THE ART OF COLLABORATION: CREATING BESPOKE THERAPY WITH THE CLIENT

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PREFACE

The evolution of my doctorate portfolio begins in Australia. I remember a family member taking me to see a friend of his who was in hospital and was HIV positive. This was in the 1980's; I was very young, maybe ten. The nurses were very protective over me, I remember they seemed worried for me; the presence of such a young child seemed to make them nervous. We were told to keep our distance from the man that was sick and I was told that I probably shouldn't touch him. This felt like a 'just in case' sort of measure. The family member I was with told me that his friend was sick and we were going to hold his hand, be close to him and stay with him for a while. I remember thinking that this sounded like a much better idea. I don't remember any exact details of the conversation we had with this sick man but I remember feeling like he was on his own, that this was sad and that it had something to do with HIV.

The family member later described in detail what the illness was and more importantly at that time, what it wasn't. It seemed to me that the usual level of compassion for someone so sick was lacking for this man because of the particular illness that he had. This made no sense to ten year old me. I found the stigma confusing and fascinating. Therefore, at a young age, I had some ideas and feelings about HIV. I thought it was an illness without a cure, that lots of people didn't seem to know much about it and that some people thought that if you had this illness you were probably of questionable character in some way.

Next stop in my journey is London. In my undergraduate course at university I came across HIV from the point of view of health psychology. HIV was vastly different to the illness I experienced in my childhood. HIV was now a chronic illness and there was effective medication that did not cure but facilitated a greater ability to 'live well' with HIV. The demographic of people being diagnosed was changing and statistics were showing that HIV was not exclusive to the gay or drug using communities. Possibly the most shocking statistics were that of sub-Saharan African regions where the illness was now

being described as an epidemic. It seemed to me that on the whole people were more informed but still a strong stigma remained.

A few years later I trained and worked with the Terrence Higgins Trust for a period of three years. This is a charity that supports those who have or are in any way affected by HIV. I worked as a volunteer on their helpline and attended several workshops about sexual health, sexual practices of several different communities, transmission of HIV, living with HIV, the rights of people with HIV and medical advances with combination therapies. During this time I accepted much of their ethos when working with HIV positive people:

1. Everyone's sexual health is his or her own responsibility. Not just the responsibility of those with HIV or a sexually transmitted disease.
2. Do not judge others sexual behaviours.
3. Keep up to date with sexual terminology and practices of all sexual cultures.
4. When speaking to clients, use the terminology they use taking into account your own comfort zone.
5. Keep up to date with legal, social and medical changes within the HIV community.

I began to research what counselling psychologists could do to develop this area further in order to better assist their HIV positive clients. I wrote my literature review on this topic in 2005 and this is included in this doctorate portfolio. I explored the history of HIV and the psychosocial effects; I explored counselling HIV positive clients when HIV was a terminal illness and the areas where counselling psychology could develop further in assisting this client group. One of my conclusions from this literature review was that the context in which HIV positive clients live and the individual experiences of these clients seem to vary and have a great impact on the client's quality of life. I struggled with which model of therapy might best fit the needs of this client group. The more HIV positive clients I came into contact with the more it seemed that there didn't seem to be a simple, single answer to this question.

Through pure serendipity I found a research article by Mick Cooper and John McLeod (2007). I was in the first year of my doctorate and the article was on the table at one of my placements. The framework was called Pluralism and this was the name of the philosophy behind it also. The paper was inspiring. Pluralism was a philosophy that celebrated difference, respected culture and contextual factors of the human condition and advocates that different methods of discovery will work for different issues at different times: it is the antithesis of 'one size fits all' (Cooper and McLeod, 2007). I enjoyed and related to the rejection of a 'one size fits all' philosophy. I immediately thought of HIV positive clients and wondered how this community might experience this framework. The notion of bespoke solutions to issues based on contextual factors felt like it would be an exciting way to work as a psychologist and felt like it could meet the complex needs of the HIV positive community.

I got on a train and went to meet John McLeod in Scotland at the University of Strathclyde in Glasgow. This meeting further cemented in my mind that I wanted to see how HIV positive clients would interact with the Pluralistic framework in a psychological setting. This is also where John introduced to me Daniel Fishman's pragmatic case study design and the postmodern concept of the pragmatic paradigm. This paradigm has been described as 'the gap between truth and justification' (Rorty, 1991:22). Research acknowledges an external world but also acknowledges that this external world exists in a context and has in itself a culture that must be taken into account. The researcher is part of this context and therefore must also be acknowledged. Pragmatism also takes the view that in research you 'do what works' (Fishman, 1999). In other words you chose the methods of research based on the subjects or objects you are researching (Fishman, 1999).

This postmodern concept reflects my own disenchantment with psychological research being purely based on positivist notions of truth. Positivists hold the belief that there are universal truths that can only be found through systematic research that centres on 'prediction and control' and artificially constructed 'cause and effect' research sequences (McLeod, 2003:7). One of the

assumptions of the positivist approach is that there is a consensus within scientific methods: that 'the same methods are applicable in all fields of knowledge' (McLeod, 2003:7). I did not wish to reject positivist notions of research as I feel they can be an important part of the research process; but I did feel that they were not adequate to fully encapsulate the experience of my participants.

Keeping in mind my participants and the sort of research I wished to produce I tried to find a form of data collection and analysis that would best fit. After reading about the various forms of qualitative analysis I came across Kathy Charmaz's version of grounded theory (2006). The notion that truth is something that is constructed through interactions between the researcher and what is being researched seemed to fit with the epistemological stance of the pragmatic case study design. Additionally, this concept of knowledge also seems to fit with the pluralistic framework. Pluralism recognises contextual factors of the human condition and advocates that

'Different explanations will be true for different people at different points in time and therefore different therapeutic models will be most helpful for different clients at different moments' (Cooper and McLeod, 2007:6).

During my time on the three-year doctorate course at City University I found that my interest in Pluralism led me to exploring many ways to work with clients. I explored my interest in recognizing the context in which clients live, working at relational depth and creating bespoke therapy for clients. I feel the case study that I have included in this doctorate portfolio reflects these interests. Even though I worked with this client using the person-centred model instead of a Pluralistic approach I feel my work was influenced by some of its philosophy. Pluralism advocates collaboration with the client in order to create an authentic therapeutic relationship. I feel that due to the level of collaboration and congruence between the client and myself that we were able to create an authentic therapeutic relationship. Due to the development of this strong therapeutic bond we were able to work at relational depth and achieve what the client wanted to achieve. When I asked the client at the end

of the therapy what was most helpful for her she told me that it was our relationship and the sessions when I was being just ‘human’ and ‘real’ with her that were most helpful. This was a learning curve for me professionally. I wanted to collaborate more with my clients, I wanted to concentrate more on what my clients were asking for and then find creative solutions to meet their needs. Additionally, the questions I was asking myself was changing. I was no longer asking which model would best fit clients. Firstly, I was asking myself how can I best use the therapeutic relationship to create a shared understanding of the client’s specific set of issues and the context in which they experience these issues? Secondly, I was asking myself how best to creatively use this shared understanding in order to meet my client’s needs? I was also asking what is it that my clients truly want from therapy?

Therefore the link between the sections of work in my doctoral portfolio is that each of them illustrates my commitment to creating bespoke therapy with clients. The particular emphasis in each piece of work is on collaboration, the therapeutic relationship and being aware of the context in which the client lives.

PART I

HIV POSITIVE CLIENTS AND PLURALISTIC THERAPY: AN EXPLORATION USING GROUNDED THEORY STRATEGIES

ABSTRACT

Introduction

Living with HIV has been described as a process of constant adjustment and re-adjustment as the person attempts to create both a good quantity and quality of life (Pierret, 2000). Most of the literature from the counselling psychology community has focused on the efficacy of cognitive behavioural therapy for this client group however; some of the theory behind this model has been questioned in relation to the needs of the HIV positive community. The current study explored the process between three HIV positive clients and twelve sessions of pluralistic therapy.

Method

Twelve pluralistic therapy sessions with three HIV positive clients were audio recorded. The participants were recruited from the waiting list of a specialist HIV mental health service in London. Grounded theory strategies were used to analyse the transcriptions of the therapy sessions. Feedback sessions were also conducted with each of the clients in order to gain insight into their experience. The client work and analysis is presented in three pragmatic case studies.

Results

Goals: These HIV positive clients had specific 'relational goals' for therapy. More specifically, the goal was to have the experience of being the 'expert' in the room. **Tasks:** A common theme was 'self care' and increasing quality of life. **Methods:** The therapeutic relationship was found to be a method within the pluralistic framework. A common element for all three clients was the absolute importance placed on 'creating a shared understanding' between the client and the therapist.

CHAPTER 1: INTRODUCTION

The purpose of this chapter is to explore the literature pertaining to the HIV positive community and how the counselling psychology community has worked with and researched this client group. This chapter also introduces the concept of pluralistic therapy and the research that I have conducted. More specifically this chapter will firstly introduce the topic of the Human Immunodeficiency Virus and some of the mental health issues that can accompany this diagnosis. Secondly this chapter will explore some of the models of counselling that are traditionally used with HIV positive clients and the efficacy of these models for this client group. I will also explore some of the methodological and focus issues within HIV research. This is followed by a brief critique of unitary models of counselling and their efficacy for HIV positive clients. The literature pertaining to the common factors in counselling that are suggested to be trans-theoretical in nature is also explored as well as the integration of unitary models. Lastly an overview of the pluralistic framework and the research relevant to this framework is discussed followed by the focus of this research and my specific research question; how do HIV positive clients experience the process of pluralistic therapy?

Definitions

HIV

Human Immunodeficiency Virus (HIV) is a virus that diminishes the efficacy of immune system functioning, disabling the body from fighting off infections and disease (Penedo, Gonzalez, Dahn, Antoni, Malow, Costa, Schneiderman, 2003).

AIDS

Acquired Immune Deficiency Syndrome (AIDS) is a collection of illnesses that occurs when the immune system has been damaged to the point it can longer fight infection (Passer & Smith, 2001).

CD4 T-CELLS

'CD4 T-cells are a type of lymphocyte that co-ordinate the immune system's response to certain microorganisms such as viruses. HIV can infect and kill CD4 T-cells, as well as some other types of cell' (National AIDS Manual, 2010).

VIRAL LOAD

Viral load is the measure of the estimated amount of infection in the blood (National AIDS Manual, 2010).

HAART

Highly Active Anti Retroviral Therapy is medication for HIV positive people. HAART is also referred to as combination therapy.

WHO

The World Health Organisation

CHRONIC ILLNES

An illness that limits optimal functioning and can persist throughout a lifespan.

Introduction to HIV and AIDS

The Human Immunodeficiency Virus

Human Immunodeficiency Virus (HIV) is a virus that can gradually weaken a person's immune system that can diminish the ability of the immune system to protect against or fend off infection (Penedo et al, 2003). The fluids that the body produces that can contain adequate amounts of HIV to pass the virus from a HIV positive person to another person include genital discharge (semen, vaginal fluids and menstrual blood), a mucous that can be found in the rectum, breast milk and blood (McKeganey and Barnard, 1992). The most common ways for HIV to be transmitted from one person to another is through sexual intercourse, from mother to baby either during the birthing process or through breast feeding and from a HIV positive person's blood entering a HIV negative person's blood stream. It is possible for a HIV infection to affect many facets of a person's life such as their career, their relationships, their sex life, their financial situation, their identity, their mental health and more obviously, it can affect a person's physical health (Miller, Weber, Green, 1986). Sometimes the effects of the illness can force some complex lifestyle adjustments and the person can experience an overwhelming sense of loss as these adjustments take place (McKeganey and Barnard, 1992). This does not mean that it is impossible for a person with HIV to have a good quality of life; however, it does mean that some HIV positive people have to work very hard to reach the quality of life that they desire.

Statistics

A decline of approximately 3% of new HIV diagnoses was reported between 2007 and 2008 however HIV is reported to be the fastest growing serious health condition in the UK (Terrence Higgins Trust, 2010). More people are living with HIV in the UK than ever before. At present there are around 83,000 people living with HIV in the UK and the group with the highest rate of infection is men who have sex with men (Terrence Higgins Trust, 2010). However, since 2003 the highest rates of new infection have occurred through heterosexual sex (Terrence Higgins Trust, 2010). It is reported that approximately 58% of newly infected HIV positive people in the UK have be

infected through heterosexual sex (Terrence Higgins Trust, 2010). It was estimated in 2008 that 33 million people are currently living with HIV worldwide (Terrence Higgins Trust, 2010).

History and treatment

When HIV was first discovered and before medical research about how to treat the virus was produced HIV would almost certainly lead to AIDS (Terrence Higgins Trust, 2010). This means that immune system functioning would most likely be completely destroyed leading to death through opportunistic infections (Terrence Higgins Trust, 2010). Some of the literature suggests that the term AIDS is an antiquated way of discussing the illness and the term 'late stages of HIV' or 'advanced HIV infection' is actually preferred (Terrence Higgins Trust, 2010). Through advances in medicine it is now possible for some people who have HIV to live a normal life span.

Combination therapy is the use of three or more different medications in order to control and reduce the quantity of the virus (National AIDS Manual, 2010). Combination therapy can sometimes reduce the amount of HIV to a point where it is almost negligible however there still remains no cure for HIV. People using combination therapy frequently experience short term and/or long-term side effects from the medication. The short term side effects include fatigue, muscle aches, nausea, vomiting, diarrhoea, sleep disturbance, issues with their kidneys or liver functioning and issues with concentration span and mood swings (Whitaker, Vogele, Mcsherry and Goldstein, 2006). The long-term side effects can include weight loss or gain, diabetes, lipodystrophy, liver and kidney issues and peripheral neuropathy (Whitaker, Vogele, Mcsherry, Goldstein, 2006). There is also an increased risk of vascular problems such as heart attacks or a stroke as well as an increased risk of cancer (Whitaker, Vogele, Mcsherry and Goldstein, 2006). An increased risk of neuropsychological and neuropsychiatric problems is also possible which can include seizures, reduced cognitive functioning, memory loss, dementia and psychosis (Whitaker, Vogele, Mcsherry and Goldstein, 2006).

