrating that therapists, from within and out of systems therapy, also use the counsellor's self in various creative and beneficial ways, during therapy, again a finding which has implications for the training and supervision of therapists.

While some therapists were able identify past situations when the manifestation of self proved harmful, on the whole, participants ensured the presence of self was useful and positive. The positive contribution of self to therapy was due to a number of interrelated factors, including therapist self-awareness, the extent to which the self was used in therapy, and various professional and personal constraints on self.

Counsellors' awareness of self, and the ability to objectively think about the self, was essential to manage, transform or otherwise moderate the involvement of self in therapy. The notion that counsellors should be aware of the 'self' in therapeutic work with clients has been advocated as a practice principle by many, over a long period of time (Cook, 1999; Hulnick, 1977; Kondrat, 1999; McConaughty, 1987; McLeod, 1998; West, 1982). Consequently, it might be expected that therapists are used to considering and reflecting about the self, as an object, as demonstrated in the present study.

Not only did therapists stress the importance of self-awareness but demonstrated the capacity to objectify the self during the interview, by referring to ‘the counsellor’s self’ or ‘a self’ as well as ‘me’ and ‘myself’. Accordingly, the counsellor’s self was simultaneously an experiential entity, and an object which therapists could talk about and describe. All 16 participants were able to do this, as evidenced during the interviews and on the returned questionnaires. The interview context and type of questions asked may have encouraged this dialectal relationship by prompting participants to talk about and describe the self in an objective and critical manner. Nonetheless, this reflectivity was essential in ensuring the counsellor’s self was positive.

While many participants identified many positive and creative uses of self, not all therapists reported using personal aspects of self in therapy. Two therapists struggled to ensure that only their professional skills and knowledge were involved in therapy and consequently neutralized or suppressed other, personal aspects of self. The concept of suppressing personal aspects of the therapist is most closely aligned to the psychoanalytic notion of the ‘blank’ or ‘neutral’ therapist, though the two therapists who described this way of working did not nominate psychoanalysis as their primary nor secondary theoretical influence (instead M4 identified systems theory and F6 nominated cognitive behaviour therapy). While both therapists said that they brought more than their professional skills and knowledge to therapy, they argued that for their own self-care and for what they considered to be effective therapy, other, personal aspects of self were ideally not to be used in therapy. For these therapists, the concept of the neutral therapist was important for both the client and themselves. As a first year probationary psychologist working in a child protection agency, F6’s limited involvement of self may be attributable to the constraints of her workplace. In comparison, M4 had nearly 20 years of counselling experience and worked as a generalist counsellor in a community organisation. The manner in which he used only his professional skills and knowledge, rather than his self or person is more likely to be his established and preferred way of working as a therapist. Consequently, while many associated the enactment of self with many useful therapeutic techniques, two participants did not regard the use of self as positive, necessary or useful.

Another group of therapists was identified who also were selective about the use of self in therapy, though 'allowed' more than their professional skills and knowledge during therapy. The counsellor's self provided these therapists with a tool which they might employ in various ways such as providing a focus in therapy, assuming power, in humour and self disclosure, metaphors, building a relationship with a client, and when interpreting the client's affective state. These therapists purposefully and deliberately decided how much and to whom they would use selective aspects of self.

The consciousness of self and its subsequent applicability (or non-applicability) in therapy, as presented by many participants, may, however, be problematic. Many therapists needed time to think about their perception and experience of self and their responses were more detailed and considered after the interview. Being asked questions in both the interview and follow up letter might have enhanced reflectivity for many participants, so that participants' experience of self may have changed both during and after the interviews. As highlighted earlier, Bruner (1997) claimed that individuals might impose meta-structures on the 'self', in order to be comprehensible to others and so, such self-representations may not necessarily reflect the self as experienced by the individual during therapy. Talking about, and thinking about the self may have changed therapist's experience of self, and in this instance, made it more conscious and deliberate than it perhaps is. Therapists, might, for example, begin to look for and consider times when the self has been influential in therapy, changing the experience of self from spontaneous to deliberate and considered.

The final group of therapists identified in the continuum of self involvement consisted of mainly female therapists, who saw the self as very involved in therapy. While specific self enactments were identified, these therapists tended to describe the self as their primary therapeutic resource and intrinsically connected to every aspect of their therapeutic work. Rather than specific techniques, the self was involved as a presence that permeated every aspect of their therapeutic work. Notwithstanding the spontaneous presence of self, these therapists still described how they were aware of self, though not

in an overtly, conscious manner as expressed by other therapists. For instance, one therapist described being able to rely on her 'self', because of previous, successful experiences. Another therapist reported 'knowing' that her use of humour is useful in therapy, and so can 'trust' rather than consciously think about and plan for its involvement in therapy. The experience of self for these therapists seems instinctive and intuitive though at the same time based on reflection and knowledge of what works for them as therapists.

Overall, there are two different processes in which therapists might use the self. In the first instance, some therapists used the self in a rational, analytical way, resulting in the selective use, or non-use of self (including those therapists who suppressed personal aspects of self, as well as those therapists who described the selective use of specific aspects of self). The counsellor's self for these therapists was like a tool, which they chose to use, or not use, depending on circumstance. On the other hand, there existed another group of predominately female therapists who described the involvement of self as intuitive and intrinsic to every aspect of their therapeutic work. While the efficacy of either approach cannot be ascertained in the present study, there appears to be different models of clinical processing in the use of self.

Gender, rather than theoretical orientation, appears to have the strongest impact upon the way in which therapists experience the self in therapy. Overall, female therapists, from a range of theories were more likely to consider every therapeutic move as an expression of self, while male therapists were more likely to consider the self as a tool, which they might, or might not use, in their therapeutic work with clients. Female therapists were also more likely to use the self when building relationships with clients. Furthermore, female participants were more likely to disclose their immediate feelings, while mainly male therapists verbally disclosed 'by the third degree', (using their own experiences but referring to someone else) and through metaphors. Shadley (1986) also found gender differences in the verbal self-disclosure statements of family therapists, and the present study extends these findings by highlighting similar gender differences across a range of orientations. Here, many female therapists, from a range of theories, linked their

therapeutic practices more closely to self and appeared to reveal and share more intimately of themselves during therapy, than many male therapists.

In one way or another, all participants described how they would constrain or place limits on the involvement of the counsellor's self in therapy. Various issues in the involvement of self were highlighted and include; the client trying to get too close to the therapist; the client not knowing when to stop or when therapy is finished; when the involvement of the counsellor's self takes the focus away from the client; when the client might worry about the therapist; for general therapist self care; and ensuring that therapists have time and the emotional energy for their family and self care. For the most part, therapists said that they were better people, when working as therapists, than with most other people in their lives, such as friends, family and work colleagues. The 'self' that they presented in therapy tended to be more accepting, careful and less rushed than the 'self' that existed outside of therapy.

For many therapists the discussion about the use of self in therapy was inextricably connected to issues of ethics and professionalism. Participants emphasized that the use of self needed to be accompanied by therapist self-knowledge and an awareness of professional boundaries and ethics. Even those therapists, who saw every aspect of therapy to be intertwined with self, acknowledged the professional constraints of self.

There were advantages and disadvantages regarding therapists self care when involving the counsellor's self in therapy. Many therapists described a range of resources and strategies the use of self afforded them as therapists. One therapist described how her own positive mood not only influenced the mood of the client, but was also essential for maintaining her own mental health. Wosket (personal communication, 2002) suggested that the use of self in therapy might assist in avoiding therapist burnout.

Toolkits of strategies and techniques don't work, or seem to only take me so far, with my clients. If I only had these to bring to the interaction I would soon feel hopeless and that I had nothing left to offer. When I rely more on myself I feel as if I can ride the ups and downs with more resilience and lack of pretence. It is

hard to keep up the idea of being an ‘expert’ when you are scared about running out of expertise.

There were however, potential problems also associated with the use of self, in terms of the therapist’s own mental health. One therapist described holding her self back from particularly ‘needy’ clients so that she is able to ‘save’ her emotional energy for her children. Some talked about the potential problems they faced if they got ‘too close’ to clients, as they might then worry or think excessively about them outside of therapy time.

This study extends previous studies by considering the various issues involved in the manifestation of self in therapy for therapists from within and out of systems therapy. Confirming previous research, a central function of the counsellor’s self is in the enhancement of the therapeutic alliance, and through various instances of verbal self-disclosure, though other useful strategies were also identified. Another potential contribution of this study is the description of the different internal processes experienced by therapists as they simultaneously engage with the client as well as their own thoughts, feelings and personal sense of being. Both general findings potentially provide valuable information for psychotherapy theory and research and in the training and supervision of therapists (and will be discussed in Chapter seven).