Even though pharmaceutical advances have increased the possibility of an augmented quantity of life it still remains challenging to achieve a good quality of life for this client group. Invariably it is possible for HIV positive people to live with many different physical issues and possible mental health issues for the rest of their lives.

Stigma

The physical effects of the illness are not the only elements that HIV positive people live with. Research that explored the attitudes and social acceptance of people with different impairments and disabilities used the Friedman Test in order to rank them in order of social acceptance (Deal, 2006). HIV was consistently ranked in the top three least acceptable impairments or disabilities to have (Deal, 2006). The discrimination resulting from HIV related stigma can be defined as mistreatment, negative attitudes and prejudiced beliefs and behaviours directed at people who are living with HIV. This stigma exists all over the world however the manifestation of this stigma takes many guises in many different communities, countries and religious groups.

HIV related stigma can be produced through people using the diagnosis as confirmation of their beliefs about communities that they consider socially unacceptable such as sex workers, people who use drugs recreationally or the gay, lesbian, bisexual transgender community. HIV related stigma can also occur in conjunction with other divisive elements of our worldwide community such as racism and homophobia. HIV related stigma can make it more difficult for a person to accept and acknowledge their diagnosis and because of this it can make it difficult for some HIV positive individuals to adhere to combination medications or commit to healthy ways of living that they may wish to pursue. Research conducted by (Antoni, Shneiderman, Klimas, Laperriere, Ironson and Fletcher, 1991) with HIV positive gay men suggested the individual's belief system could affect their ability to cope and can affect immune system functioning. Therefore it could be suggested that there is a possibility that stigma can hinder or even impede a HIV positive person's ability to cope on an emotional level but possibly on a physical level also.

This review of the statistics, the history of HIV and the stigma that can accompany this diagnosis show that this is complex illness that has evolved and changed over a short period of time. Feasibly it also suggests that this chronic illness that can affect almost every section of someone's life and still remains heavy with stigma.

Psychological Sequelae

The most commonly reported mental health issues reported in the HIV positive community are depression and stress (Miller, 1987; Bing, Burman, Longshaw, Fleishman, Sherbourne and London, 2001; Cruess, Petitto, Leserma, Douglas, Gettes, Ten Have, and Evans, 2003). It firstly should be recognized that these are all quite understandable responses to a diagnosis of HIV and/or the difficulties that come with living with this diagnosis (Miller, Hubble and Duncan, 1986). These psychological issues have been connected with the possibility of physiological disease development and further impairment of the immune system (Ickovics, Hamburger, Vlahov, Shoenbaum, Shuman, Boland, and Moore, 2001).

Depression

Depression can create quite serious issues for people living with HIV through its associations with the possibility of decline in CD4 cells and HIV viral load increase (Ironson, O'Cleirigh, Fletcher, Laurenceau, Balbin, Klimas, Schneiderman, and Solomon, 2005; Burack, Barrett, Stall, Chesney, Ekstrand, and Coates, 1993), progression to the later stages of HIV (Page-Shafer, Delorenze, Satariano and Winkelstein, 1996; Leserman, DiSantostefano, Perkins, Murphy, Golden, and Evans, 1994; Leserman, Petitto, Gu, Gaynes, Barroso, Golden, Perkins, Folds and Evans, 2002) and even death (Mayne, Vittinghoff, Chesney, Barrett and Coates, 1996; Patterson, Shaw, Semple, Sherner, Nannis, McCutchan, Atkinson, and Grant, 1996; Ickovics et al., 2001). Similarly, depressed mood has been related to higher levels of substance use (Dixit and Crum, 2000), higher possibility of sexual behaviour that could put them or others at risk (Kalichman, Kelly and

Rompa, 1997; Desquilbet 2003; Chin-Hong 2004; Vincent 2004) and poor adherence to combination therapy pharmaceuticals (Kumar and Encinosa, 2010).

A study conducted in the 1990s investigated depression from the early to the late stages of HIV in order to assess whether rates of depression change throughout this time and also to look at the predictors of depression as the illness develops (Lyketsos, Hoover, Guccione, Dew, Wesch, Bing and Treisman, 1996). This was the first study to assess the development and course of depression throughout the stages of HIV illness progression. The authors collected data over a ten-year period from nine hundred and eleven (n=911) HIV positive men.

The results of this study suggest that the rates of depression increased in the participants as the HIV infection progressed towards the later stages of HIV (Lyketsos et al, 1996). The authors also found that the most consistent predictor of the development of depression towards the later stages of HIV was the presence of depression in the earlier stages of HIV infection (Lyketsos et al, 1996). The authors suggest that this finding may indicate that depression in the late stages of HIV may be a relapse from the original depressive episode. However, one third of the participants that reported depressive symptoms in the later stages of HIV did not report these symptoms during the earlier stages of the infection meaning that one third of the participants experienced symptoms of depression for the first time during the later stages of the infection (Lyketsos et al, 1996).

A longitudinal analysis examined what effect depression had on rates of mortality and CD4 lymphocyte counts in over 700 HIV positive women for a time period of seven years (Ickovics, et al, 2001). Depression was measured by using the CES-D. The CES-D contains twenty questions that assess depressive symptoms that have occurred in the last seven days. At six month intervals the women were interviewed and physically examined. This established that those women who had long-drawn-out incidences of depression were twice as likely to die as women who had minor, limited or no

symptoms of depression (Ickovics et al, 2001). It was also suggested that depressive symptoms were allied with a decline in CD4 cell counts (Ickovics et al, 2001). However, the results of this analysis were limited by the use of the CES-D scale due to the fact that this is used as a screening tool rather than a rigorous psychiatric diagnostic tool for depression. Therefore, a clinical diagnosis of depression was not definitive.

Additionally, adherence to medication and the use of psychiatric treatment were not measured within the study and Ickovics and colleagues (2004) suggest that these may have had an effect on the results of the study (Ickovics et al, 2001). It was also reported that the effect of depressive symptoms on CD4 cell count decline may not have been clinically significant.

Ickovics and colleagues (2004) suggest that HIV disease progression may be different for each individual even though they may have the same CD4 cell count (Ickovics et al, 2001). In saying this there were a large amount of participants recruited and the study took into account indicators that have been shown to influence disease progression as well as psychosocial factors. Additionally, due to the longitudinal nature of this study, the effects of depression on disease progression were able to be tracked over a seven year period (Ickovics et al, 2001).

In another longitudinal study, psychosocial variables including depression were examined in relation to CD4 cell count and viral load in one hundred and seventy seven HIV positive men and women (Ironson et al, 2005). Unlike other studies, one of the significant methodological choices of this study was that the authors chose to control for adherence to HIV medication thereby allowing a more accurate measurement of the possible effects of the psychosocial variables (Ironson et al, 2005). Participants were assessed every six months for a period of two years and measures were taken through questionnaires, interviews and through taking blood. Depression was assessed using the Beck Depression Inventory (BDI) (Ironson et al, 2005). The results suggested that even when participants were using and adhering to a medical regime using HIV medication, psychosocial variables such as

depression still had a significant impact on their CD4 cell count and on the results of their viral load. However, due to the study only being over a two-year period it can only really make a predictive statement about this link. An additional strength of this study is that the authors chose to use a mixed cohort of men and women where other similar research has concentrated on gay, male participants (Ironson et al, 2005).

The research pertaining to depression and the HIV positive community suggests that even with effective medication, depression may still affect quantity and feasibly, quality of life (Ironson et al, 2005). This research also suggests that depression in this community may occur more than once over the lifespan and that the occurrence of depression is not always related to the later stages of the illness (Lyketsos et al, 1996). This research also highlights some of the methodological issues of studying and diagnosing depression in this population as the confounding variables such as medication, and the effects of the illness itself can be problematic to control for.

Stress

Another commonly reported mental health issue within the HIV community is stress (Miller, Weber, Green, 1986**;** Miller, 1987; Kalichman and Catz, 2000; Segerstrom and Miller, 2004). The source of stress related to HIV can come from a vast variety of sources including physical symptoms, stress about death or dying, facing stigma, financial, relationship and employment stressors as well as stress from issues surrounding disclosure (Miller, 1987; Kalichman and Catz, 2000). Much of the research focuses on the possible effects that stress can have on immune system functioning and disease progression and the mediating variables that are associated with the process of stress (Vadhara and Nott, 1996).

Segerstrom and Miller (2004) conducted a meta-analysis of nearly 300 studies that examined the effects of stress on immune system functioning in both healthy and medical populations including studies relating to the HIV population (Segerstrom and Miller, 2004). The results of this meta-analysis suggest that variables such as age and disease can affect the usual flexible

response of the immune system to stress that can be seen in healthy populations (Segerstrom and Miller, 2004). The authors highlight that due to the disabling effects that HIV has on immune system functioning, HIV positive populations are more susceptible to the 'negative immunological effects of stress' (Segerstrom and Miller, 2004:620). Therefore it could be suggested that a reduction in stress or the increased ability to deal with stressors may have an effect on immune system function in the case of the HIV community. Improvement in immunity for this client group could mean a longer lifespan as well as an improved quality of life within this increased lifespan.

Another study concerning HIV and stress also found an association between stress and disease progression (Leserman, Petitto, Gu, Gaynes, Barroso, Golden, Perkins, Folds and Evans, 2002). The focus of this study was to examine the association between 'life events, social support, depressive symptoms, anger, serum cortisol and lymphocyte subsets with changes in multiple measures of HIV disease progression' (Leserman et al, 2002:1059). The authors recruited ninety-six HIV positive, gay men from the North Carolina region for the purpose of a longitudinal study over a period of nine years. Both psychosocial and physiological measurements were taken every six months except for the social support variable which was measured once each year.

A modified version of the Psychiatric Epidemiology Research Interview (PERI) (Dohrenwend, Krasnoff, Askenasy, and Dohrewend, 1978) was used to create a list of stressful life events and then these stressors were rated. The severities of symptoms of depression were assessed using a revised version of the Hamilton Depression Rating Scale (HDRS) (Hamilton, 1960). The revisions made to this scale were to account for symptoms of HIV that may overlap with symptoms of depression such as weight loss. The Brief Support Questionnaire (Sarason, Sarason, Shearin, and Pierce, 1987) was used to assess participants' satisfaction with levels of social support they were receiving; measurements of anger were also taken. Physiological measures were taken through cortisol measurements and taking blood to assess

participant's immune system functioning and more specifically, CD4 cell count and viral load.

The results of this study suggested that an above average number of stressful life events coupled with a below average amount of social support predicted faster disease progression (Leserman et al, 2002). More specifically, for every increase of one point in the stressful life events variable the possibility of disease progression rose by 14% in respect to progressing towards a diagnosis of AIDS or the late stages of HIV. Additionally, the potential for developing an 'AIDS clinical condition' rose by 35% (Leserman et al, 2002).

Although this study has used a large cohort and accounted for appropriate control variables such as CD4 cell count, age, race and medication the participants are quite a specific group and therefore there may be problems with extrapolating the study's findings to other populations. Other studies have noted that HIV positive women may have a different experience of depression and stress than HIV positive men (Ickovics et al, 2001). Additionally it is problematic to infer a causal relationship between the measured variables such as anger, social support and depression and disease progression. Because of the complex nature of HIV it is difficult to know whether these variables actually cause disease progression, or whether they are a result of a HIV diagnosis and disease progression.

The research pertaining to stress and the HIV positive community suggests that stress can come from a wide range of sources such as financial stressors, challenges in relationships and issues around employment (Miller, 1987; Kalichman and Catz, 2000). The research also suggests that HIV positive people are more likely to experience the immunological effects of stress than the rest of the population (Segerstrom and Miller, 2004). Due to the effects that stress can have on immune system functioning, stress has been associated with disease progression (Ickovics et al, 2001).

Approaches to counselling HIV positive clients

Research into how counselling psychologists can help their HIV positive clients manage psychological and psychosocial effects such as depression, and stress has mainly centred on the efficacy of unitary models with a focus on adherence to medication and the prevention of the spread of the virus. The predominant unitary model of counselling that features in the literature is cognitive behavioural therapy (CBT). The other model of therapy that I feel deserves attention is the systemic model however, as far as I am aware there are no studies that explore the efficacy of this model for HIV positive clients. Bor, Miller and Goldman (1993) have written a review of how to use the systemic model specifically with HIV positive clients and their work will also be considered within this thesis.

Cognitive Behavioural Therapy and HIV

Cognitive behavioural therapy (CBT) is based on the theory that maladaptive thoughts (cognitions) and behaviours can impact emotions (Beck, 1976). This can have an effect on, or cause, mental health issues as well as physical issues (Lazarus, Folkman, Gruen and DeLongis, 1986). *CBT* and certain behaviour change strategies such as increasing daily exercise, training in meditation, assertiveness skills training, stress management skills, self-hypnosis, and practicing muscle relaxation exercises have been incorporated into a variety of treatment plans for HIV clients (Antoni, Schniederman, and Fletcher, 1990; Antoni, Baggett, Ironson, LaPerriere, August, Klimas, Scneiderman, and Fletcher 1991; Mulder, Antoni, Emmelkamp, Veugelers, Sandfort, Van de Vijver, and de Vries, 1995; Kelly, Murphy, Bahr, Kalichman, Morgan, Stevenson, Koob, Brasfield, and Bernstein, 1993; Taylor, 1995). CBT is the most widely researched model of counselling in relation to HIV positive clients.

In a meta-analysis of CBT interventions for HIV positive clients the authors wanted to evaluate the efficacy of CBT for improving the mental health and immune system functioning of people living with HIV (Crepaz, Passin, Herbst, Rama, Malow, Purcell and Wolitski, 2008). Crepaz and colleagues (2008) also

wanted to assess the literature to see if any positive effects of a CBT intervention are sustainable over time. Lastly the authors conducted exploratory analyses to identify the interventions that are linked with intervention efficacy (Crepaz et al, 2008). The literature suggests that coping with 'negative affect states' may be more demanding for people living with HIV as it is possible for this community to face frequent or even continual physiological, psychological and psychosocial stressors opposed to isolated stressful events or stressors that have an 'ending' to them (Crepaz et al, 2008). Therefore this community's response to a CBT intervention may be different to the reaction of a client that is not living with the demands of a chronic illness; even though both clients may be experiencing similar issues in connection with depression, anxiety and stress.

The authors included intervention trials into to their meta-analysis on the basis of several inclusion criteria (Crepaz et al, 2008). This included intervention trials where CBT interventions such as challenging irrational thought processes, cognitive restructuring and managing stress and developing adaptive behavioural coping strategies were used. A total of fifteen randomised controlled trials were analysed. The main outcome measures that were assessed were the effects of the intervention on symptoms of depression, anger and stress. The intervention effects on CD4 cell counts were also examined. The results of the initial analysis indicated a significant intervention effect for reducing symptoms of depression, anxiety and stress however, there was no indication that CBT interventions had an affect on CD4 cell count (or immune system functioning). The authors suggest that the reason for this result could be that the interventions may have been too short to affect immune system functioning. Another suggestion from the authors is that the most effective way to improve immune system functioning is strict adherence to medication therefore they advocate that future research should analyse the relationship between CBT and adherence to medication and immune system functioning (Crepaz et al, 2008)

Crepaz and colleagues (2008) then conducted stratified analyses to identify any specific characteristics or factors that may be the 'root cause' of the

significant depression and anxiety outcomes (anger was not included in the stratified analysis as the number of randomized controlled trials that included anger were too low) (Crepaz et al, 2008). The specific factors reported from this analysis were trials that included stress management skills, the inclusion of more than ten intervention sessions and trials that assisted clients in learning how to assess and change irrational thought processes (Crepaz et al, 2008).

Additional analysis of the trials indicated that these significant intervention effects for depression and anxiety were consistent in the final assessment after the intervention however the authors found no evidence that CBT had long-term effectiveness for these HIV positive clients (Crepaz et al, 2008). The authors suggest that the reason for this could be that the clients might require 'boosters' in order to keep practising the effective stress reduction strategies and challenging of irrational thought processes (Crepaz et al, 2008). Although this sounds like a definite possibility, the author also suggests that due to the fact that HIV positive clients can potentially live a 'normal lifespan' the nature of their needs may change and evolve over time. This client group may require psychological support several times throughout their life, feasibly with a range of different issues at the time of each intervention.

The authors also advocate further research concerning how intervention efficacy may differ concerning different groups of HIV positive clients. Their results suggest the possibility of differences between intervention efficacies for different subgroups however they suggest the results are not definitive due to the small number of trials included in the analysis (Crepaz et al, 2008). However the literature does suggests there may be differences in needs according to gender, sexual orientation and ethnicity (Ickovics et al, 2001; Kaaya, and Smith Fawzi, 1999; Cook, Grey, Burke, Cohen, Gurtman, Richardson, Wilson, Young, and Hessol, 2004). Due to the complex and changing nature of HIV positive clients' needs it is feasible there may be additional differences for elements as specific as the clients' goals, coping strategies or age.

The above research indicates that CBT interventions can be effective for people living with HIV, however it is not clear whether this result can be sustained over time (Crepaz et al, 2008). One of the main critiques the authors have of the literature they analysed was that the different types of interventions were not independently evaluated in any of the trials (Crepaz et al, 2008). The authors suggest further research is needed to independently evaluate specific interventions that are effective and that this research should report the results in a 'clear and transparent' way in order to better facilitate future meta-analyses (Crepaz et al, 2008).

Following on from Crepaz and colleagues (2008) call for further research concerning adherence to medication, the first piece of research concerning a psychosocial intervention that aimed to integrate the treatment of depression with 'adherence skills enhancement' for any chronic illness was conducted specifically with HIV positive participants (Safren, O'Cleirigh, Tan, Raminani, Reilly, Otto and Mayer, 2009). The psychosocial intervention was a specifically designed cognitive behavioural therapy to enhance medication adherence and reduce depression called (CBT-AD) (Safren et al, 1999). CBT-AD is a combination of traditional CBT for the treatment of depression and intervention techniques used with clients living with chronic illness. CBT-AD involves an initial session that concentrates on adherence to medication, which includes eleven 'behavioural steps' (Safren et al, 1999). These eleven behavioural steps include informational, problem solving and cognitive behavioural interventions. There is an emphasis in all of the steps on collaboration between the therapist and the client to define the problem, identify alternative solutions and create plans for implementing the most appropriate solutions. The other eleven sessions involved a series of stages or modules including psycho-education about HIV and depression, behavioural activation interventions, cognitive restructuring, problem solving and relaxation and breathing techniques (Safren et al, 1999).

The research conducted was a two armed, randomized, controlled, crossover trial with three conditions. Group one received CBT-AD and Enhanced

Treatment As Usual (ETAU), group two received ETAU and CBT-AD (because they chose to cross over to the CBT-AD condition) and group three received ETAU (because they chose not to cross over to the CBT-AD condition) (Safren et al, 2009). The results suggested there was an improvement on ratings of depression and adherence to medication in both groups one and two however a significant result was not shown for group three. The authors conclude that this result is a consequence of CBT-AD due the fact this was the element absent in the third condition.

However, the authors question whether this result was clinically significant. Although the symptoms of depression were reduced, they were still elevated and a clinically significant result would mean a '*return to normal functioning'* (Safren et al, 2009:8). The authors suggest the reason for this was the complexity of the population they were studying. Many of the participants lived with 'multiple co-morbidities and medical and psychiatric symptoms' (Safren et al, 2009:8). Therefore the authors have suggested that this result could be called a meaningful reduction in symptoms rather than strictly clinically significant.

It seems that the research pertaining to the use of CBT with HIV positive clients suggests that CBT can be effective for this client group, particularly for the reduction in symptoms of depression, anxiety, stress and adherence to medication (Safren et al, 1999, 2009; Crepaz et al, 2008). However, the literature suggests that this client group is difficult to diagnose using traditional diagnostic methods, it is challenging to conduct research that adequately controls for a wide range of possible confounding variables and it is not clear whether CBT has long term effectiveness (Crepaz et al, 2008). Additionally, it seems there may be different needs within the HIV positive community according to gender, sexual orientation and ethnicity (Ickovics et al, 2001; Kaaya, and Smith Fawzi, 1999; Cook et al, 2004). This research also indicates that it is still not clear which specific interventions within CBT might be effective. Most obviously, it seems this research highlights that the counselling psychology community has mostly focused on the efficacy of CBT

for HIV positive clients and research into the efficacy of other models is lacking.

Systemic Therapy and HIV

Although most of the literature pertaining to efficacy has focused on CBT other models have been reviewed most notably the systemic model. This form of therapy suggests that the themes of potential loss and loss are central to working with HIV clients. Bor and colleagues (1993) suggest that both the HIV positive individual, as well as the social systems around this individual, need to create their own construction of the illness. The idea is that the social system and the individual's personal construction of the illness will help create a sense of hope and power as well as a way to construct what support may be needed. Stynes, Lipp and Minichiello (1996) further suggest that in order for effective counselling to take place the 4C's: context, connections, circularity and constraints within the systems model of therapy need to be taken into account.

Focus is given to repeating cycles and interactions within the client's life. What has been observed is that often clients appear to be 'trapped' in circular patterns of interactions with others and into predictable cycles of thinking, behaving and interacting with the world around them (Bor et al, 1993). Bor and colleagues (1993) has named this pattern of being as 'reciprocity in relationships'. Therefore in a therapy session the client is seen within the context of their past, present, and future and in terms of their culture, employment history, socio-economic status, sexuality, financial status and family culture (Stynes et al, 1996).

The elements of constraint within the constraints 4C's model can manifest itself on a number of levels within the client's life. This can range from cultural issues to individual belief systems. Therapists have reported the individual belief system of the client can be a significant constraint to the client adjusting to a HIV positive diagnosis as well as being able 'live well' with the illness (Stynes et al, 1996).

Conclusion

Although the research into the efficacy of CBT has been positive there have also been several critiques of using this model with HIV positive clients. Additionally, there seems to a significant gap in the research pertaining to the efficacy of other models for the HIV positive community. Due to the complex nature of the illness, the vast psychosocial effects that living with HIV can have and the reported effects that stress and depression can produce it could be suggested that it might be more effective to think about this client group from a more pragmatic stance.

Critique of the literature

Methodological Problems and HIV Research

The problematic nature of studying the interaction between the psychosocial, physiological and psychological effects of HIV is well documented in the literature (Safren et al, 1999, 2009; Crepaz et al, 2008). Many of the studies investigating psychological distress in the HIV population tend to over sample men contracting HIV through having sex with other men (Antoni et al., 1990, 1991; Mulder et al., 1995; Kelly et al., 1993; Taylor, 1995; O'Cleirigh, Ironson, Antoni, Fletcher, McGuffey, Balbin, Schneiderman, and Solomon, 2003). Many of the samples are also Caucasian, well educated, and of middle income, further contributing to the difficulty for generalizing findings to other HIV positive populations. Cohort effects resulting from social support, multiple losses, unemployment, interpersonal conflicts, the physical effects of HIV and religion provide researchers with additional confounds when measuring the prevalence of mental health issues or making a psychiatric diagnosis in this population (Antoni et al., 1990, 1991; Mulder et al., 1995; Kelly et al., 1993; Taylor, 1995; O'Cleirigh, et al, 2003). A further critique of the literature suggests that a significant percentage of the research is only applicable in the western world (Kaaya and Smith Fawzi, 1999).

An additional critique of the research pertaining to people living with HIV suggests that although the psychological, physiological and social impact of HIV is well documented there is a limited amount of research concerning how people live with HIV and the most effective therapeutic interventions (Pierret, 2000). In a review of the research Janine Pierret (2000) asks the question, 'How can the knowledge produced by ``experts'' be linked to the knowledge coming from the direct experiences of patients themselves? According to Pierret (2000) this question still largely remains unanswered (Pierret, 2000:1592).

The focus of HIV Research: can success in one area make us blind to others?

As suggested previously, due to advancements in medication, HIV positive people can potentially live a normal life span living. However, this community may have to cope with physiological issues within a larger context of psychological problems and psychosocial problems. The literature suggests that this level of stress can create an increased risk of further physiological impairment, psychological disruption and can lead to isolation within the wider community (Miller, Weber, Green, 1986**;** Miller, 1987; Kalichman and Catz, 2000; Segerstrom and Miller, 2004).

However, it seems that the dominant model being used to work with the HIV positive community is a 'physician-dominated' medical model where pharmaceutical interventions are key. Evidence from the studies cited suggest that even though pharmaceutical interventions are hugely important for this community they do not address many of the issues that can accompany a HIV diagnosis. It could be further suggested that many of the psychosocial and psychological issues that this community can potentially face are more 'susceptible to techniques in psychological and behavioural medicine*'* (Whitaker, Vögele, Mcsherry and Goldstein, 2006:312).

Most, of the key pieces of research focus on how to encourage these clients to adhere to medication, continue to make sure that the virus is under control

and how the psychological and psychosocial factors can effect disease progression (Pierret, 2000). There is also a focus on preventing the spread of HIV and encouraging clients not to engage in what is commonly called 'risky sexual behaviour' (Pierret, 2000). In one review of the literature pertaining to the treatment of depression in HIV positive individuals it was suggested that there is a focus on antidepressant medication and very few pieces of research that focus on psychotherapy (Ferrando and Freyberg, 2008).

When HIV was first identified it produced fear in the medical community and the wider community due to the complexities of the illness and the rate at which HIV positive people were dying (Miller, Weber and Green, 1986). This focus on the virus and the physiological effects is not only understandable but it is hugely important. It means that pharmaceuticals were created which moved HIV from a terminal illness to a chronic illness. However, It has been suggested that this substantial pharmaceutical success has meant that research that focuses on the 'experience of living with HIV' has been somewhat delayed (Whitaker, Vögele, Mcsherry and Goldstein, 2006). The focus on quantity of life and symptom control has met some truly vital needs of the HIV positive community but perhaps a more plural research focus may help this community to cope with the additional quantity of life granted through pharmaceuticals, while striving for an improved quality of life (Whitaker et al, 2006). Research from the counselling psychology community could greatly contribute to this particular area.

In a review of HIV in the literature pertaining to psychological and behavioural medicine six categories of focus were identified (Whitaker et al, 2006). The first focus of the research centred on preventing the spread of the virus by encouraging behavioural change. Secondly the research started to focus on an emerging community call the 'worried well'. This group consisted of people who were HIV negative or were not able to determine their status and experienced anxiety about the possibility of a HIV diagnosis (Whitaker et al, 2006). This research concentrated on managing anxiety surrounding illness or the threat of illness. The third focus of the literature pertains to people newly diagnosed with HIV and how people can adapt and integrate this

diagnosis into their lives. Distinctions were made between people who had very recently been diagnosed and those with 'long standing infection'. Much of this research focused on both the anxieties that can surround a very recent diagnosis and the management of the virus through medication (Whitaker et al, 2006). The fourth focus of HIV research concentrated on the psycho-education of HIV positive people as they entered into a very confusing world where they had to make decisions about which medication they might use? When they might start using medication? And how to fit taking medication into their lifestyle (Whitaker et al, 2006). The fifth focus of HIV research seems to be a mixture of studies pertaining to adherence to medication, side effects of medication, recreational drug use and in recent times this fifth focus has included research with a focus on behavioural and psychological interventions (Whitaker et al, 2006). The sixth and final focus of HIV research is mainly made up of psychological research that focuses on issues concerning adjustment to living with HIV, loss, death and dying and living with a chronic illness (Whitaker et al, 2006).