Connections between conceptualisations of self and therapy

In the interviews, connections between participants’ conceptualisations of self and their way of practicing therapy were not explicitly explored. However, participants made connections implicitly throughout the interviews and many connections also surfaced during data analysis. Accordingly, tentative comments may be made, that connect participant’s description of self and their experience of self in therapy.

Participant’s concept of self directly influenced the perception that they could regulate and ‘manage’ the positive contribution of self to therapy. As the self was considered an individual, localized entity, participants tended to assume ownership for their reactions,

thoughts, feelings, beliefs and values and assumed the subsequent ability to then use and involve these aspects of self in their therapeutic work with clients. Inherent in this perspective is the assumption that the individual is able to step back and observe, critique and manage it's own performance, an underlying Western assumption behind many traditional philosophical approaches to the self (Kondrat, 1999). However, the idea of a transcendent self capable of 'looking down on itself' is rejected as a myth within current postmodern thinking and instead replaced with the notion that the self emerges unendingly from the interactions between people and society in general (Gergen, 1985). As has been presented earlier, most contemporary training for therapists is still invested in the traditional, research paradigm (Aiken et al., 1990; O'Gorman, 2001) and therapists in the present study confirmed a reflective or objectifying self awareness process consonant with this training approach. However, as Kondrat (1999) points out, while many postmodern theories might reject the possibility of being able to stand outside of oneself, the ability to objectify the self for consideration, as articulated by participants here, makes personal learning possible. Consequently, while not conforming to notions of socially constructed notions of self, the positive contribution of self was principally due to the perception participants had that they could control or otherwise manage the self.

While not particularly defined or situated by others, the self, for participants here, was important when connecting with clients. It seemed that counsellors were able to use their individuality to reach out and build relationships, and to interpret and make sense of what was happening for their clients. There was no merging of selves, or overlapping boundaries between the client and counsellor's self, but instead the meeting of two, different selves, that most succinctly expressed the experience of self in therapy for many participants here. Therapists individuality, and their resulting thoughts and feelings, were an important way in which they demonstrated respect, connected with, understood and interpreted what was happening for their clients.

The paradox of bringing two autonomous beings together in the intimate context of therapy has also been highlighted by others (Hobson, 1985; Mearns & Thorne, 2000;

Schmid, 2001a, 2001b, 2002). Mearns and Thorne (2000) have pointed out that while the self is essentially 'our most private place' it is also one that we 'yearn to share' (p.57). The coming together of two individuals is the pretext of therapy and is intrinsic to the concept of self and the involvement of self, for many therapists in this study. Similarly, Schmid (2001b) stressed that therapy needs to be about both difference *and* similarity between the therapist and client.

The meaning of 'contact' in psychotherapy points to the fact that all understanding of therapy is based on the sameness *and* diversity of (at least) two human beings. What we have in common enables us to empathise and thus to do psychotherapy; what is different between us, stimulates us to increase the sensitivity of empathy and, therefore, self-exploration and the development of the client's identity (Schmid, 2001b, p.188, emphasis in the original).

Participants highlighted the singular and unique nature of the counsellor's self though at the same time using their separateness to connect with, and understand the self of the client. The counsellor's self was closely attuned with clients, but was nonetheless separate and distinct.

Participants did not generally support the notion of a self as formed and maintained in the therapeutic relationship or broader cultural dynamic. Instead, participants considered therapy as the forum in which the self of the client and counsellor meet, as two different and separate beings. The counsellor's self exists along side another self, which rather than work 'on' the client, was important in working 'with' the client. At the same time, many enactments of self were motivated by the therapist's intent to enhance the therapeutic alliance, explicitly or indirectly. For instance, some therapists said they self disclosed to a client for the purpose of building an open and honest relationship. Identifying their own affective state was another way in which some therapists attempted to move closer to their clients, and an understanding of their clients, without as it were, 'merging' or being defined by the client or the broader context of therapy.

Some therapists describe a process of being open to self and how they felt and thought, being conscious of their own personal histories and former experiences, while at the same

time concentrating and listening to the client. In other words, as therapists become open to the experiences of self, they become at the same time, receptive to the client and the therapeutic relationship. For instance, one therapist referred to his self as a reference point, and a place from which he could then connect and understand his clients. Similarly, Spence (1982, p.117) has contended that

Sensitive, empathic listening can probably take place *only* if the words spoken by one speaker are invested with private meanings by the other. Unless some kind of internal elaboration takes place, the listener hears only words (emphasis in the original).

It seemed that in order to give meaning to the client's story, some therapists used and involved the self in a variety of ways and stances. This internal place, which for one participant acted as a 'reference point', was important to make sense and meaning of the client's own inner experiences. Subsequently, moving closer to the client, in the therapeutic relationship, also occurred as some therapists moved closer to their own experience of self. This is an important finding because it directly relates to how therapists might build effective relationships with clients, which, in turn is associated with effective outcomes in therapy.

Another source of data is the researcher's journal and recorded meetings with the peer debriefer. These will now be presented and discussed in the following chapter.

Chapter six: Researcher's insights and possible biases

It was argued previously that researcher subjectivity, while possibly contaminating, might also provide potential insights. Consequently, another set of data may be sourced from the researcher's journal and recorded meetings with the peer debriefer. These data are presented separately from the findings drawn from participants, in order to distinguish between what I, as the researcher, and participants have to say. Furthermore, the epilogue at the conclusion of the thesis outlines what I have learnt about my *own self*, as a therapist. In other words, the epilogue considers my own self, while this section considers my ideas about the counsellor's self generally, whilst talking and listening to other therapists' ideas about self.

There are two, broad themes concerning researcher's subjectivity; first methodological issues regarding the project, and second, my reflections as the researcher over the course of the study, regarding the counsellor's self.

Issues involved in research

Some general comments will be made regarding my own expectations, potential biases and selectivity and how these may have impacted on the overall flow of the interviews and subsequent data analysis.

Initially I found the interview process unnatural and uncomfortable for example, 'I tried to write while she talked. I never do this while counselling, why do it now?' (journal, 21st June, 2001, p.1). Following an interview schedule, with predetermined questions, even though semi-structured, meant I was nervous about including all relevant sections. However, after the initial set of questions, I 'stopped writing and just listened to the client' (journal, 21st June, 2001, p.1). As a result of 'just listening' I was then able to relax and take in more of what the respondent was saying and question and probe from the respondent's framework. The peer debriefer, however, suggested that this style of interviewing might prove problematic for subsequent data analysis.

Just 'listening' has to be a good skill, but how will you use the data when it is recollections... complete with all the filtering that goes on so that you remember some bits (that probably have a connection to you) and not others. If you plan to 'just listen' to all the other interviews you'd need to indicate that that's the case in your writing up... this might affect your ability to generalise between your cases (peer debriefer, 24th August, 2001).

Subsequently, while I listened, and worked from the participant's frame of reference, I did ensure that throughout subsequent interviews, the interview schedule was considered, and that all questions and issues were covered, before the conclusion of the interview. Audiotapes were also used to ensure that all information was recorded, and not just those 'bits', that were connected and meaningful to the researcher. This appeared to be a compromise between going with the flow, and adhering to the interview schedule.

As reflected in the journal, I also considered my dual positions as both interviewer and therapist. For example, on one occasion, I described my concern regarding the volume of cases one inexperienced participant was taking on, and the need for this individual to obtain adequate supervision. The ethical responsibility of whether to intervene, provide advice and/or assistance was reflected in some of the questions I asked during the interview, for example, '*Do you have supervision, like, you know, regular supervision?*' and '*Are you able to talk about these sorts of things in supervision?*' These questions were not asked of other participants. Similarly, many of the participants talked about personal and at times painful issues from their own lives, and how these impacted on who they were as counsellors. The role of counsellor rather than interviewer, seemed appropriate, and as the peer debriefer pointed out,

The immediate question I asked of myself was, what is the difference between counselling and researching? Both are systematic ways of gathering data that involve the use of questioning and listening (peer debriefer, 24th August, 2001).

However, being a counsellor and being a researcher entails two, different ethical responsibilities to the individuals involved. The peer debriefer continued saying that the specific goal of therapy is client change, while my goals as an interviewer were different.

Counsellors, of course, can go down this path - and do - but is it appropriate for a researcher? Might you have been slipping into therapy mode? (peer debriefer, 24th August, 2001).