However, as more people are now living longer with HIV this sixth focus of research is receiving less attention. Additionally, it has been suggested that a new focus of HIV research should be encouraged that focuses on issues surrounding long-term diagnosis and living with this diagnosis. Whitaker and colleagues (2006) suggest that none of these categories adequately conceptualize the current needs of the HIV positive community today. It could be suggested that it might be advantageous if future research focuses on a re-conceptualization of the needs of this community and that the focus does not rest purely on physical survival (Whitaker et al, 2006)

The counselling psychology community could contribute to this re-conceptualization of needs by creating research that uses 'bottom up processes' in order to highlight what this community may need from a therapeutic experience. Additionally, it may be helpful to start from what the needs and wants of this community are, rather than from what model of therapy we might use.

Unitary Models and HIV

It is reported that clients who are HIV positive can be best characterized as in a 'continuous process of adjustment and readjustment' that occurs in correlation with the illness or the psychosocial effects of living with the illness (Church, 1998:80). It could therefore be suggested that if a client is living in a 'negative medical and social reality' then negative thought processes might feasibly be a rational outcome of this reality (Church, 1998:79). Therefore certain traditional elements of CBT such as reality testing or challenging negative thought processes could be seen as ineffective and insensitive (Church, 1998).

Church (1998)

Church (1998) has suggested that greater time be given to assessing the client's needs as a greater focus may need to be on processing and expressing emotions rather than restructuring cognitions. Church (1998) also suggests that CBT techniques can be helpful for HIV positive clients as it can help to challenge and reduce feelings of helplessness and can help the client get a sense of regaining control over their lives. For example, it may be unhelpful and insensitive to challenge a clients thoughts about the fact they don't want to be HIV positive, but it may be helpful to challenge thoughts such as 'I am worthless because I am HIV positive', or ' I am not worthy of love because I am HIV positive'. However, Church (1998) does suggest Beck's (1976) theory that forms the basis of much of the CBT literature concerning depression, lacks an awareness of the social and situational aspects that can affect the onset and maintenance of depression. As mentioned previously, it is these social and situational aspects that seem to affect HIV positive clients the most.

Church (1998) advocates that when working with a HIV positive client using the CBT model several things should be considered. Clear goals should be set for therapy and unrealistic goals such as completely accepting the concept of being unwell or dying should be avoided. The author also suggests that the 'personal meanings of illness' for each client be explored and some time

should be devoted to the expression and processing of emotions (Church, 1998:87). Church (1998) further suggests that the evidence for the efficacy of CBT with HIV positive clients has shown that it can be useful however, according to the author most of this evidence is anecdotal. It seems that Church (1998) is suggesting that in many ways CBT could be a very effective way of working with HIV positive clients. CBT can create clear coping strategies and can help create an environment of hope and choice. However, it seems that Church (1998) is saying that when using CBT with HIV positive clients the therapist should tailor this model to the client's needs making the therapy more sensitive and relevant. It would seem that Church (1998) is making a case for being pragmatic about therapy rather than simply saying that certain models are 'good' or 'bad' for specific client groups. These individual differences and different needs might not be apparent in randomised controlled trials and it seems that Church (1998) is suggesting that it is these individual differences that are important for making therapy affective and relevant for each client.

Ussher (1993)

Practitioner Jane M. Ussher has documented her own experiences of psychology and HIV positive clients (Ussher, 1993). Ussher (1993) was trained in many different techniques and therapies and describes her frustrations with using unitary models of counselling. Ussher (1993) states many of her HIV positive clients could be framed within one of the unitary models such as CBT or person centred therapy but she felt these frames often excluded important parts of the HIV positive client.

One example that Ussher (1993) documents, describes the author using CBT with a HIV positive client. The client was what the unitary model CBT would discuss as having maladaptive thought process about his appearance due to the effects of HIV. Firstly, Ussher (1993) was unsure that these thoughts were irrational; the author was also unsure what to challenge them with. The client's appearance had changed, people were probably looking at the client and it was upsetting for the client to cope with. Ussher (1993) felt this client's issues were nothing to do with pathology or irrational thought and the author

certainly did not see the client as psychologically 'ill'. Additionally, Ussher (1993) discusses that as a therapist this often made her feel that the treatment she was offering her HIV clients was not adequately meeting their needs.

Conclusion

Due to the pervasive nature of HIV, the uniqueness of all clients and their respective communities, it could be suggested that a therapist who does not have an understanding of the client's personal construction of their illness nor their identity and social systems they live in, would find it difficult to know where to start in order to provide an empathic and understanding counselling service for HIV positive clients.

Common factors in therapy

Something we all share?

Research that has compared the efficacy of unitary models such as psychodynamic, person centred and CBT suggests there is little significant difference in the efficacy of each of the models when counselling people who were HIV positive (Olatunji, Mimiago, O'Cleirigh, and Safren, 2006). However, this has been reported more generally within counselling psychology also.

Once the field of psychology accepted the notion that counselling has a more positive effect than no treatment at all, researchers attempted to examine the specific weaknesses and strengths of the different models of therapy available (Oldfield, 1983). The results of these investigations were surprising; the examination of psychotherapy outcome research revealed almost no difference in the disparate therapies level of efficacy (Bergin and Garfield, 2003; Wampold, 2001). Researchers described this as a 'paradox of outcome equivalence' or 'content non-equivalence' (Wampold, Mondin, Moody, Stich, Benson and Ahn, 1997; Lambert and Bergin, 2004). It was suggested that a possible cause of this paradox was the presence of 'common factors' that underlie all of the different types of therapy (Wampold et al, 1997; Lambert

and Bergin, 2004). It was also suggested that it was the 'common factors' that may have the greatest impact on the effectiveness of the therapy and the eventual outcome (Wampold et al, 1997; Lambert and Bergin, 2004).

The expression 'common factors' refers to fundamentals that are common to all models of therapy that influence the outcome. Some of the common factors that have been identified are extra-therapeutic change, the therapeutic relationship, hope and expectancy, and therapeutic technique (Norcross and Goldfried, 2005). These common factors are basically created through the therapist, the process of therapy and also what the client brings to the therapeutic relationship and the therapeutic experience (Norcross and Goldfried, 2005).

A comprehensive meta-analysis of over 40 years of outcome research conducted by Lambert (2003) focused on the implications of outcome research for the field of psychotherapy. Through this robust meta-analysis four principal factors emerged that can influence a positive therapeutic outcome. In the literature each factor was given a percentage of significance to the outcome of therapy. The author suggested that extra-therapeutic factors accounted for 40% of positive therapy outcome, the therapeutic relationship for 30%, hope and expectancy factors for 15%, and therapeutic model or technique for 15% of the positive outcome of therapy (Lambert, 2003).

However these findings were viewed by some members of the psychotherapy community as unreliable and currently the field is divided into factions based upon their loyalty to a specific clinical model or theory (Lambert and Bergin, 2004; Prochaska, 1992; Beutler, 1991; Jones, Cumming and Horowitz, 1988; Messer, 1996). This debate has resulted in a divide on the topic, creating two schools of thought. One school of thought believes that psychotherapy should be more integrated allowing clinicians to focus more on the factors involved in practicing effective therapy and less on model or theory (Lambert and Bergin, 2004; Prochaska, 1992). Other researchers believe that additional studies should be done in this field, suggesting that the deduction that the four

common factors are having an impact on the outcome of therapy regardless of the theory may be an impulsive one (Beutler, 1991; Jones, Cumming and Horowitz, 1988; Messer, 1996). Due to this divide in the field, research has become more prolific in the debate over the common factors and their influence or lack of influence on a positive therapeutic outcome.

The majority of exploration in this area has used quantitative methods. As a result, an empirical basis for the common factors theory has developed. Recently, however, an increasing number of qualitative studies have come to the forefront of common factors research.

The Therapeutic Relationship

It is widely documented in the literature that the therapeutic relationship can be viewed as one of the most important elements of the therapeutic process (Bordin, 1979; Horvath and Symonds, 1991; Rogers, 1957; Gelso and Samstag, 2008; Norcross, 2002). A study by Horvath and Symonds (1991) reported that through their meta-analysis of 24 different studies they found that the therapeutic relationship explained about 9% of positive therapeutic change. In a later extensive review, Horvath and Luborsky (1993) examined how the therapeutic alliance develops and the correlation between a positive alliance and a positive therapeutic outcome. The conclusions from their review suggested that there was a robust and important link between a positive outcome in therapy and the therapeutic relationship (Horvath and Luborsky, 1993). In commenting on their conclusions the authors stated the importance of putting these findings into practice (Horvath and Luborsky, 1993). The report encourages therapists not just to nurture their relationships with their clients, but also to place more emphasis on a highly collaborative approach between the client and the therapist.

In a review of the literature pertaining to the therapeutic alliance Wampold (2001) concluded that the alliance is a 'key component of psychotherapy' (Wampold 2001:158). Wampold (2001) also suggests that the alliance is an important element of therapy regardless of the model being used. In the review, Wampold (2001) suggests that an important part of creating the

therapeutic relationship between the client and the therapist is their level of agreement about the goals and the tasks of the therapy.

Gatson (1990) suggests there are four key components that frame the therapeutic alliance. Firstly there is the client's emotional relationship to the therapist, secondly the client's ability to work within the alliance, thirdly the therapist's sense of empathy, understanding and involvement and finally the level of client-therapist concurrence on the activities and goals of the therapy (Gaston, 1990). Gatson (1990) also agrees with the aforementioned mentioned research on the alliance, in that the relationship between the therapist and the client is a significant part of the therapy and has therapeutic properties that can be as equally effective as the therapy itself. Gaston (1990) suggests that the alliance is an important prerequisite for therapist interventions to be effective due to the fact that the therapist/client relationship interaction with various techniques can determine a positive therapeutic outcome (Gaston, 1990). Gatson's (1990) work also places heavy emphasis on collaboration between the client and the therapist throughout the course of therapy.

Luborsky (1994) conduced a comprehensive review of 15 years worth of research on the correlation between alliance and outcome (Luborsky, 1994). Luborsky's (1994) goal was to identify the factors that influence the correlation along with the extent to which the correlation influences the outcome. Some of the factors were; the way in which alliance is measured (which was established to have little or no degree of correlation with outcome), the nature of the treatment (little or no correlation), opinion of the client, therapist, or witness (reasonable degree of correlation by all opinions, particularly the patient's), positive in opposition to negative alliance (positive alliance correlates most highly to positive treatment outcome) (Luborsky, 1994). The author suggested three possible curative factors in psychotherapy. These curative factors include the stipulation to create a positive therapeutic relationship; the client should be given space to express their conflicts and there should be collaboration between patient and therapist about ways to cope with them. Luborsky (1994) believes that even if a partial therapeutic

alliance is created between therapist and client then at least one aspect of potential positive outcome has been created.

The therapeutic relationship has been investigated in relation to a range of models including cognitive therapy, psychodynamic therapy, gestalt therapy, and behavioural therapy (Horvath and Luborsky, 1993). Each model of therapy describes the alliance between client and therapist as an important part of the therapeutic process. The alliance is also seen to have a significant impact on positive therapy outcome in each alternative model of psychotherapy (Horvath and Luborsky (1993). In a comprehensive meta-analysis concerning common factors in therapy, Lambert (2003) attributes 30% of the variance within a positive therapeutic outcome to the therapeutic relationship.

However, in a more recent meta-analysis concerning the contribution of the therapeutic alliance to positive therapeutic outcome it was found that the alliance actually contributes much less. Beutler and colleagues (2004) suggest that 'relational factors' account for between seven percent and seventeen percent of the variance (Beutler et al, 2004). Additionally Cooper (2008) reminds us that although research has suggested positive therapeutic outcome and strong therapeutic alliance do appear to occur together, this correlation does not definitively imply cause.

Bordin (1979) suggests that the therapeutic alliance consists of three main dimensions:

1. The therapist and the client's agreement on the goals of therapy.
2. Therapist and client consensus on the tasks of therapy.
3. The existence of a positive effect bond between therapist and client.

More recent research seems to agree with Bordin's (1979) break down of the therapeutic relationship finding that collaboration and goal consensus are significantly related to a positive therapeutic outcome (Tryon and Winograd, 2002). In summary, the literature suggests that the therapeutic relationship and positive therapeutic outcome are frequently correlated; but this does not

necessarily mean that a positive therapeutic relationship alone will definitely create a positive therapeutic outcome. Additionally, according to Bordin's (1979) definition of the therapeutic alliance, it may not be relational factors and a positive therapeutic bond alone that constitute a strong therapeutic alliance. A strong therapeutic bond may also include the creation of a shared understanding about what the client wants from therapy and collaboration between the therapist and the client about which tasks might successfully realize their goals.

The Extra-Therapeutic Factor

Another common factor that has been described in the literature is the 'extra-therapeutic factor'. The extra-therapeutic factor is a blend of components that are external to the therapy including various aspects of clients and their experiences (Asay and Lambert, 2009). Such aspects include the client's past experiences, diagnosis, and systems of people around them, their ability to cope, and life stressors. Asay and Lambert (2009) also name some more specific aspects of the client such as the client's personal level of motivation, ego potency and the ability of the client to focus.

Bergin and Garfield (2003) have investigated the research concerning client factors. The two authors identified that general diagnosis of common forms of mental illness can potentially create problems for therapists due to extra-therapeutic factors. Their study suggested that even when the same diagnosis is given, a client's extra-therapeutic or external factors can greatly influence the effectiveness of the therapy and the therapeutic outcome (Bergin and Garfield, 2003). These unique client factors include the client's preceding life experiences, existing personality traits, ethnicity, expectations of the therapeutic experience and how the client perceives the therapist (Bergin and Garfield, 2003). The research stresses that although the client comes to see a therapist on his or her own, they cannot be fully understood until the therapist understands them within a context. Therefore, according to Bergin and Garfield (2003), each therapeutic experience is varied according to the characteristics of the individual and this individual within a context: not just their problems or diagnosed illness. Additionally, if this is the case then it

could be suggested that client's personal and external characteristics would also have a profound impact on either a positive or negative therapeutic outcome (Bergin and Garfield, 2003). This research links to previous research discussed from Church (1998) who was highlighting the importance of the individual differences of clients' being an important part of tailoring therapy to the client instead of the other way round. As suggested by Church (1998), for HIV positive clients one of these individual differences could be their individual construction of their illness. Therefore this could be an important part of the client's extra-therapeutic factors that they bring into therapy.