All participants were provided with a list of professional counsellors for debriefing if they felt they needed to talk further about the issues that arose during the interview. However, this seemed inadequate, for it resulted in what I considered to be an inappropriate delay and an abdication of my responsibility. It was more comfortable and appropriate, I think, for both the participant and myself, to deal with issues as they arose during the interview time and myself. Sometimes this meant the interview time went over the prescribed one to two hours and that certain issues were discussed outside of the framework of this thesis. The tape recorder was switched off, and these discussions were subsequently not included in the transcripts for the present study. Furthermore, the participants were reminded that the interview transcripts were their own, and that they were able to change, delete and modify any part of what they had said. As far as I am able to ascertain (within the boundaries of confidentiality) none of the participants contacted the professional counsellors for further resolution of the issues raised during the interviews. The fact that the participants were able to reveal themselves openly suggests that they perceived the interview environment to be warm and trusting and that their personal issues were managed appropriately.

Other issues arose concerning potential biases toward certain demographics. While participants ranged in experience, the peer debriefer pointed out that I focused more on some participants than others.

Years of experience significant? Have you noticed that you have written more about the experienced folk? Do you value their statements more than the new kids on the block? Perhaps these folk are still consciously skilled and very much keeping their 'self' to themselves until they can relax into their roles a bit more (peer debriefer, 24th November, 2001).

Not only was the researcher writing more about the experienced participants in the journal, but also the interviews with these participants were significantly longer, as

measured by the audiotapes. After these comments I went over the transcripts, questionnaires, and analyses to consider potential differences between experienced and inexperienced therapists. However, I found no significant differences in terms of the content of their responses. The major difference however, was the experienced counsellors had more to say, and hence there was more to present. The question was whether inexperienced counsellors were not comfortable discussing the self, and/or did not know how to talk about their self though it may have been an important issue for them in their counselling practice.

Prolonged engagement (Lincoln & Guba, 1985) may be important for more inexperienced counsellors, that is, time and thoughtful observation, for them to process and feel comfortable discussing the topic at hand. Repeated interviews were only undertaken at participants' request, and this may have been difficult for the inexperienced counsellors to initiate. Perhaps future research could engage inexperienced participants over repeated interviews, so they have the opportunity to reflect and consider the various issues before, during and after the interview process.

The peer debriefer also highlighted potential biases, in regard to participants' theoretical orientation. The following is a journal entry that describes my overall impression of one participant,

Clear succinct psychoanalytic therapist, easily able to relate to topic (journal, 21st June, 2001, p.1).

To which the peer debriefer responded,

Does being a psychoanalytic therapist mean that the person will be better able to relate to the topic? Might this set up all sorts of expectations, and dare I say it, positive discrimination? You know that this sort of person will grasp the concept so will listen for certain things as evidence that this is so. The flipside of the coin is that you might treat others as being less able (peer debriefer, 24th August, 2001).

Similarly, the peer debriefer wrote in reference to another comment I made about a cognitive behavioural therapist.

Is this good that she's CBT - what baggage do you have with this? (peer debriefer, 24th August, 2001).

In terms of how to manage these potential biases and preconceived conceptions, the peer debriefer also said,

It might be useful to think of the other baggage that went in with you, and whether it is really possible to leave it outside (peer debriefer, 27th August, 2001).

The prologue of this thesis and sending participants interview transcripts were measures employed in this thesis to declare and 'manage' potential researcher bias, though it is acknowledged that it is impossible to completely eliminate researcher bias and positioning.

Other problems were also raised in terms of my positioning throughout the interviews and data analysis. While the use of interviewer summaries may be an effective way of pulling together the various threads and themes as they occur during the interview (Patton, 1990), I found that my use of these during the interview said more about my own structuring of ideas.

I was very aware during this interview (F9) of my summary statements - though I did do this all the time, in the earlier interviews. However, this time I noticed that my summaries used the categories that I have drawn from the other participant transcripts, rather than using HER words/images/phrases. She did pull me up once and said that my summary of what she had said was not quite how it was, and while related was slightly different... I do wonder how long I have been doing this, and whether others have not pulled me up and have just agreed with the summary I have given them? (journal, 11th November, 2001, p.3).

The peer debriefer came up with three suggestions, or comments regarding this problem. First, participants had the opportunity to correct the interviewer during the course of the interview, if they considered my summary was not consistent with what they had to say. This occurred with F9, who had the confidence and perhaps the experience to correct the

interviewer, but may not have occurred with other counsellors. Second, participants had another opportunity to correct interviewer summaries, when they received their transcripts. This tended not to occur, and instead, participants added to, rather than changed or modified the information on their transcripts. The final point the peer debriefer made was to re-read the transcripts, identify my summaries throughout the interviews and then consider whether there were any other ways of restating or summarising the participant's position. This may highlight other potential ways of interpreting the data and was subsequently undertaken when reviewing transcripts.

A related issue was also found when reporting on results. After receiving feedback from one of my supervisors I recorded the following in my journal:

My supervisor says that I have too many participant excerpts in the results section. [My supervisor] suggests that 'I take charge of all this data', use less of it, and pull it together. I wonder about this. In the past, using a qualitative framework, I always understood that the results should be able to speak for themselves, and that I should not be involved in their presentation (my interpretation and 'voice' was to come in the discussion). It feels like I am somehow being intrusive and shaping what they have to say to my predetermined notions of where things should go and how things should be. Not sure about this (journal, 12th December, 2002. p.7).

Following my supervisor's advice I then reshaped the results sections and subsequently wrote:

I think I agree with [my supervisor] and the results come out cleaner, simpler and easier somehow. However, I still feel like I am somehow shaping and moulding (changing?) what the participants had to say originally (journal, 2nd January, 2003, p.7).

When I put these concerns to the peer debriefer he wrote back with the following comments:

... the very fact that you decided to intrude into people's lives with a question or two that you dreamt up, heralded the start of your shaping their responses. The responses they gave you, at the best, are only their own truths, which doesn't mean that they're lying, but simply that there are bound to be other truths – or

perspectives – that others could give as well. Then you are left with the task of representing what they say and to try to make some sense of it as well.

If, as your supervisor suggests, you tried to put everything in out of respect for the people you interviewed, you would surely get swamped with data, so the act of sorting and sifting is really just another extension of your own intrusion into the research. You have, after all, I gather, dreamt up some themes – these are again your interpretation of what you think your respondents told you. Their truths plus your truths... it starts to get murky.

As you indicate in your subsequent entry, the filtered data would be easier to manage, but I guess what you need to do, which seems like such a logical thing that I'm sure you've done it this way, is to find exemplars amongst their life stories... Once you've got a few of those, then it seems to be relatively straightforward to try to interpret what they're saying (or not)... Try to be faithful to what your people told you, but do bear in mind that you have been shaping it from the word 'go' (peer debriefer, 7th January, 2003).

Coming from a positivist background, in my training and research experience, has led me to appreciate value-free research, and though acknowledging that there is no such thing, to at least aspire to let the data 'speak' for itself. I still argue with this in principle. However, just as I have argued that my self is implicitly involved in therapy, so too I have come to the realization that my self, including my subjectivity and insights, is inevitably involved in every part of the present research. As the peer debriefer writes above, I have been involved at each step of this research project, from the very beginning.

The place and positioning of my self as the researcher has been problematic for me, throughout the course of this study. This has been reflected in the hesitation I have in using the first person, at different times throughout the thesis, though in sections clearly acknowledged to be 'mine' (such as the prologue), I do not find this problematic. In other parts of the thesis, however, I have been reluctant to acknowledge my presence or involvement. One of the final entries in my journal suggests that on, one level at least, I was able to resolve this.

The process of talking to counsellors about who they are in counselling mirrored a similar process I undertook while writing and researching this thesis, in that I also had to consider who I am, as a researcher. I had been given the 'formula' for doing research and research reports in the past, and over a period of time, tried

earnestly to apply these formulas to my thesis. In the end, however, I gave up and instead applied what I considered to be the most appropriate section, chapter or information that fitted sequentially, logically and relevantly, to my mind at least. It felt like taking charge of all this information I had collected and giving the thesis a direction and flow that came from me, and no one else. It was also very risky and scary. It seemed too personal and not rigorous enough. But, in the end, the thesis is a project of mine and not my supervisors (journal, 15th January, 2003, p.11).

Similarly, I have been aware, as the researcher, of competing definitions that consider counselling either as a science or as an art form. In many ways this tension is reflected in how the present research was implemented, and the questioning of my stance throughout the thesis. Research into the counsellor's self has alternatively been called marginalised, unprofessional (Oke, 1994) and unscientific (Lambert, 1989). Perhaps I have not wanted to own up to my involvement in the present research because I wanted to make it more professional and scientific. While referring to family therapists, Oke's (1994) observation may equally be applied to other counselling theories.