Qualitative studies have also produced relevant and progressive research into the field of extra-therapeutic factors. Rennie (1992) attempted to ascertain clients' experiences of the process of therapy by evaluating a recent therapy session with them. The participants previous therapeutic sessions were taped onto videocassette and then played back to them with the researcher present. Participants were asked to indicate anything of importance that they recalled experiencing in the session. From the qualitative analysis of the client's interviews the core category of 'client's reflexivity', defined as 'turning back on oneself' was formed (Rennie, 1992). Four main categories were also formed from the interviews; the client's perception of personal meaning, the client's opinion of the relationship with the therapist, the client's experience of the therapist's techniques, and the client's experience of the outcome of the therapy (Rennie, 1992).

Therefore, many different individual aspects of the client have been identified to have a possible impact upon the client's experience while in therapy and eventually the therapeutic outcome. It was suggested by Lambert (2003) that extra-therapeutic factors could account for the largest among the four common factors with it having an impact on 40% of the outcome results.

Therapeutic Model and Technique

As stated previously, research investigating the efficacy of various models of psychotherapy repeatedly demonstrates that there is little difference between

the models used and the outcome produced (Lambert, 2003; Lambert and Bergin, 2004; Miller, Duncan and Hubble, 1997). It is this aspect of the research in 'common factors' that has been met with such controversial derision from the academic community, as it implies that one orientation in the field of psychotherapy has no more of an impact on client change than any other orientation. As the training of therapists has traditionally been divided by theoretical model, these findings directly challenge the current establishment of how therapy is learned and taught. Some researchers suggest that because of these findings, training in specific models and techniques serves little purpose (Strupp and Anderson, 1997). Another perspective on these findings suggests that as a long as a therapist is skilled and has a grasp of the discussed common factors then the client can expect some positive progression; this will be regardless of the type of therapy they receive (Lambert and Bergin, 2004). This thesis asserts an emphasis on collaboration between the client and the therapist, understanding the client's goals and creating appropriate methods and tasks to meet these goals may be more important than which theoretical model is used.

An inclusive evaluation of both meta-analytical research and comparative studies comes from Lambert and Bergin (2004). In their analysis of the particularly vast amount of research on common factors the authors confirmed that psychotherapy has a significant effect on symptom reduction as compared to wait-list and no-treatment control groups (Lambert and Bergin, 2004). Their review findings also support the notion that there is little difference between the therapeutic models in terms of the outcome they produce (Lambert and Bergin, 2004). The authors tender three possible explanations for their findings. Firstly, different therapies can achieve similar goals through different processes; secondly, different outcomes do take place but are not detected by past research strategies; and lastly, different therapies embody common factors that are curative although these are not necessarily embedded within the actual theory of any particular model (Lambert and Bergin, 2004). Any of these explanations, the authors conclude, may be supported and defended, as there is not enough evidence available to rule out any one of them. The previously mentioned meta-analysis by Lambert (2003)

concludes that 15% of variance in treatment outcome can be attributed to models and techniques.

Hope and expectancy

The final domain of the common factors found to affect positive therapeutic change are hope and expectancy (Miller, Duncan and Hubble, 1997). The creation of hope for a positive therapeutic outcome and the expectation of how this will be achieved are common to most models of therapy (Miller et al, 1997). It is believed expectations will arise through the interaction between the client and therapist- it is also believed the client has significant influence on their therapeutic outcome (Hubble, Duncan and Miller, 1999; Lambert, 2003; Miller et al., 1997).

A framework for conceptualising this 'common factor', called 'hope theory' has been suggested by Snyder, Michael and Cheavens (1999). It is proposed that hope can be considered in terms of goals and the way people think about their goals and this was split into two components of thought (Snyder, Michael, and Cheavens 1999). The first component of thought when people consider their goals is the concern over their capability to create appropriate methods and tasks that will set them on the best route towards their goals. The second component is the thoughts concerning their capacity to instigate and persist working toward these goals (Snyder, Michael, and Cheavens 1999). The authors speculate that both of these components (known respectively as 'pathways thinking' and 'agency thinking') should be present in order for a client to encounter positive expectation for therapeutic change.

Hope and positive expectations linked to outcome has also been explored in the field of general health as well as mental health. A study conducted by Snyder and colleagues (1991) connected hope to specific individual constructs such as optimism, self-efficacy, helplessness, and resourcefulness, elucidating that these constructs are related to the construct of hope (Snyder, Harris, Anderson, Holleran, Irving, Sigmon, Yoshinobu, Gibb, Langelle and Harney, 1991). Their review identified that if a client had elevated levels of hope, they were allied with enhanced ability to set therapeutic goals and

elevated self esteem in being able to solve problems. This was also correlated to the improvement of physical and/or mental symptoms (Snyder et al, 1991). This research was conducted using a multi-method approach of self-report and objective assessments. The research concluded that therapists should be aware of both components of expectation and need to develop these components with the client. The paper suggests this can be achieved by nurturing the client's sense of goal directed determination (agency) as well as the creation of relevant methods and tasks necessary to realize their goals (pathway). Snyder and colleagues (1991) suggest the joint bond between these two components defines the core of what hope and expectation is, and that this common factor of expectation is significant for the nourishment of psychological health (Snyder et al, 1991).

Before clients attend therapy some have a very lucid understanding of what might take place, others have an imagined view of what it might be like and other clients have little to no idea of what a therapeutic experience might consist of. The Isis Centre, which provides different models of counselling to clients, states that when clients were asked what they expected the centre could do to help them; they appeared to fall into five main groups of expectation (Oldfield, 1983). The first category of clients were very uncertain as to what to expect from the therapy; the second group said they were simply wanting to talk through their problems and be listened to; another category expressed a hope for 'psychological insight' into their issues; others expected to gain advice and the final group expected support from their therapeutic experience (Oldfield, 1983).

These sorts of hopes and expectations prior to the beginning of therapy would conceivably have an effect on therapeutic outcome. Research conducted by Lazare (1975) and his colleagues formed the basis for what they described as the 'customer approach' where the therapist works with the client to carefully deduce the client's expectations from therapy and to help them define their goals (Lazare, Eisenthals, Wasserman, Harford, 1975)

This '*customer approach'* also allows the clients views of his/her therapy to be respected and incorporated into the decision making process so both client and therapist are working toward a known and common goal (Oldfield, 1983). It is this early development of a shared ethos that could possibly be the essential foundation for a positive therapeutic outcome; an ethos that would be problematic to create at any other stage other than the very beginning of the therapeutic experience (Malan, 1976).

Hope and expectation have received an increasing amount of consideration from researchers as a key factor in the ascription of positive therapeutic outcome. It has been found that this factor contributes essential elements to all models of therapy. In the meta-analysis conducted by Lambert (2003) it was reported that hope and expectancy account for 15% of the variance in treatment outcome.

Conclusion

The search for the common factors or the 'common components' in therapy has been hailed as some of the most significant psychotherapy research of the 1980's (Bergin, 1982). Much of the common factors research concurs with the idea that a significant proportion of positive therapeutic change and positive psychotherapy outcome can be attributed to common elements and features that are common to all therapies (Garfield, 1980; Karasu, 1986; Lambert, 1986; Beutler, 1986; Frank, 1971; 1989; Lambert, 2003; Lambert and Bergin, 2004).

Integration and Eclecticism

Everybody is Invited

It has been suggested that common factors research and dissatisfaction with unitary models of therapy was some of the driving force that created a movement towards psychotherapy integration and eclecticism (Grencavage and Norcross, 1990). Surveys that were conducted with both integrative and eclectic therapists suggested that this dissatisfaction with unitary models was partly the reason why they chose to work in a more integrative way (Garfield

and Kurtz, 1977; Norcross and Prochaska, 1988). Through research into the efficacy of the different models of therapy and the increasing clinical demands of clients the possible limitations of unitary models became more apparent (Grencavage and Norcross, 1990). Beutler (1983) advocates that singular theories and the techniques based on these theories can be inadequate in meeting the demands of complex psychological needs. Another motivation towards psychotherapy integration and eclecticism comes from the research that suggests there is little difference in the efficacy of the different models (Grencavage and Norcross, 1990). Therefore there is little evidence that would advocate using one model over and above another (Wampold, 2001). The move towards integration eclecticism was an attempt to better meet the needs of clients by utilising the variety of theories and techniques available to therapists.

Three main approaches to integration

Three main approaches to therapy integration have been identified as 'theoretical integration', 'assimilative integration' and 'common factors' (Arkowitz, 1989; Stricker and Gold, 2003). Theoretical integration is a process where multiple models or approaches to therapy are integrated (Norcross and Grencavage, 1990). Theoretical integration has been described as 'an articulated framework or roadmap' or a 'superordinate umbrella' (Norcross and Grencavage, 1990:11). Assimilative integration is the assimilation of a model or theory with variety of new techniques; and as discussed previously, 'common factors' approaches to integration seek to identify the common factors or components that are common to all models of therapy (Arkowitz, 1989; Stricker and Gold, 2003). As mentioned previously, 'common factors' integration research advocates it is these common components that can explain a significant proportion of positive therapeutic change (Garfield, 1980; Karasu, 1986; Lambert, 1986; Beutler, 1986; Frank, 1971; 1989).

Eclecticism

The eclecticism movement within psychotherapy was also in response to the dissatisfaction of unitary models and an attempt to better the meet the needs

of complex client groups (Norcross and Grencavage, 1990). This approach to therapeutic eclecticism 'uses procedures drawn from different sources without necessarily subscribing to the theories that spawned them making this approach 'relatively atheoretical' in nature (Norcross and Grencavage, 1990:10).

Critique of integration and eclecticism: How do we invite them all?

While eclecticism and integration in psychotherapy have most certainly added valuable contributions to the field of psychotherapy there continues to be issues within this movement. Some of the main issues concerned are; Issues questioning adequate training for therapists (Robertson, 1986); trying to marry sometimes contradictory ontological and epistemological assumptions (Norcross and Grencavage, 1990); insufficient amounts of research in part due to a lack of a clear framework and a lack of a common integrationist or eclectic language (Norcross, 1987).

Other critiques of integrated approaches have suggested that in the attempt to move away from unitary models through the synthesis of multiple models or theories, they have actually created what they were trying to move away from; namely the creation of a new unitary model albeit based on multiple models or theories (Downing, 2004). Even though the model of integration may approach client work armed with multiple models and theories, it could be suggested that it is still operating from unitary model mode of thinking, interacting and working with clients. Therefore it could be suggested that 'existing models of integration are not fully responsive to the possibility that different clients may need very different things at different times' (Cooper and McLeod, 2007:5).

Even though the range of ways to meet clients' needs is increased, practitioners are still without a guiding conception 'for deciding which technique to implement in which situation' (Cooper and McLeod, 2007:5). Without a guiding framework or conception it is problematic for practitioners to make these choices and it also makes this area difficult to develop through systematic research (Cooper and McLeod, 2007).

Pluralism

A design for the invitation to all therapies and clients.

Cooper and McLeod (2007) have developed a framework called the pluralistic framework to address these questions and issues with conceptualisation. The philosophy (also called pluralism) that this framework is founded on suggests the modernist aim of consensus in scientific enquiry is a misdirected and possibly unethical aim as 'the normal human condition is dissensus' (Cooper and McLeod, 2007:6). By aiming for consensus in scientific discourse those people that have experiences outside this consensus are inevitably left out. Rescher (1993) suggests a vast range of complex human experience exists and therefore trying to locate similarities between these experiences ignores the diversity of the human condition. This feels particularly relevant for research in the field of counselling psychology due to the fact that it is the human condition and the experience of the individual within this condition that we are trying to understand. The philosophy of pluralism advocates that, due to the complex nature of humans, when asking questions about the human condition a variety of possible, and sometimes contradictory responses can be found. Basically pluralism does not wish to ignore these possible responses just because they are contradictory in nature. Just because they don't agree or fit neatly into a comprehensive response does not make them any less plausible or valuable. Cooper and McLeod (2007) suggest that pluralism can be viewed as a 'form of a humanistic-existential ethic' in the sense that it is committed to inclusiveness and 'otherness' (Cooper and McLeod, 2007:6). In a sense the pluralistic philosophy is an open invitation to different belief systems, ways of working with clients, different types of therapists, different models and theories and most importantly different clients. Pluralism seems to be designed from 'the client up' rather than from 'the therapist down'.

Therefore the pluralistic framework is responsive to the fact 'that different clients may need very different things at different times' (Cooper and McLeod, 2007:5) and it seeks to provide a conceptualization 'for deciding which

technique to implement in which situation' (Cooper and McLeod, 2007:5). The framework consists of three domains: goals, tasks and methods (Cooper and McLeod, 2007). However, in the spirit of its philosophical underpinnings this framework does not seek 'to specify a single process or pathway by which therapeutic change happens. Rather, it is to create a structure in which multiple change pathways can be conceptualised' (Cooper and McLeod, 2007:6).

Goals

The focus of the goals domain is 'what do clients want' opposed to 'what do clients need' (Cooper and McLeod, 2007:7). The skills needed to create this domain with the client consist of remaining open to the fact that clients may have different or even contradictory goals and that these goals may change as time goes on; goals should be viewed as fluid and evolving. In this sense the therapist is being truly responsive to the clients' desires in the 'here and now' meaning pluralism helps the client and the therapist to 'stay on the same page. Additionally, goals should be viewed as moving processes rather than rigid 'targets' that the client has to be held accountable to (Cooper and McLeod, 2007:8). Cooper and McLeod (2007) also advocate 'checking' with the client whether they feel their goal is being met and also 'tracking' with the client when the goal has been met (Cooper and McLeod, 2007).