... in the rush to be considered a legitimate profession identified with scientific research and methods, the field of family therapy has subjugated the overt articulation of its human and relational dimensions (p.63, 64).

This human dimension is apparent in counselling and so, arguably, intrinsic to the way in which this research was carried out and interpreted. I have realised that by acknowledging and writing about the human dimension of counselling and research, the work in both areas does not become less professional or scientific, but on the contrary becomes more 'real' and honest.

My insights as the researcher

The main aim of this thesis is to consider how therapists describe the counsellor's self and their experience of self in therapy. Here, I report on some of my reactions and ideas about the counsellor's self, as recorded in the reflective journal and during discussions with the peer debriefer. As presented earlier, according to Walker and colleagues (Elliott

et al., 1992; Walker & Nias, 1995) a researcher's insights potentially provides additional, useful information, that may be used in conjunction with participant responses.

There are several findings drawn from these sources. The first highlights the potential use and misuse of the counsellor's self in therapy. The two therapists who argued for the suppression or neutralization of aspects of self in therapy were the most adamant about the risks associated with the use of self to their own mental health and to the overall process of therapy. I was also acutely aware of the problems associated with the use of self from my own dealings with clients. However, alongside such risks came the realization that the availability of self affords many more resources and options than therapists might normally have. I recorded in my journal,

An impression I have, from talking to many participants is that the counsellor's self gives counsellors so many more options, it frees them up to experiment, to go with the flow, to trust their instincts, and to gauge their own emotional reactions, rather than shun or dismiss them. Many therapists have said that the presence of self is intimately connected to their work and this is why they enjoy their work so much... there do appear to be risks involved but at the same time the potential for rich, alternative work with clients... reminds me of my work with Sally [a client, not her real name] (journal, 18th November, 2002, p. 12).

Sally was a client that I worked with several years ago. I only met this woman once and she came in saying she wanted help 'to leave her husband', because he never helped her with the housework and she felt she had to do it all herself. We talked together for a while, and I was struck with the force of her determination to leave him, apparently because of his apathy towards housework. She was unable to recognise or discuss any other reasons for her discontent. While I rarely self disclose, towards the end of the session I said that I too got frustrated at my partner for not doing the housework, but I never felt like leaving him for that reason. She was quiet for the first time in the whole session, while she processed this information. I remember waiting quietly, hoping that she would not ask me how I managed the whole issue of housework and relationships, something I was not really keen to do, as I did not believe this to be central to her frustration and anger (and nor did I have any answers). Instead, however Sally started to talk about the underlying reasons for wanting to leave her husband, and her feelings of

loneliness and worthlessness, quite separate from the issue of housework, but intimately connected to the source of her unhappiness in the relationship.

My use of self, in this instance, helped the client see herself more clearly and identify her own motivations and feelings. I was actively searching for a way to help her recognise what might be happening in her relationship with her husband and found that my own experiences and subsequent reaction was a useful way of helping her do this. The risk was that her focus might have turned onto myself. However, on this occasion, the use of my self allowed the client to examine her own motivations more clearly and perhaps re-evaluate or at least articulate them in a different way. Similarly, Wosket (1999) has also described how the use of her self in therapy invites clients to look closer at themselves, and enhance the bonds and attachments associated with the therapeutic alliance.

While the use of the counsellor's self has the potential to harm the client, not using the self at all is also a problem. Hayes (2002) contends that

As therapists, it is altogether possible to keep ourselves safe, practicing comfortably behind the shields of authority and expertise, limiting our involvement in the client's work and thus, in all likelihood, our effectiveness (Hayes, 2002, p.96).

Consequently, while there are risks involved in the involvement of self, there are also costs in *not* involving the self. Reflecting on this issue, Burka (1996) errs on the side of involving her self when she considers the alternative, 'What deadness is insured and what vitality is precluded?' (p. 274). Being open to the self, and involving the self in therapy makes available to the therapist a number of interventions and resources. For many therapists the involvement of self encouraged rather than inhibited clients' expression in therapy and enhanced the alliance between therapist and client.

Nonetheless, the involvement of the counsellor's self in therapy may potentially disrupt therapy; for instance, by taking the focus of therapy off the client and onto the therapist and may potentially harm the therapist's own mental health. Perhaps one way, of several, to identify whether the use of self will be a disruptive or constructive force in therapy, is

to ascertain the motivation and intention behind the therapist's use of self. While therapists may not consciously know why they do certain things in therapy, their objectives and goals may nonetheless be identified in subsequent and repeated therapeutic actions and/or interventions (Caspar, 1997; 1998; Hamer, 1995). When the counsellor's self is involved to meet the therapist's own needs or to alleviate his or her own anxiety the overall goals of therapy may be jeopardized. For instance, while I was frustrated at Sally's reluctance and inability to consider other reasons for her discontent, my use of self was not aimed at relieving or expressing my exasperation, but was instead aimed at inviting her to look deeper at her own situation. Similarly, one participant (F10) said that while she may feel distressed and anxious listening to clients, she chooses not to act on these personal feelings, but instead allow clients to experience their feelings and 'gut wrenching pain'. She acknowledges she has 'power' in the therapeutic dynamic to take the client's pain away, though generally chooses not to assume that power during therapy. For this therapist, her non-involvement of self was motivated by the interests of the client, and not driven by her own anxiety and needs. Subsequently, her motivation regarding the use of self determined whether it was destructive or constructive for the client. Consequently, it might be argued that underlying therapist motivation and intent are powerful indicators for the potential use or misuse of self in therapy.

The other insight sourced within the researcher's reflective journal regards therapists' interpersonal style. Some therapists were more personally revealing during the interview than others, and this tended to be also reflected in how they involved the self in therapy. For example, one therapist said that she rarely self-disclosed to clients, and subsequently did not disclose personal information to me during the interview. In comparison, other therapists said that they shared much about themselves with clients, in many ways, and during the interview spoke intimately about their own families, and other counselling and personal issues. Their style of working during therapy seems to be reflected in the interview undertaken with me, and might also be indicative of their interpersonal relationships generally.

Chapter seven: Summary, implications and conclusion

In summary, participants describe the counsellor's self as encapsulating their individuality and personal identity. While common themes were identified, 16 different selves were identified. On the basis of the descriptions provided by therapists, there does not appear to be a right or a wrong way to present the self, which is neither inflexible nor rigid. Accordingly, every therapist involves his or her self differently, again reflecting the individual style of each therapist. It has been argued previously, that the personal and individual style of the counsellor is, and needs to be, an important part of the way counsellors work and make use of theory (Crouch, 1997; England, 1986; Friedman, 1992; Karasu, 1996; Wilson, 1993; Wosket, 1999). Each therapist will counsel differently, regardless of his or her theoretical influences, because of his or her 'self' (McConaughty, 1987; Satir, 1987, 2000; Strupp, 1978). The counsellor's self as presented here allows for individual difference and so is consonant with these views.

However, the model of the counsellor's self this thesis presents is not meant to be definitive or conclusive; it will vary from counsellor to counsellor, and may vary in other studies, different sample groups, questions and methodologies. Nonetheless, some of the possibilities regarding the counsellor's self have been highlighted in this study and are important as the start of developing theory in this apparently under-researched area.

Previous research on the counsellor's self has focused on system therapists only (Oke, 1994; Shadley, 1986; Tester, 1992; Turney, 1991), on particular behaviours and variables thought indicative of the therapist's self (as highlighted by Gurman, 1987; Hayes, 2002; Herman, 1993; Kline, 1992; Lambert, 1989; McConaughty, 1987) or outline an individual therapist's ideas about his or her self in therapy (Basescu, 1990a, 1990b; Carlock, 2000; Duhl, 1987; Elliott, 2000; Haber, 1990, 1994; Hardham, 1996; Keith, 1987; Kottler, 1986, 1995; Lomas, 1981; Lum, 2002; Paterson, 1996; Prosky, 1996; Real, 1990; Rober, 1999, 2002; Smail, 1978; Smith, 2000; Wosket, 1999). The findings of the present study contribute to the existing literature by examining how therapists, from a

range of orientations, perceive and experience the self in therapy. Another potential contribution this study has made is by highlighting the internal processes of therapists as they simultaneously focus on the client and the self.

There are various findings from the present, integrative study that add substantially to previous knowledge regarding the counsellor's self in therapy. First, regardless of theory, participants described the counsellor's self as a singular, autonomous entity, distinct from the client and the broader context of therapy. This means that the therapist, as a person, is an entity in his or her own right and subsequently very much a part of the therapeutic environment. It seems that therapy is not just about the client, the therapist's reactions to the client, or the professional knowledge and expertise of the therapist; according to therapists interviewed in this study, an important part of therapy also centres on the therapist as a person and individual, with his or her own thoughts, feelings and experiences. Consequently, the individual and unique therapist needs to be acknowledged in future psychotherapeutic research and in the training and supervision of therapist.

Second, the self that therapists bring to their clients is overwhelmingly a positive entity within the therapeutic context. Participants, from a range of theories and years of experience, articulated the positive nature of the self that they brought to therapy, even if the therapist is not a perfect person outside of the therapeutic environment. Therapists strove to be the best therapist that they could be, and worked hard to ensure that the self that they presented to clients was useful, robust and functional. Consequently, the counsellor's self potentially provides a useful and constructive resource within the therapeutic environment.

Third, therapist self-awareness and reflexivity, which existed on various levels, are critically important in the positive experience of self. Some therapists described an ability to suppress and/or selectively use personal aspects of self, while others describe the self as intimately intertwined in all aspects of their therapeutic work. While these constitute different ways of experiencing the self, all participants suggest that they are

able to control, monitor or otherwise manage the involvement of self in therapy. Professional and personal constraints were important for therapists in the positive experience of self in therapy. Consequently, the positive contribution of self is inextricably linked to therapist awareness regarding what aspects of self to involve (or not to involve), and an awareness of the clients best suited to the use of self.

Finally, irrespective of their nominated theory, therapists identified a range of interventions and perspectives in which the counsellor's self played a pivotal role. Overall, the engagement of self afforded many therapists, from a range of theories, a variety of stances and techniques that were beneficial to therapy. One of the primary ways the self was involved in therapy was relationship building with clients, an intervention that has been previously linked with effective outcomes in therapy.

The implications of these findings are for the education and supervision of counsellors as well as for counselling research and theory.

Training and supervision of counsellors

Participants argued that the counsellor's self is more than their professional skills and knowledge. Even the two therapists, who strove to ensure that personal aspects of self were not involved in therapy, acknowledged that their beliefs and values, past experiences and personality, were a part of the self they brought to counselling. This finding highlights the point that the training and supervision of therapists should not only focus on various therapeutic techniques and theories, but also on each individual's unique personal qualities that they bring to therapy. Based on their strengths rather than weaknesses, each therapist might consider what they personally *have* and *want* to offer their clients.

The focus of self in training and supervision needs to be flexible, because, as participants identified in this study, there are many different ways therapists might involve the self when working with clients. Some participants described the self as intimately

intertwined in every aspect of their therapeutic work, whilst others regarded the self as a tool, amongst several, that they might use, or not use, when working with clients. Not all participants reported using the self in therapy. In this study, withholding the overt use of self in therapy does not seem to be due to theoretical influences but may instead be an organisational constraint, and/or constitute a preferred and individual way of working. As this study did not set out to examine the relationship between use of self and outcome efficacy, the manner in which therapists engage the self needs to be appreciated.

Nonetheless, many useful therapeutic interventions were identified when participants described their experience of self in therapy and these interventions might be disseminated to other therapists and trainees. Having said this however, asking therapists to duplicate others does not acknowledge the context and the life and clinical experiences upon which such skills and qualities are drawn. For instance, one of the therapists described how important, though scary it was for her to develop her own individual style, based on her strengths and life experiences, rather than copy her supervisor. In addition, many participants said that the counsellor's self constituted a style, a particular stance and manner of doing things, as well as specific technical enactments. Whilst personal qualities may be encouraged and modelled by others, they may not necessarily be taught at a formal, academic level. Even so, the various ways in which therapists described the enactment of self in therapy might provide useful information for practicing and trainee therapists to adapt or modify in their own way and/or prompt other ways the self might be involved. This list is not meant to be exhaustive and other researchers and therapists are encouraged to initiate other ways of using the self. Consequently, the subsequent suggestions are provided in the light of McConaughy's (1987) assertion that, 'Any techniques we select will become distilled into our own special style of interacting with clients' (p.303). The techniques that are the best expressions of their individual selves are those that therapists need to consider.

The various training possibilities generated by the interventions identified by participants and subsequent therapeutic aims are summarized in Table 6.

Table 6: The potential training opportunities afforded by the uses of the counsellor's self, and specific therapeutic aims.

Uses of the counsellor's self in therapy	Therapeutic aims	Potential training activities for trainees and practicing therapists
<i>Relationship building</i>	Understand the client. Respect the client. Connect with the client.	Consider how therapists might demonstrate respect and understanding to clients. Trainees and therapists might first consider how they do this in relationships outside of therapy. Consider how therapists connect with clients, by using the self as a 'point of reference' from which to listen to clients and to compare and contrast their own experiences (even if not verbally disclosed).
<i>Interpret the client's affective state</i>	Client understanding.	Ask therapists to monitor their affective states when with clients and ascertain whether this might provide useful information that they can use, in a variety of ways, in therapy.
<i>The application of theory and training to practice</i>	Use theory and training as a scaffold from which to then apply personal style, values, and experiences.	Consider first which theory or theories therapists find most personally compatible (see Wilson, 1993, for an example of such a process). Then consider how they might use their own personal experiences, values and beliefs to adapt and shape theory and training experiences into an applied setting.
<i>Self-disclosure statements; various types identified, some intimate and self-revealing, others less so.</i>	Normalizing. Education. Rapport building. Enhance credibility.	Discuss the potential uses and misuses of therapist self-disclosure generally (see Egan, 2002, p.207-209, for a summary of the main issues involved in therapist verbal self disclosure). Consider different types of self-disclosure statements and whether therapists might constructively use them. Consider also how self-disclosure statements might be usefully applied to these various therapeutic aims.
<i>Providing a focus in therapy</i>	Guide therapy in a certain direction that the therapist considers important.	Consider when it might be useful to work outside the presenting agenda of the client and how the therapist might do this while still

		demonstrating respect.
<i>Humour</i>	Relieve tension and help the client relax. Build client-therapist relationships.	Consider whether therapists use humour generally and if this is something that might assist in these various therapeutic aims.
<i>Assuming a position of power</i>	Providing direct advice about what to do or not to do.	Discuss generally the position of power the therapist assumes during therapy, and whether they might be able to constructively apply power in therapy and the most appropriate conditions and clients for its use.
<i>By providing a role model for clients</i>	Education.	Discuss how a therapist's lifestyle, interpersonal skills and his or her problem solving abilities might provide a role model for clients, even if not directly self-disclosed.
<i>Influencing mood</i>	Therapist self care. Enhancing the client's mood.	Discuss general principles of self-care and whether this strategy might work for them. Consider indirect ways the therapist's own mood might influence the client's mood.
<i>Through metaphors</i>	(Indirect) education.	Discuss how to provide indirect education to clients. Provide examples of metaphors and practice developing various metaphors for current clients.

Table 6 represents one possible way the findings of the present study might be utilized for training and supervision purposes. For instance, several therapists described using their own emotional reactions to tentatively interpret the client's affective state. Whilst such a technique is generally considered a psychoanalytic technique (pertaining to countertransference *vis-à-vis* projective identification) the therapists who identified this intervention did not nominate psychoanalysis as their primary theoretical influence. Understanding the therapist's affective responses could subsequently prove useful for therapists from a range of orientations, as the dynamics revealed can be related to any theoretical perspective on therapy. Other, useful techniques identified by participants, such as humour and the telling of metaphors, are also teachable (Egan, 2002; Kuhlman, 1994) though may not suit each therapist. Accordingly, the various self 'tools' or enactments as well as stances, as identified here, such as providing a role model, self-

disclosure and so forth, might be disseminated to trainees, in various ways, some of which are outlined in Table 6.

The findings of this study also highlight other training issues. The potential risks associated with the use of self involved jeopardizing the therapeutic process and endangering the therapist's own mental health. Participants stressed the importance of self-awareness and the researcher's journal highlighted the importance of identifying underlying therapist motivation driving the use (and non use) of self. Consequently, the use of self needs to be accompanied by the ability to self reflect (though different processes were identified in this study) and an openness to critically examine why we do what we do. The focus of such issues might be best raised during supervision and/or during a counsellor's own personal therapy.