Tasks

The tasks domain can be defined as 'a sequence of actions carried out by a person, in collaboration with a counsellor, in order to be able to get on with their life' (McLeod, 2007:54). The skill needed to create this domain is to shed light on 'the question 'what is it that we are doing now?' Being able to specify the tasks that are amenable to psychotherapeutic intervention is a straightforward way to explain to potential clients, and stakeholder such as employers and GPs, just what it is that counselling or psychotherapy has to offer' (Cooper and McLeod, 2007:8). Tasks may include 'exploring meaning, problem solving and negotiating life transitions' (Cooper and McLeod, 2007:9). As suggested earlier, research conducted by Gersons et al. (2000) found that creating tasks within therapy led to higher rates of significant

positive therapeutic change. Like the domain of goals, the therapist is required to track a task with a client from beginning to end. The task is created through the collaboration of the ideas of both the therapist and the client (Cooper and McLeod, 2007).

Methods

The methods section of the three domains can be defined as 'practical ways in which the therapist and client fulfil therapeutic tasks, and can be broken down into 'client activities and therapist activities' (Cooper and McLeod, 2007:9). Methods can be based on established models of therapy such as cognitive behavioural therapy, person-centred or gestalt therapy however pluralism advocates thinking creatively about client work and being pragmatic in the sense that you do what works for the client. Pluralism encourages the therapist and the client to brainstorm together about what cultural or personal resources may be available to the client in order to meet their goals (Cooper and McLeod, 2007).

In this sense methods can be very personal to the client. For example, a client who is coming to terms with being diagnosed with HIV may find it helpful to pray or write creatively about his experience. This client may find that going to the theatre or watching certain movies helps to clarify or understand his experience or express his feelings. This client may find it helpful to spend time with other people who are also HIV positive or research others experiences their diagnosis. In this sense the possibilities for methods are almost endless. The therapist is not there to provide one intervention that would fit the client's needs, 'the therapist's role is to facilitate an exploratory discussion around the possible methods they might use together' (Cooper and McLeod, 2007:10). The client is 'at the centre of change' and this process acknowledges that extra-therapeutic factors coming from the client will have an impact in the therapy (Cooper and McLeod, 2007:10). As mentioned previously, it has been suggested by Lambert (2003) it is the extra-therapeutic common factor that will have the most impact on therapy.

CHAPTER 2: METHODOLOGY

The research question

The question that will provide the focus for this research is:

How do HIV positive clients experience the process of pluralistic therapy?

The choice of my methodologies have been based on this research question, the context in which the research question has been asked and what is possible within the setting that I am conducting the research.

The objective of this research is to use the pragmatic case study method and grounded theory strategies to show the process of HIV positive clients experiencing pluralistic counselling.

A critique of counselling psychology research is that it doesn't always produce clear ways to work more effectively with clients (Cooper and McLeod, 2007). Cooper and McLeod (2007) suggest that the pluralistic framework has been designed in such a way that it helps to facilitate research and demystify the counselling experience. Pluralistic counselling frames the therapeutic work in three clear domains (goals, tasks and methods) and thus allows research to work within this frame to show client/counsellor process in order to more concretely inform practice (Cooper and McLeod, 2007).

I have allowed the research to unfold using the pluralistic framework to collect data and grounded theory strategies to analyze this data. I have used the writing of qualitative pragmatic case studies to explore each participant's case

Definitions and descriptions

This section will explore what I mean by the term 'process'. This section will also explore and describe the concept of grounded theory and pragmatic case studies.

Definition of Process

Worsley (2002) describes process from the client's point of view as the 'how of her experiencing' (Worsley, 2002:18). Process is described as 'the way she makes meaning out of life's raw data from the acts, sensations and functions of living' (Worsley, 2002:18). Worsley (2002) describes the therapist's process as encouraging the client to explore the 'how' of the content of what the client is saying. The therapist's process is to truly listen to what the client is saying and then move to 'how' the client is saying what they are saying. Worsley (2002) refers to this as 'the texture of the conversation' (Worsley, 2002:19).

Rennie (1998) refers to process as 'the activities in which clients engage in as they work with their experience from moment to moment. These activities may be cognitive or behavioural' (Rennie, 1998:71). Rennie (1998) suggests that process can be reflexive or spontaneous in nature. However, a critique of Rennie's (1998) definition of process asks the question is process only cognitive or behavioural? Worsely (2002) suggests that there can be a significant emotional aspect to process that Rennie (1998) does not allude to.

For the purpose of this thesis I want to explore the process between pluralistic therapy and the client. In doing so, I will extend this definition to include the process between two objects; namely the therapy and the client. The William Burroughs and Brion Gysin's book 'The Third Mind' was written using the 'cut up' method where 'scissors and paste assemblies of sentence fragments (are) cut out of context and rearranged for totally new meanings' (Burroughs and Gysin, 1978). Through this process of collaboration and working with the text that is already there something new is created through this collaboration: a

'Third Mind' is created. When Burroughs and Gysin were using the 'cut up' method no judgment was made on any one piece of the text; each piece of the text was just as important as another piece. This concept of the 'Third Mind' reminds me of what psychologists call 'process' between the client, the therapist and the therapy. Through collaboration between these two people, both focusing on the same thing, another intangible 'something' is created in the room between them. This intangible 'thing' is often difficult to explain to others not involved in the collaboration and is sometimes even difficult for the people involved to define themselves.

Therefore, for the purpose of this research, process can be defined as a 'third element' or a 'Third Mind' that is created through collaboration between two people in a relationship, working within the pluralistic framework. Process is the 'how' of this interaction.

Grounded Theory

Due to the fact that only the original data from the counselling sessions will be analysed, an abbreviated version of grounded theory has been used (Willig, 2001). This means that grounded theory strategies and principles will be used to analyse the data from the original data collection and the researcher will not collect any further data as a result of this initial analysis. The choice to use an abbreviated version of grounded theory analysis has been made due to the time restraints of the doctorate research.

Grounded theory was initially created as a process that enabled the researcher to discover and generate theory (Strauss and Corbin, 1990). The researcher allows the 'discoveries' to emerge from the collected data rather than try and produce theory on the basis of pre-existing theory. Grounded theory as a method allows the researcher to identify categories within the data and to identify relationships between these categories. Once these categories and relationships between categories have been established grounded theory allows the researcher to produce a framework that enables understanding of the specific phenomenon being researched (Willig, 2001).

Certain versions of grounded theory have been criticized due to issues of reflexivity (Willig, 2001). Grounded theory suggests that theory emerges from the data and does not acknowledge the possible influence of the researcher who is 'allowing' the theory to emerge. Consequently, it has been suggested that the underlying philosophy behind grounded theory is essentially positivist in nature. Therefore this research will use Charmaz's (2006) version of grounded theory which holds a symbolic-interactionist theoretical perspective and carries a social constructionist epistemology in order to acknowledge that the discoveries made constitute one possible 'truth' about the data from the researchers point of view rather than the only possible truth (Charmaz, 2006). Social constructionism's view of knowledge is that individual people construct knowledge though their interactions with the world around them. Therefore it is this 'social interaction' between an individual and their environment that constructs their knowledge of themselves, the world and others (Willig, 2001). This way of considering the data is more aligned to the pluralistic epistemology behind the rest of the research being conducted. This is due to the assumption that the data and emergent theories are not discovered by the researcher but are constructed through interaction between the researcher and the data (Charmaz, 2006). Therefore the results of this analysis can be seen as one way of interpreting the data rather than a universal truth (Charmaz, 2006).

Pragmatic Case Studies

The writing of pragmatic case studies is the chosen method for presenting this study. It has been suggested that case studies have been the foremost research strategy for the development of knowledge about human beings for some time although this is not really acknowledged in the literature (Valsiner, 1986).

The pragmatic case study approach that this research uses is the combination of writing multiple case studies with qualitative data collection methods, the use of grounded theory strategies to analyse the data and feedback sessions in order to produce rich data from multiple sources (Fishman, 2000).

There is much debate surrounding the case study method. It has been criticized for its lack of generalizability and its lack of validity and rigor as a form of research (Marks and Yardley, 2004). Again, the thinking behind the pluralistic framework rejects the absolute importance of generalizability and would suggest that much can be discovered in a single case due to the richness of the data it produces (Bromley, 1986). The pluralistic framework also postulates that counselling psychology needs to generate more research that shows the therapeutic process and outcome in order to inform professional practice (Cooper and McLeod, 2007). The pragmatic qualitative case study approach sets out to achieve this transparency within the therapeutic process.

Additional replies to such criticism have suggested because pragmatic case studies frequently use data source triangulation it could be suggested that the case study method is in fact a triangulated research strategy (Fishman, 2000). Therefore this inherent data source triangulation will increase the validity of the research and has allowed me to check that the data remains consistent throughout different contexts (Fishman, 2000).

The process of creating a pragmatic case study consists of using the standard structure for a case study that includes the client's background, the model of therapy used, the context in which the therapy took place and also a formulation about the client's issues from the perspective of the pluralistic framework (Fishman, 2000). When writing these sections the idea is to create a 'rich narrative' about the client. Fishman (2000) places emphasis on the description of the contextual factors such as historical, psychological, cultural, physical or social elements in the client's life. It is a combination between this rich contextual information about the client, the client's issues and the pluralistic framework of goals, tasks and methods that create a complete client formulation.

Just like in a traditional case study design there is a description of the course of the therapy. Particular attention is paid to the description of the interventions and the evaluation of the interventions as well as the challenges

faced (Fishman, 2000). The final part of the pragmatic case study is the results section. In this section the results from the abbreviated grounded theory analysis of the transcriptions are presented.

Following the case studies is a synthesis of the analysis and a discussion. This will include recommendations for practice using the pluralistic framework with HIV positive clients.

Philosophical and epistemological assumptions

***The process of a bricoleur and the art of integration*.**

Within my research there are several different methods for collecting, presenting and analyzing the data and these methods all take a slightly differing view on what knowledge, truth and research is. I have not used quantitative methodologies within this piece of research. However in the spirit of transparency and in line with the pragmatic approach to research I do not completely reject the positivist paradigm even though it is not used in this piece. In the spirit of pluralism I aimed to find common ground between my epistemologies rather than complete consensus (Rescher, 1993).

As a qualitative researcher I have an interpretive, naturalistic approach to the world. It has been suggested that 'all understanding is inevitably mediated by interpretation' (Nuttall, 2006:434). This means that I research things 'as they are' in a 'real world' context and I endeavour to interpret phenomena in terms of how people construct meaning within this context (Robson, 2002). I have used multiple methods including case studies, feedback from clients and transcriptions of counselling sessions. Due to the variety of methods I see myself as a 'methodological bricoleur' (Denzin and Lincoln, 2005). A bricoleur is seen as one who creates a 'methodological quilt' out of many different pieces of research material. A bricoleur takes a pragmatic stance in that they work within a context, they do 'what works' and use the 'empirical materials' that are 'at hand' (Denzin, Lincoln, 2005). You could liken a bricoleur to a jazz musician in so much that the notes sometimes appear irregular and dissimilar on their own, but together they create a coherent piece of music (Levi-

Strauss, 1966). Levi-Strauss (1966) advocates that this idea is not so concerned with methodology and epistemology; he felt a bricoleur was someone who could take an object and use it in an unusual or unique way for a particular purpose.

However, due to this choice to be a 'methodological bricoleur' I also had to make the choice to be a 'theoretical bricoleur' in order to create an epistemological stance that was coherent (Denzin, Lincoln, 2005). A 'theoretical bricoleur' is one who incorporates their knowledge of the many different interpretive paradigms and brings them to their research question (Denzin, Lincoln, 2005). The 'theoretical bricoleur' does not necessarily feel that they can achieve complete consensus among the different paradigms and their different ontologisms and epistemologies, but they construct a belief system or perspective within these different worldviews (Denzin, Lincoln, 2005). I was asking my participants to work with me in a pluralistic framework and it feels congruent to take this stance in my research also.

My research could be thought of as the result of a bricoleur constantly 'defining and extending' themselves in order to create 'bricolage' (Harper, 1987). The term 'bricolage' feels like a close sister to my pluralistic framework and philosophy due to its pragmatic stance, its ease with 'dissensus' and its willingness to use different methods and perspectives to create a grounded theory. This was my aim; that as a bricoleur I wish to incorporate a group of compatible interpretive paradigms that can create an epistemological 'family' that are all different but have a common perspective or world view.

The first part of my bricolage is the pluralistic framework. The pluralist is one who 'accepts the inevitability of dissensus in a complex and imperfect world. She strives to make the world safe for disagreement. She works to realize processes and procedures that make dissensus tolerable if not actually productive' (Rescher, 1993:5). In regards to the search for knowledge pluralism is kind of a middle ground between the dogmatic absolutism of the purely positivist perspective and the apathy of relative nihilism. It is a philosophy that believes it is irrational to think that humans are going to

achieve compete consensus about the nature of knowledge and enquiry and that trying to is a waste of valuable time and resources. This philosophy advocates the celebration of dissensus and also believes that through trying to achieve consensus among humans we are missing the contextual factors that lead us to different decisions and different ways of being.