The therapists in the present study included their beliefs and values in the concept of self, but did not acknowledge the cultural context in which these were shaped. Kondrat (1999) points out that most therapists do not recognize the importance of contextual factors in the formation of their personal attitudes and beliefs, a finding in accord with the data in this study. Consequently, she argues that therapists need to understand how beliefs and values, such as racism, is more than a matter of personal attitude, but is also a part of the structure of social institutions and the relationships that all therapists engage in. In such an approach counsellors are invited

... to tell their own narratives about who they are and how their own unique stories predispose them to particular ways of perceiving and knowing. The goal is for social work practitioners to understand how the selves they are and the background they bring to each encounter intersects with the stories of other social actors to produce particular meaning, understandings, or distortions. The larger question would be how racism is woven into their self-narrative (Kondrat, 1999).

The contextual features of self were not considered particularly important to therapists in the present study for a variety of possible reasons, one of which includes a possible lack of awareness of how much society shapes and informs their sense of self. This highlights a potential problem for therapists here in their therapeutic practises, and one that might be

rectified in further training and supervision. Consequently, future training and supervision may need to highlight the broader social, cultural and political frameworks in which therapy occurs, as well as the personal and individual self of each therapist.

Overall, training and supervision needs to facilitate therapists' own self-discovery and to adapt and modify those techniques and strategies that best suits their own needs and that of their clients. This study has been able to show how various therapists, from a range of theories, involve their self constructively in therapy; other therapists might also like to consider how they might involve their self in ways that are also useful to the overall therapeutic environment.

Counselling theory and research

This study centered on transcripts from 16 experienced and inexperienced counsellors, from a range of orientations. This 'practical wisdom' is sometimes dismissed as idiosyncratic, anecdotal, and atheoretical (Polkinghorne, 1992). A research climate that nominally requires scientific credentials has disadvantaged many investigations into the counsellor's self. However, an applied knowledge base has paradoxically been shown to be integral to the professional socialisation and development of counsellors, once formal and institutional learning has been completed (Orlinsky et al., 2001; Skovholt & Rønnestad, 1992). This integrative study extends previous research by articulating how a range of therapists describe and experience the self when working with clients.

There have been several attempts in recent years to manualize and standardize therapy (Elkin, 1994; Wilson, 1996). This approach to therapy and research is based on the premise that articulating an empirically tested procedure in the form of a manual for other therapists to follow will guarantee success. However, whilst every effort is made to control various client and therapist variables, different therapy outcomes are still found (Ahn & Wampold, 2001; Castonguay et al., 1996; Lambert, 1989; Luborsky et al., 1985). This study has shown that different therapists involve their self in many and varied ways and may account, in part at least, for some of these differences. Furthermore, the various

techniques often prescribed within a manual are generally based on the therapeutic relationship and the quality of this relationship depends to a large extent on the personal abilities and limitations of the therapist. Consequently, understanding how therapists involve their self in therapy and in particular the therapeutic alliance assists in understanding the different results generally found in manualized treatment approaches.

One of the common factors generally associated with effective outcomes across theories is the therapeutic relationship (Miller et al., 1997; Norcross & Grencavage, 1989; Prochaska & Norcross, 1999). Horvath and Luborsky (1993) for instance, found that at least ten per cent of psychotherapy outcome across different psychotherapies is attributable to the quality of the therapeutic relationship. How therapists go about forming this relationship is still, however, unclear. This study is not able to demonstrate that the counsellor's self is associated with effective outcomes. It has, however, been possible to identify that the counsellor's self is important for many therapists, across a variety of theoretical orientations, in the process of building relationships, specifically by connecting, respecting and understanding clients. The counsellor's thoughts, feelings, personal style, beliefs and past experiences were all important in building an effective and trusting alliance with clients for many, particularly female therapists. More research is required in the area of the counsellor's self and relationship building, to ascertain how other therapists go about building a relationship and the role of self in this process.

In this study, the counsellor's self has been a concept that 16 therapists, from a variety of theoretical orientations, were able to describe and relate to, in their therapeutic practice. Even though differences were noted, particularly in the importance and use of self in therapy, each of the 16 therapists acknowledged that the counsellor's self was a feature of the counselling environment. Accordingly, it may be argued that the counsellor's self is a common factor across theories, rather than being theory specific. Just as the therapeutic relationship is a common factor across a variety of theoretical approaches, though at the same time differs in terms of type and importance, the counsellor's self may also be regarded as a common factor, for the 16 therapists interviewed here. Further work is regarded from a large sample group of therapists to verify these arguments.

Problems and limitations in the present study

The key problems and consequent limitations of the present study are the subjectivity of participants and the researcher.

The data collected from the interviews collectively form the basis of what participants were able, and willing, to disclose about the self of the counsellor. The extent of each counsellor's self-awareness and their willingness to disclose to me, the interviewer, represents both a fundamental flaw and strength in methodology. Participants, for example, cannot report aspects of the self unknown to themselves, or deceive themselves about, consciously or unconsciously (Jopling, 1997; Luft, 1984).

My own subjectivity, as the researcher, is another potential limitation to the present study. As the researcher and interviewer I have been actively involved in every part of this project, and so my own insights and biases are potentially my greatest resource, as well as limitation. However, that I was able to also represent other points of view, such as the suppression and neutralization of the counsellor's self, demonstrates that I am able to listen for, and consider alternative view points of my own.

Another problem in the methodology of the present study is that while confidentiality was assured, the therapists presenting for interview were not anonymous to me. I got to know them and may see them at professional gatherings in the future. Regardless of the ethical procedures carried out (that is, providing participants with a list of therapists for debriefing; guaranteeing confidentiality) participants may still have been reluctant to discuss deeply personal and/or negative aspects of self. In addition, as many more therapists were sent letters inviting them to participate in the interview process, the therapists interviewed here represent those most interested in the research topic and were perhaps more open to explorations about the self in the counselling context.

While the views expressed by the participants need to be interpreted within the context of this research project, important issues might nonetheless be drawn and tentatively discussed in terms of integrative or common factors research. Finally, this study did not consider client experiences or other outcome measures and this also might be addressed in future studies.

Future studies and directions

The focus of this thesis was to consider how therapists describe and experience the self that they bring to therapy. The focus was not on client's experience of the counsellor's self. Consequently, client's experiences and perceptions of therapists, from a range of theoretical orientations, might provide useful research in the future. Of further potential value would be to compare those therapists who consciously suppress the self with those counsellors who actively involve the self in therapy, and examine differences in terms of outcome efficacy and client satisfaction. The role of self within the therapeutic alliance might also be further investigated. Therapist satisfaction, burn out and stress are other factors that may also be linked to the counsellor's self and could be considered in future research.

Epilogue

Here, my perspectives, in terms of the self that I bring to my clients, will be outlined and aim to provide closure to the prologue outlined originally.

I have found that who I am, as a therapist, has changed throughout the course of this thesis. The process of writing a literature review and interviewing other therapists has challenged and extended the way I think about myself and my sense of self, and in many ways clarified my original thinking. The differences found amongst all the 16 therapists I interviewed confirmed my original premise that in spite of similarities noted, we are all different, and we all counsel differently.

One of my original premises was that the counsellor's self had the potential to be helpful as well as harmful. The participants I interviewed, however, did not articulate this and instead suggested that the self that they bring to therapy was positive and useful, even if the self outside of therapy is not. I still consider it important and ethical for therapists to acknowledge how they might contribute to problems occurring in therapy, rather than blame or otherwise defer negative outcomes onto the client. I do not think, however, that the counsellors I interviewed would disagree with me here. Nonetheless, they do seem to say that the self that they bring as counsellors to therapy is useful and manageable and that they have managed to transform or otherwise moderate potentially negative aspects of self whilst in the counsellor role.

The major difference I think is that I consider my own weaknesses as a counsellor and a person, for instance, my fear of conflict and argument, to be still current. However, while this is reflected in my reluctance to be assertive or challenging, rather than not challenge at all, I might tentatively point out inconsistencies that I see, and then carefully monitor the client's overall reaction. I know that I am still fearful of conflict, but will nonetheless risk a potential disagreement with a client, if I have had a chance to think about the issues at hand, and I am reasonably clear about what needs to happen for therapeutic change to occur. Nonetheless, I am not too surprised when I have missed a chance in therapy to

provide an effective, challenging statement or some other opportunity that might potentially result in conflict. The therapists I interviewed who acknowledged the presence of their own unresolved personal issues appear to have resolved or otherwise managed these, and I cannot say the same for myself. Those parts of my self that I consider inadequate or undeveloped are still current, and sometimes (though not always) impacts on my therapeutic work with clients.

While there are many calls from the literature for therapists to be skilled, ideal, professional and competent, I now most relate to Connor's (1994) concept of being a 'good enough' therapist and acknowledge that I will never be the perfect or ideal therapist, for each client that I might see. When I look back over my personal and professional life I can see that I have constantly endeavoured to make my 'self' better, by being more 'professional', educated and knowledgeable. When I was a young adult, I can remember saying to a friend that I did not want to make any mistakes in my life; he laughed at me and said that he wanted to make as many mistakes as possible. I think I only now understand what he meant, and how he wanted to live his own life. Consequently, rather than continually wanting to change and 'better' myself, I think I am now, tentatively at least, reaching a point of self-acceptance so that I may now allow myself to 'have a go' and take a few, well calculated risks. I understand that I cannot wait indefinitely for my various negative attributes to be developed, or overcome. I would probably be waiting forever, and may never get the opportunity to use my self in my therapeutic work.

The research project has taught me that the self that I present to clients needs to be robust, strong and sturdy, though at the same time accept, with leniency, my own limitations and imperfections. Thus, while I may try to change parts of myself, I also understand and accept that I will not work well with all my clients all of the time. I find myself accepting this, and do not, as one of the participants described in her interview, 'beat myself up about it'. This is reflected in my belief about the usefulness of self, while at the same time acknowledging the risks its involvement might potentially entail. Consequently, rather than see my self in terms of black and white, that is either good or bad, positive or

negative, I think that I have come to a point of acceptance that is neither one way nor the other, but instead just 'is'. Perhaps many participants hesitated to describe their self as negative because they accepted who they are, without trying to judge or qualify themselves. As I learnt from some of the participants, I think that those parts of my 'self' as a therapist that I have always considered inappropriate or non-facilitative, may not necessarily be detrimental all the time and with all clients. For instance, the part of my therapeutic style that dislikes change and conflict may well be suited to some clients better than others and consequently is neither good nor bad, but just is 'me'.

I have also learnt that it is important to focus on the client as well as on me, the therapist. My original counselling training was predominately 'client centered', and tended to ignore what was happening for me, as the therapist. This 'other' oriented focus can also be seen in much of the research methodology I was exposed to as a psychologist, which advocated objectivity and science as the best guarantor of competence and subsequently shunned subjectivity.

The therapists all talked about the importance of self-awareness and demonstrated an objectivity of self throughout the course of the interviews. Many therapists at the same time actively and seemingly effectively involved their subjective experiences and sense of personal being (and knew when not to) in their therapeutic practices. Acknowledging and involving my feelings, thoughts and reactions, and at the same time being aware of myself as an ethical and professional therapist, mirrors the two seeming opposing approaches of subjectivity and objectivity. Accordingly, I can see that I am both a part of the therapeutic environment as well as separate from it. Rather than conceptualizing these elements as competing dichotomies, that is, science versus or art, or objectivity versus subjectivity, I would argue that both approaches are required for the therapist in the use and involvement of self. Consequently, rather than an either-or situation, I have come to the conclusion that both stances provide different answers and strategies for therapists and that both processes are important in the use of self.

Consequently, rather than turn ‘outside’ of myself, I now realize that I am able *also* to turn within, to my own self, my not perfect and not without blemishes self, but who I am; that is, someone honestly interested in what my clients have to say and someone who aims to facilitate positive change in clients. In addition to skills, technique and theory, which all participants said was important, there ultimately remains me, the person of the therapist, that is, who I am, and how I live.

Looking back I think that part of my motive for doing research in this area was to know more about my self as a therapist, and I optimistically thought that by talking to other therapists I might get some answers or otherwise resolve some of these issues myself. In many ways this journey is far from being completed but nonetheless, I have learnt several key things about my self as a therapist, and as a person. I have learnt to accept myself, and rather than block or deny my feelings, reactions, and inner sense of being, I have learnt to accept these as a part of who I am. Simultaneous self-understanding and acceptance seems more important to me now than at the start of my dissertation, and not just for my sense of well being. My self understanding and acceptance, even if partial and biased, are what I have to offer my clients and perhaps may serve also as a role model for their own self understanding and acceptance.

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Appendix A: Interview guide

To be read to all interviewees prior to interview,

This is a purely voluntary interview. If you decide at any stage during or after the interview that you wish to withdraw you may do so. Any data already collected will be turned over to you for disposal and not used in the thesis or related reports.

Ensure that the consent forms are signed and participants understand the minimal psychological risk that this interview may entail. Accordingly, the following is also read out to each participant.

A study investigating who you are, as a counsellor, may, by its very nature become personal to you. If this is in any way upsetting or distressing you are able to stop the interview at any time. You are also able to contact the following counsellors for professional debriefing.

Provide participants with the list of professional counsellors from across the region. If the interviewee has previously agreed to have the interview audio taped, check that this is still acceptable prior to starting the interview.

Initial demographic data to be asked of each participant:

Code:

Gender:

Years experience as a counsellor:

Qualifications reached to be a counsellor:

Amount of your day that is spent in counselling?

What theoretical orientation or orientations, if any, is most closely aligned with the way you counsel?

In order to obtain a shared understanding of the terminology of the thesis, and before the first question was given the following was asked,

This is a study about what you bring as a person to therapy. This involves who you are, as a therapist. The literature sometimes calls this concept the ‘self’ or ‘person’ of the counsellor. What do you think is the best term or phrase to describe this concept?

The first group of sample questions relate to describing the self that therapists bring to therapy. They may not be used with all participants.

**What does this concept (the counsellor’s self or person) mean for you?
Does it exist for you? What is it?
What do you bring as a person to therapy?
How do you describe the self that you bring to therapy?
What are the personal qualities you bring to therapy?
What are the different aspects of your self or person when counselling?
What aspects of the self that you bring to therapy are positive or useful to therapy, if any?
What personal qualities do you bring that are useful or positive?
Is the self that you bring to therapy positive?
What is positive about the self you bring to your clients?
What aspects of self that you bring to therapy are unhelpful or negative in therapy, if any?
What personal qualities do you bring that are not so useful or negative?
Is the self that you bring to therapy negative?
What is negative about the self you bring to your clients?
Do you bring your unresolved personal issues to therapy?
Do you bring any personal limitations to therapy?
Does the counsellor’s self or person include both positive and negative aspects? How is this so?
Does the counsellor’s self or person include private and public aspects? If so, in what way?**

The second part of the interview focuses on how the counsellor’s self/person/who you are, is manifested in therapy, if at all. Questions are also asked to gauge whether the self contributes positively or negatively to therapy. Accordingly, the questions are;

**How is your self or person a part of therapy?
If your self or person is not a part of therapy, how is this so?
Is your self or person present during counselling? If so, how? If not, explain how this is the case.
How is your self a part of your therapeutic practices, if at all?**

What have you got to offer your clients, as a person? Is this useful? If so, in what ways? Is this in any way unhelpful? If so, how?
How are your personal qualities manifested in therapy?
How does your self contribute helpfully to therapy, if at all?
How do the personal qualities you bring to therapy contribute positively in your therapeutic work?
How does your self contribute in ways that are not so helpful, if at all?
How do the personal qualities you bring to therapy contribute negatively in your therapeutic work?
Do you ever make errors in your therapeutic practice? If so, are these errors attributable to who you are, as a person?
Does your self or person impact negatively and/or positively on counselling? Explore the various ways this might be so.
Are there ways in which you involve your self differently as a therapist than in other relationships in your life? How might you support a friend as opposed to a client? What are the differences? Similarities?
Do you involve your self differently with different clients? Why? In what ways is this so?
What interventions do you use, or not use because of your self? Explain how this is part of your counselling.
On what basis do you decide which counselling interventions to use? Do you use your self for this?

At the end of the interview remind participants about the list of professional counsellors that they may access if need be. Also let participants know that transcripts of their interview will be sent to them, at a later date, for changes, amendments or confirmation. Ask participants if they have any concerns or queries they still have, and thank wholeheartedly for their support.

Appendix B: Letter to professional bodies

(A similar letter was also sent to the coordinator of the local social worker interest group)

La Trobe University,
Albury/Wodonga Campus,
Parkers Road,
P.O.Box 821,
Wodonga, 3689
02 60 583865

To the local Branch President of the Australian Psychological Society,

Re: contact details for registered psychologists in the Albury/Wodonga area.

My name is Andrea Reupert and I am a PhD student at La Trobe University, Albury/Wodonga campus. The focus of my thesis is what is sometimes referred to in the literature as the counsellor's self or person, and how, if at all, it is involved, in the counselling environment. This letter requests a list of registered psychologists in the Albury/Wodonga area. A reply paid envelope is enclosed.