Richard Rorty suggests that the 'present-day' doctrine of pluralism is in fact pragmatism (Rorty, 1982). Rorty (1982) suggests that pragmatism shares ideals with pluralism such as, there is no such thing as a completely objective researcher, that contextual factors within the research need to be taken into account and they both agree that there is no 'simple, unique, ideally adequate conceptual-framework for 'describing the world' (Rescher, 1993). Rescher (1993) suggests that it is futile to think that when working with the 'phenomena of nature' there will be a singular or correct way of describing or explaining the phenomena. This seems to be where pluralism and pragmatism agree. Immanuel Kant seems to provide a thread of agreement between my epistemologies as Rescher describes (1993):

> 'There is no good reason to think that natural science as we know it is not something universally valid for all rational intelligences as such, but a cultural artefact. We have little alternative to supposing that our science is limited precisely by its being our science. The inevitability of empiricism- the fundamentality of experience of our knowledge of the world-means that our scientific knowledge is always relativized ultimately to the kinds of experiences we can have. The 'scientific truth' that we discover about the world is our truth, not so much the sense that we make it up, but rather in the sense that it reflects our technologically available modes of interaction with nature. The development of a science- a definite codification of the laws of nature- always requires as input some inquirer supplied elements of determination. The result of such an interaction depends crucially on the contribution from both sides- from nature and from the intelligence that interacts with it' (Rescher, 1993:41).

More specifically, Fishman suggests that the pragmatic psychology stance can be seen as 'a moderate constructionist position that also falls in the middle of the realist versus constructionist position' (Fishman 2008:9). Fishman explores Held's thoughts that this is the middle ground between the belief of naïve realism; that it is possible to fully understand and encapsulate human experience of reality through passive observation, and constructionism that believes you can never fully understand and encapsulate human experience of reality because through the process of observing, analyzing and explaining the reality is changed to a version of the researcher's reality (Held, 1995).

This concept of 'moderate constructionism' links with the pragmatic view as it places more importance on 'functional realities' and 'open constructive dialogue' rather than placing emphasis on 'ontological issues of what is real' (Fishman, 2008:9). In this sense pragmatism remains 'agnostic' on issues concerning how much we can fully encapsulate and understand human experience of reality (Fishman, 2008:9).

Additionally, Held suggests that radical constructionism advocates that every time an attempt to describe a reality is made a completely new reality is constructed (Held, 1995). Therefore, this denies the 'possibility of systematic, trans-individual knowledge' (Fishman, 2008:9). This is one of the reasons that a 'moderate constructionism' position is more appropriate for this research in that I would like to join Held's and Fishman's quest in creating 'knowledge that is generalizable across persons and situations' (Fishman, 2008:9). Fishman advocates gathering this knowledge through a process of 'systematic description of many individual cases and then inductively deriving generalizations as they emerge from cross case analysis' (Fishman, 2008:9).

Therefore my bricolage seems to be this; that there are plural methods of inquiry and that these methods should be chosen in respect to what is being studied. Phenomenon exists within a context and this context affects the 'knowledge' that is produced. There is no such thing as a perfect conceptual framework that will work to describe all of the phenomena in the world. By the

very nature of research, that is the researcher interacting with the data, the researcher influences the knowledge that is produced in some way and this requires reflexivity on the part of the researcher.

Evolution of the research design

Initial research design

My initial research design was to work with a maximum of eight (N=8) HIV positive clients using the pluralistic framework over the period of twelve sessions. It has been suggested that for the purpose of writing case studies you could actually centre a piece of research on just one however I wanted more than one case study so some comparison between cases could take place (Loewenthal, 2007). Therefore I chose eight participants in order to allow for a high dropout rate due to the very personal nature of what is being studied, to write up more than one case study and to allow for comparisons between these cases. I decided to audio record each session and take quantitative data at the end of each session using the Working Alliance Inventory (Hatcher, Gillaspy, 2006). I decided to take further quantitative data at the beginning and the end of therapy using the CLINICAL OUTCOMES ROUTINE EVALUATION (CORE) (Evans et al, 2000). I decided to ask each participant to keep a journal during the twelve sessions and I would keep a reflexive journal also.

Out of the eight (N=8) participants I decided to randomly choose three cases to develop into pragmatic case studies. I decided I would chose these randomly so that it stopped me from choosing what I thought were the 'best' cases and would also not give the message to the participants that somehow their case was 'not good enough' to include. I decided I would transcribe the three cases audio recorded sessions and then analyze the transcriptions using Kathy Charmaz's (2006) version of grounded theory.

I decided to write three pragmatic case studies including the qualitative analysis and the results of the quantitative analysis. The end product would

be a grounded theory of my research with quantitative measures that would give a sense of the outcome of the therapy.

My research design evolves

During the process of gaining ethical approval from City University some of the tensions in my research design became apparent. By conducting this research I would be taking on a variety of different roles and there were possible conflicts between them. Particular tension lay between the roles of therapist and researcher; this tension was increased due to my choice of quantitative measures as they implied a measure of outcome. The question I began asking myself and that other ethical bodies were asking was; was it ethical for the researcher who is also the therapist to postulate about the outcome of the therapy?

After many discussions with my university research supervisor I came to the conclusion that for the purpose of this doctorate research and the constraints of time perhaps it would be better to concentrate on the process of the therapy through the qualitative aspects of my research design. At this stage, I had not applied for ethical approval from the NHS and I had to make the choice whether I had the time to make my case for the inclusion of outcome measures. City University ethics committee had already questioned this choice and therefore there was a great possibility that the NHS would also. I made the decision to remove the quantitative measures from my research design however; I still wanted to make a case for my ability to ethically conduct a study where I am both researcher and therapist.

The main tensions in this dual role were:

1. My ability to provide the same level of therapeutic care to my participants.
2. Issues of confidentiality within the therapeutic relationship and how these can still be upheld during the research process.
3. Did I have the ability to be both reflexive and transparent enough with my participants and in reporting and conducting my research? Seeing I would be so embedded in the research process I would need to be

self aware, reflexive and open enough to share how I was affecting the research.

Additionally, in my initial discussions with my research supervisor at CASCAID (organization that is part of the South London and Maudsley NHS trust) it seemed that the choice of working with eight (N=8) participants was a bit too ambitious. I would be just starting this placement at the same time as starting my research and he felt that a maximum of six participants (N=6) spread over two days a week would be a better choice. Six participants (N=6) would still leave the possibility of a fifty percent dropout rate from the research and this felt adequate. Therefore the fact that I wanted to write three case studies would not be changed. Of course one of my roles was also to be a trainee-counselling psychologist with CASCAID and therefore I had to take my ability to work effectively and ethically within their framework into account also.

Sample

I selected six (N=6) clients from the top of CASCAID's waiting list. All participants are HIV positive. The case study approach does not aim for generalizability and therefore getting a representative cross section of age or gender is not applicable (Fishman, 2000). The health of the individuals is discussed within the research however it was not applicable in choosing the participants. Pluralism prides itself on its inclusiveness and I have attempted to reflect this in my sample of participants (Cooper and McLeod, 2007). I chose to select six participants in order to allow for up to a fifty percent dropout rate from the research.

The sample collection was not based on 'special' cases, but on HIV positive people that wish to enter into a therapeutic relationship.

Data collection

The original conception

Six (N=6) HIV positive people experience twelve, fifty-five minute sessions of pluralistic therapy. I was the counselling psychologist that provided the twelve sessions. Audio recordings were to be taken of each session.

The evolution from the original conception.

Out of the six (N=6) participants, five agreed to participate in the study and sign the consent forms and one declined. I had spent three sessions with the client at the point where she declined. For the purpose of this study this client will be called client A. It was clear from our three sessions and from Client A's CORE form that the client was experiencing suicidal ideation. I discussed this with my supervisor. My supervisor asked me whether the client was engaging with me and whether I thought a relationship had already been created in our initial three sessions. I felt a relationship had developed and I also felt that the client had started to engage in the therapy. We both decided that due to the client's suicidal ideation and her investment in our relationship that it would be unethical at this point to put her back on the top of the waiting list or ask another counsellor to take over. Therefore I continued to work with this client.

One out of the five participants that signed the consent form decided they no longer wished to be a part of the research after our fifth session. However, the client wished to keep working with me and we continued to work together, as agreed, for a further seven sessions.

Another participant out of the five participants that signed the consent form decided after the third session that he no longer wished to engage in therapy as he was finding it challenging to fit the sessions into his work schedule.

Therefore, three (n=3) HIV positive clients experienced twelve, fifty-five minute sessions of pluralistic therapy. I was the counselling psychologist. Audio recordings were taken of each session.

Journals and feedback sessions

The three participants were asked to write in a journal that I provided for them. The clients were informed that at the end of our time together it was their choice whether or not they felt comfortable with me using their journal in my research. It has been suggested that keeping a journal can help us to focus on our internal thoughts and feelings and can help us keep track of our development and perception of the world (Etherington, 2004). They were asked to write in the journal each week sometime after their therapy session. There were no guidelines set for their journal entries so as not to influence the data. However, participants were informed that they could use any medium of expression within the journal (for example; drawing, film reviews, painting or collage). The pluralistic framework encourages the 'whole' person to be invited into therapy and therefore this very personal piece of data should reflect that invitation (Cooper and McLeod, 2007).

During our sessions I asked the clients if the journal was helpful. All of the clients said the journal was helpful but that they did not feel like using it each week. They preferred using the journal as and when they needed it. One of the clients also told me that he would not feel comfortable with me using his journal in my research as he didn't want to feel like he had to 'edit' his experience when writing in it. I asked the other clients how they felt about their journals and their reaction was very similar.

I decided to ask my clients whether they felt they would benefit from, and feel more comfortable with giving me 'face to face' feedback about the case studies once I had written them. I also asked the clients if I could include their feedback verbatim within the thesis. All three clients suggested that this idea appealed to them. They liked the idea of a 'feedback session' and they liked the idea that their words would be in the research as well as mine. Therefore it was agreed that instead of an analysis of the journals, we would arrange a 2 hour 'feedback session' that would be audio recorded and transcribed and parts of which would be included in the thesis verbatim. The journals were

still used by all of the clients but only for private use at home and within our sessions.

Procedure

I selected six clients from the top of CASCAID's waiting list. I contacted each of the 6 (N=6) participants on the phone and personally explained the research and offered them an appointment. A letter was then sent out to officially invite the participants to come to their first session. In the initial assessment sessions with the participants I went through the information sheet I created to explain my research (see Appendix 1). I invited questions and allowed them to take the information sheet home to think about it further before they signed the consent form (see Appendix 1). When the participants felt ready I asked them to sign a consent form that would in no way bind them to the research but would give me their consent to proceed to include them in my research. After this process, one of the six participants, client A, declined to participate in the research however, due to ethical issues and my personal choice as a therapist, I kept seeing her as a client. One participant decided not to be a part of the research after our fifth session. However, he wished to still engage in therapy and I continued working with him for rest of the twelve sessions that we agreed to work together for. One participant decided not to engage in therapy after three sessions due to practical reasons.

I then proceeded to meet my now three participants (n=3) each week, at the same time, for fifty-five minute sessions of Pluralistic therapy. I taped each session using an audio-recording device.

At the end of the therapeutic process with my participants I then transcribed the sessions. It has been suggested that the process of changing spoken words into text is a part of the creation of the data (Silverman, 2000). After the sessions were transcribed I then analyzed the data using grounded theory strategies. I then incorporated the results into the three pragmatic case studies.

After writing the three pragmatic case studies I organised a 'feedback session' with each of the participants. The feedback sessions lasted two hours. I explained the analysis, read parts of the case study to them in the session and invited them to comment. These sessions were audio recorded and then transcribed. Parts of the transcriptions from these feedback sessions were then added verbatim into the thesis.

Grounded Theory Analysis Strategies

Once the data was collected a grounded theory coding strategy was used to code the data. Grounded theory coding is where the researcher begins to categorize the data and starts to construct and shape a frame from which definition and analysis can take place (Charmaz, 2006). Initial coding consisted of being open to the data and coding what emerges from it rather than from preconceived ideas or theories. It is important for the researcher to remember that the way they construct the codes and the language used are an attempt to understand the participant's actions in their world however, it is inevitable that the researcher's own world will influence the construction (Charmaz, 2006).

Therefore the process is interactive; it is the researcher's view of the participant's world. Coding at this stage was 'line-by-line' coding. This consists of giving a brief concise label to each line of data after the researcher has asked questions of each line of data such as:

1. What process might be at work here and how might I define that process?
2. What is the development of the processes at work? (Charmaz, 2006).

The next grounded theory strategy used was focused coding. This process consists of choosing the codes that occur frequently within the data or make most analytic sense of larger segments of the data. This is where the initial coding is tested and honed through further interaction with the data (Charmaz, 2006). The aim was to create analytic categories that best explain the data. This process was emergent and unfolding which means that the researcher

constantly interacts, compares and questions that data as new categories or ideas emerge.

During this phase of analysis I used a ‘clustering technique’ (Charmaz, 2006 to make sense of this second phase of my analysis. Clustering is a creative, non-linear and flexible process that ‘allows for chaos’ and keeps the analysis grounded in the data (Charmaz, 2006:87). I created a nucleus process from the focused coding that I felt explained one of the main processes occurring in the data. I then went back to the transcripts and asked my data what were the ‘defining properties’ of this nucleus process? In the case of this research these ‘defining properties were the smaller process that occurred within the main process. I then created smaller circles that contained definitions of these ‘defining properties’ with connecting spokes to the nucleus process and used bullet points underneath these to further define and explain these smaller circles. The idea was to use all of the data that was available in the transcripts and with each new part of the analysis; I would return to the data and continue asking it questions. This clustering analysis was used to help me understand my data in a creative way before I started writing.

Following from the clustering analysis I began to write memos about my categories. When writing the memos I named and defined each major process and then the more detailed processes within this major category. I continued to compare ‘data with data’ as I described the internal workings of each category. The process of memo writing ‘began to frame them (the categories and sub-categories) into a theoretical statement’ (Charmaz, 2006:86). I continued to change the memos as I compared the ‘data with data’ until I reached a stage where I felt I had adequately questioned the data and had encapsulated the process that had emerged from the transcripts. This required moving from the original ‘raw data’ and the line-by-line coding to the clustering analysis and then back to the memos. These completed memos were then added to the pragmatic case studies. I also used ‘memo diary’ in order to stay close to the data and as a way to analyze ideas and thoughts about the coding process. The ‘memo diary’ was also used to

explore the coding process, document it and make it more concrete (Charmaz, 2006).