I aim to send the attached letter to registered psychologists and social workers in the local area. The study's design involves in-depth, semi-structured interviews, and requires responses from counsellors across a variety of theoretical orientations. Confidentiality will be maintained for all interviews, with no names of any participants ever being used. However, the results of the study may be published. The safekeeping of all collected data will be maintained in a secure file at the home address of the researcher.

The process of interviewing will provide counsellors with an opportunity for self-reflection, and the chance to discuss what they feel is important in this area. This

research will make a significant contribution to the counselling field. If you have any queries regarding this study please do not hesitate to call me on 02 60 567 265.

Any further concerns or queries regarding the conduct of this study may be addressed to the supervisors of the study, who are

Dr. Lorraine Ling, and Dr. Bernie Neville,
La Trobe University,
Bundoora 3083 (03) 94791111

In the event that these supervisors are unable to resolve an issue, please contact,

The Secretary, Human Research Ethics Committee,
Student Administration Building,
La Trobe University,
PO Box 1999,
Bendigo 3552.

Your support in this study is appreciated,

Sincerely yours,

Andrea Reupert.

Appendix C: Letter sent to potential participants

La Trobe University,
Albury/Wodonga Campus,
Parkers Road,
P.O.Box 821,
Wodonga, 3689

02 60 583 865

tea bag
attached to
right hand side
of letter

Dear participant,

Re: A request to participate in a study into the counsellor's self.

Dear Colleague,

Your help would be most appreciated in a study that I consider is important to the field of counselling. So please have a cup of tea on me and consider my proposal.

PhD study into the counsellor's self:

I am undertaking a PhD at La Trobe University in the area of what is sometimes known in the literature as 'the counsellor's self' or 'person'. In spite of the importance of the counsellor's self or person in the training and supervision of counsellors, there is no consensus across the literature, about the use of the term 'counsellor self'. The goals of this study are to obtain from practising counsellors their perspectives regarding the counsellors self or person, and how (if at all) the counsellor's self or person is involved in counselling. The self or person of the counsellor may be the vital ingredient that enhances effective psychotherapy and consequently warrants further investigation.

This study's design is based on interviewing counsellors across a variety of theoretical orientations. Confidentiality will be maintained throughout all interviews and no names of any participants will be used. However, the results of the study may be published. The safekeeping of all collected data will be maintained in a secure file at the home of the researcher.

Interview format:

Proposed interviews with counsellors will be conducted at a location convenient to you (either the university campus or your place of work)) and will take approximately one to two hours.

The interview is semi-structured but is concerned with the following issues,

This is a study about what you bring as a person to therapy. This involves who you are, as a therapist. The literature sometimes calls this concept the 'self' or 'person' of the counsellor. What do you think is the best term or phrase to describe this concept?

What is the concept you think these terms are trying to convey? What do you think is the best way to describe your self or person, as a therapist?

How is your self or person manifested in therapy, if at all? How does your self or person influence your therapeutic practices, if at all?

Possibly you may feel some hesitancy when meeting an unknown interviewer (Andrea Reupert) when you are in the role of interviewee. I am a registered psychologist and have worked as a counsellor for 12 years, in a variety of work places including schools, prisons, unemployment and rehabilitation agencies and in private practice. I have supervised numerous counsellors and have taught counselling theory and skills at a tertiary level.

The interview may provide you with the opportunity for self-reflection and the chance to discuss what you consider to be important in this area. This study aims to ask counsellors

their views about who they are as a counsellor in therapy, what this means for them, and how it may influence their counselling. Consequently, the interview may be personally revealing for people, and in this way entails a slight psychological risk for interviewees. The study is concerned with how your own ‘self’ shapes your work as a therapist, rather than on your own personal details. As such, I perceive it entails a slight risk only. In any case, a list of professional counsellors and their contact details will be made available for interviewees if the interview is in any way stressful.

Ethical considerations:

Participants may withdraw from the study at any time and any material collected from the withdrawing counsellor will be destroyed, so it is not included in the study findings. In addition, transcripts of each interview will be made available to each individual, after the interview. The participant will be invited to amend, change or delete any information regarding their original interview. Again, all documentation regarding the interviews will be securely filed at the home address of the researcher. Ethics approval has been given for this study by the Human Ethics Committee at LaTrobe University Faculty for Regional Development at Bendigo Campus, HRE approval number A 43/01.

Responses of counsellors will be audio taped for the purposes of data transcription and analysis. If, for any reason, a participant would like to participate in the study, but does not want the interview recorded, please let me know on the enclosed form.

This research will potentially make a significant contribution to the counselling field. If you have any queries regarding the study please do not hesitate to call me on 02 60 583 865. Enclosed is a form for completion. Please return by 1st November 2001, in the reply paid envelope provided.

Any further concerns or queries regarding the conduct of this study may be addressed to the supervisors of the study, who are

Dr. Lorraine Ling, and Dr. Bernie Neville,
La Trobe University,
Bundoora, 3083.
(03) 9479 1111

In the event that these supervisors are unable to resolve an issue, please contact,

The Secretary, Human Research Ethics Committee,
Student Administration Building,
La Trobe University,
PO Box 199,
Bendigo. 3552.

Your support in this study is appreciated,

Sincerely yours,

Andrea Reupert.

Participant's Agreement Form (sent with the letter to potential participants).

I have received information regarding a study into 'the counsellor's self' or 'person'.

I agree to be interviewed as part of this study.

I give/do not give my consent to this interview being audiotaped.

Signature of Participant _____ Date _____

Name: _____

Contact details: _____

Please complete this form and send it in the enclosed reply paid envelope.

Thankyou, your support is much appreciated. Andrea Reupert.

Appendix D: Participant agreement form

Participant's Agreement Form

(Participants to fill out before the interview commences)

I _____ understand that this study will examine my views regarding 'the counsellor's self' or 'person'. I have understood this information and I agree to participate in the study. I know that the data may be published and/or will be made available to other researchers upon its completion. I have been briefed as to the possible psychological risk this may entail. I have been given the names and telephone numbers of counsellors in my local area that I am able to contact if I feel the need to discuss this further. I know my name will not be used and that I may withdraw from the study at any time. I give consent to this interview being audiotaped. If I withdraw, I know the material I have given will be destroyed.

Signature of Participant _____ Date _____

Signature of Investigator _____ Date _____

Appendix E: List of professional counsellors for debriefing

If the interview is in any way distressing to you please contact one of the following professional counsellors. Those therapists that are in private practice will charge me for their services, without informing me of your name.

Professional counsellors available for debriefing include:

Lifeline

24 hour telephone counselling:	13114
Face to face counselling:	60 211077

Les Langmead,	60 244 759
Wodonga.	

Sherbrooke Consulting Psychologists,	
Wodonga.	60 566 567

Nexus Consulting Services,	
Wangaratta.	60 561 551

Appendix F: Letter sent to participants regarding their interview transcript

La Trobe University,
Albury/Wodonga Campus,
Parkers Road,
P.O.Box 821,
Wodonga, 3689

02 60 583865

Dear (participant's name),

Thank you for participating in the PhD study about the 'counsellor's self' or 'person'. Please find enclosed a verbatim transcription of your interview.

I would like to invite you to read through this transcription. You are encouraged to change, modify, delete and otherwise comment on any part of this interview. I would suggest you make these changes on the actual transcription, in the margin. Additional comments and suggestions are also encouraged, and I would suggest that you write these on the brief questionnaire enclosed, or on the back of any of the sheets. I have prepared a brief questionnaire with the central themes of this thesis and this is also enclosed. Once finished, please send the sheets back to me in the enclosed, stamped envelope.

Any further concerns or queries regarding the conduct of this study may be addressed to the supervisors of the study, who are

Dr. Lorraine Ling, and Dr. Bernie Neville,
La Trobe University,
Bundoora, 3083.
(03) 94791111

In the event that these supervisors are unable to resolve an issue, please contact,

The Secretary,
Human Research Ethics Committee,
Student Administration Building,
La Trobe University,
PO Box 199,
Bendigo. 3552.

Again, thank you for your time and effort in the study so far. The results at this point look interesting. With your assistance I hope to make a worthwhile contribution to counselling literature.

Your support in this study is appreciated,

Sincerely yours,

Andrea Reupert.

Appendix G: Questionnaire

SHORT QUESTIONNAIRE

This is a study about ‘who you are’ as a counsellor. The literature sometimes calls this concept the ‘self’ or ‘person’ of the counsellor. If you have any additional comments or suggestions I would encourage you to please make these here.

What does the term mean, the counsellor’s ‘self’ or ‘person’ ?

How is your self or person, as a therapist, manifested in therapy (if at all)?