Limitations of the research

I found the following five limitations to the research:

1. Due to the nature of the case study approach some lack of generalizability to the general public is the most obvious limitation of the study.
2. The therapist's ability to deliver the pluralistic approach effectively and consistently.
3. The fact that the researcher and the therapist are the same person means that this person will influence the research.
4. The ability of the author to use the pragmatic case study approach.
5. Reliability and validity issues due to the small sample and absence of a control.

Accounting for the limitations

It has been suggested by Cooper and McLeod (2007) that due to the overarching framework of pluralism and the richness of data within the case study approach that some aspects of generalizabilty may be achieved (Cooper and McLeod, 2007). Fishman (2000) suggests that by using multiple cases within research similarities within certain client groups may emerge giving rise to the possibility of transferability.

In order to ensure that I am able to deliver the pluralistic approach effectively and consistently I have attended Cooper and McLeod's workshop in Dundee and will continue to have contact with John McLeod.

In order to make sure that my own material and judgments have affected the data as little as possible supervision during this time is paramount. SLAM NHS Foundation Trust has provided the supervision sessions. I have also kept a journal during this time in order to reflect on the process.

In order to use the pragmatic case study approach effectively I have kept up to date with new developments in this method. In line with the pragmatic case study method I chose to use several different methods of data collection such as journals and recorded therapy sessions thereby engaging in a process of triangulation in order to improve the reliability and validity of the research.

CHAPTER 3: ETHICS

Prior to participants being approached, full ethical approval was granted by COREC (see Appendix 1). I was also granted an honouree contract with CASCAID that is an organization that is part of the South London and Maudsley Trust. This organization provides a counselling service for people who are HIV positive. CASCAID agreed to provide me with clients from their waiting list and a clinical placement within the organization. CASCAID also provided me with a clinical supervisor and a research supervisor.

Confidentiality

Confidentiality is an important part of counselling psychology and a vital part of the agreement between therapist and client. Although the clients participating in this research are aware that their therapy will be reported within a thesis, it is paramount that their identity be confidential. Any information that the client did not want to be included in the research has been excluded from the thesis.

Unfortunately being HIV positive today can effect employment, benefits, housing and travel (Terrence Higgins Trust, 2010). Sometimes HIV positive people face rejection from family, friends or partners. It is my belief that it is an individual's right to disclose or not disclose their status. This is a personal choice and I choose to honour the client's autonomy in this matter. The ways this research ensured confidentiality are as follows:

1. A secure email address was provided to me by CASCAID for purpose of communication between my research supervisor, clinical supervisor and if necessary the clients.
2. My notes are stored in a locked cabinet that only I have access to. The names of the clients have been stored separately to the client notes.
3. The names and any identifying features of the participants have been changed in the writing of the thesis or when I spoke to my university research supervisor.

4. I asked the participants consent before discussing the case outside of my research supervisor, clinical supervisor or other professionals within the service.
5. During the feedback sessions the participants were given the opportunity to review the case studies and analysis and request that I remove or change any details that they felt uncomfortable with.

The Practitioner-Researcher Role

Being ethical in both roles simultaneously

The practitioner-researcher is one who 'holds down a job in some particular area and is, at the same time, involved in carrying out systematic enquiry which is of relevance to the job' (Robson, 2002:534). In my case, I am holding down a placement as a trainee counselling psychologist and at the same time carrying out research with my clients from that placement. Robson (2002) has outlined some of the advantages and disadvantages of this practitioner-researcher role:

Disadvantages of the practitioner-researcher role

(Robson, 2002)

1. **Time**

   Probably the main disadvantage. Trying to do systematic enquiry on top of normal commitments is very difficult.
2. **Lack of expertise**

   This obviously depends on the individual. There is a need for some background in designing, carrying out and analyzing studies. A major problem can be 'not knowing what it is that you don't know'.
3. **Lack of confidence**

   Lack of experience in carrying out studies leads to lack of confidence.
4. **'Insider' problems**

   The insider may have preoccupations about issues and/or solutions. There can also be hierarchy difficulties (Both ways, i.e. with high-status

and low-status practitioner-researchers); and possibly the 'prophet in own country' phenomenon (i.e. outside advice may be more highly valued).

Advantages of the practitioner-researcher role

1. **'Insider' opportunities**
   You will have a pre-existing knowledge and experience base about the situation and the people involved.
2. **'Practitioner' opportunities**
   There is likely to be a substantial reduction of implementation problems.
3. **'Practitioner-researcher' synergy**
   Practitioner insights and role help in the design, carrying out and analysis of useful and appropriate studies.

Disadvantage number one was certainly an issue. I was doing this research in the time frame of a three-year doctorate and I had about one year to carry out the actual research. Therefore this has placed pressure on me and has made me more flexible with certain parts of my method. The main element this has affected was my original idea to include quantitative data. Due to the issue of time, such as time ethical approval may take, this had to be taken out. The second disadvantage listed above I had mixed feelings about. I felt I had some expertise in the field of research through my undergraduate degree and lectures during my doctorate, however this sort of research was a learning curve for me. But certainly this was nothing that some diligent reading and drawing on supervisors experience couldn't fix. The third disadvantage, a lack of confidence, I also had mixed feelings about. I felt confident that the research could be carried out and I was passionate about the way in which I wanted to do it. However, I had to research my own epistemological stance and philosophical base before I really felt confident.

I also felt that due to my undergraduate degree, my masters and my doctorate training that I had been trained to be in many roles at one time. I also felt my training had taught me to be a reflexive practitioner. In my work with clients I

had to reflect on my own beliefs, I had to learn to 'bracket' my own emotions for the sake of the client and I had to make ethical choices in a 'client-centred' way (Schneider et al, 2001).

The final disadvantage was about 'insider problems'. If I translate this to my own research I feel this disadvantage relates to my position as an 'insider' in my NHS placement that was providing me with participants. Because I am a trainee counselling psychologist at CASCAID this has meant that I have had to be a part of their way of organizing clients, supervision and things like paperwork and notes. This has been a learning curve and I have had to adjust my research and my time keeping accordingly.

The final part of the tension within this practitioner-researcher role was making sure that the same level of psychological care was given to my participants as any of my other clients.

The questions I asked myself were:

1. How would I divide myself? When was I researcher? When was I a therapist?
2. How can I make sure my needs and the client's needs are met adequately?
3. How can I make sure that I am present in each session for the client and not thinking about my research?

Levinas (1995) has advocated 'that ethics (putting the other first) must always precede ontology (the study of being)'. Levinas (1995) went on to clarify this by suggesting that ethical questions must always come before those of being or in my case, what is being researched. This was a grounding thought for me as I worked with my clients and led me to a couple of choices. During the twelve weeks I was with the participants they were my clients and I was their therapist. Therefore decisions were made according to the ethical codes I adhere to as a counselling psychologist even if they affected my research in a challenging way.

Once my work as a therapist was done then I could become a researcher and begin to analyze my data. Any further decisions about content of my case studies would also be made from the role of therapist. My clients came before my research. This at times made me feel uncertain and anxious but ultimately made me feel clear about my role at each stage of my research. I certainly felt stretched emotionally, I felt exhausted and challenged professionally but I did feel clear about my roles and how to make ethical choices. My research into how to make this choice about what my roles were at different stages of my study reminded me that there is a world outside my research that is infinitely more important and it is in fact this real world that I am trying to explore; therefore it must be treated with respect and be given higher priority than the research itself. After a while of adopting this stance it actually helped me to feel grounded and calm.

Reflexivity

I have been reflexive throughout the discussion of my methodology however there were a few parts of the research process, my different roles and some of the difficulties I faced that warranted their own section and further discussion.

I was warned by many people that the research process was going to be challenging for me personally and professionally but I don't think I realized how challenging until I was actually doing the research. I think the first realization came about half way through the phase where I was still collecting my data. My participants were first and foremost my clients. I was first and foremost their therapist, not a researcher. This really became apparent when I made the decision to continue with client A instead of offering her another psychologist to work with. My clients had to come first: I believed this personally and I was also ethically bound to believe this. This meant that my research was secondary to the care of my clients, which ultimately meant: my clients came before my doctorate. This was eventually a humbling and grounding experience but first of all, it was a frightening one. I've worked

diligently for a period of seven years to finally get the chance to achieve the accolade of doctor and this is still something I very much want to achieve.

I did initially want to put this research as top priority in my life over everything else, just for this year, in order to achieve my goal. However, due to my choice of research, this was not possible. At first this felt like my research was out of my hands and the uncertainty was difficult to process. However, there are so many parts of the research process that are subject to uncertainty that eventually I learnt to live with the change that is out of my control and adapt to it. With such a barrage of change and uncertainty you either learn very quickly how to cope or you would probably give up. This developed me not just as a researcher or counselling psychologist, but as a person also. To live with uncertainty and adapt to changes out of my control meant that I was better equipped to consistently put my clients first, above my research.

It was also the clients that helped me to put things into perspective. Why was I doing the doctorate? I was doing the doctorate in order to work with clients and go as far as I could academically. However, if I stepped into the 'here and now' I was working with clients and I was stretching myself academically. Regardless of the accolade of doctor I was privileged enough to be doing what I wanted to do right now. These clients trusted me to be a counselling psychologist right now. This thought kept me grounded in my work as a therapist and kept my work as a researcher in perspective.

CHAPTER 4:

THE PRAGMATIC CASE STUDIES

The Formulation

Apart from using the goals, tasks and methods framework of pluralism to conceptualise the client's goals there was no formal, fixed formulation that became a part of the treatment. The treatment was lead by the client's goals as and when they came up in the sessions. The client was then invited to collaborate with me to form our formulation of the client's issues and we then pooled our ideas together on how to work with these issues. Pluralistic therapy is an open invitation to the client to focus on their 'own plans, strategies and assumptions' (McLeod, 2007:121).

Additionally, through the process of identifying and clarifying the client's goals these goals frequently evolved into new goals or changed in their definition. These goals also changed as the client changed during the course of therapy. One of the key elements of the pluralistic framework is that the client is truly at the centre of the therapy and is included, and sometimes leads, what shape the therapy will take. Therefore in each of the sessions pluralism allows the client and the therapist to focus on what is most important and relevant to the client at that time. A formal formulation prior to this may in fact be a barrier to this openness and flexibility. Rosenzweig (1936) suggested that 'the therapist formulations of the problem need only have enough relevance to impress the client to begin the work of change' (Duncan, Miller and Sparks, 2004:52). Duncan and colleges (2004) advocate that this suggestion reflects Rosenzweig's belief 'in the client's capacity for change and the enlistment of the client in that endeavour' (Duncan et al, 2004:52).

Case Study One: Client ‘B’

(The client requested that his name be changed to ‘B’ for the purpose of this case study)

The Client

B was born and grew up in the UK. He was born prematurely and had problems with his lungs for the first four years of his life. He is the middle child of three children and has one older brother and one younger brother. B recalls that he cannot remember a time when his parents did not argue. B recalls that he was about five years old when he knew he was different in some way; this was when he first started to realise that he was gay. When B was eight his father took him to Europe without his mother’s consent and he lived there for about two years. Around the age of ten his mother won a court order and B came back to the UK to live with his mother. B’s parents divorced around this time also. When B was ten his mother remarried and he gained two older stepbrothers and a stepsister. When B was eleven his father remarried and his new wife had three children from a previous marriage who were all younger than B. B had very little contact with his father after this and he felt that he had abandoned his ‘old family’ to go and be with his ‘new family’.

B was bullied in school because of his sexuality although he reports that he also had very good male and female friends. When B was fifteen he was raped by man. This is the same year that he told his family he was gay and the same year that B left school. B’s family did not accept his sexuality and he left home at the age of sixteen to live with an older man who he was seeing at the time. One day B woke up and he found that this man had left their home and he never found out why.

When B was nineteen he started training as a health care professional and qualified a couple of years later. B loved his job and experienced the feeling of success in some of the projects he was involved with. In 1996 B was mugged and suffered severe head and brain trauma as a result.

In 1998 B was diagnosed as HIV positive and four months later he developed bi lateral blood clots in both legs and lungs. He also had persistent generalized lymphpandopathy and this diagnosis remains today. In the following months he developed meningitis, encephalitis and a diagnosis of HIV encephalopathy. He also developed several pneumonias and peripheral neuropathy. B was eventually given an AIDS diagnosis.

When B was extremely sick he lost his job and was also denied his pension. At this time both B and his partner were in the same hospital facing their mortality due to their AIDS diagnosis. In 1999 B's partner died. He started to prepare for his own death. He said goodbye to friends and family and felt he had made peace with his life. B then started to grow in strength. Eventually he was well enough to leave hospital and started writing his memoirs from home.

In 2003 he attempted to return to work and he met his current partner Anthony. Anthony is also HIV positive. In 2005 they decided to go on a trip around the world together. They didn't know how much time B would have left and decided to travel while he was well enough to do so. In 2006 B developed encephalitis, left with trigeminal neuralgia and severe ice pick headaches. Since these diagnoses B has lived with periods of severe and debilitating pain that he has to manage with medication.

In 2006 B reports that his partner started drinking as a way of coping and their relationship became volatile. Their relationship has been volatile since this time and B reports that this includes physical, verbal and emotional abuse.

B approached CASCAID (mental health service for people affected by HIV) for psychological support. Our therapeutic relationship began in 2009. B arrived in the therapy room with a sense of urgency as he felt that both he and his partner needed support.

Assessment of the client's goals

For the purpose of this case study I will identify some of the client's main goals and how these changed over time. In our initial sessions the client's goal was to gain access to effective psychological support for his partner. He felt that the support his partner was getting was inadequate and he felt this negatively affected him, as he was his partner's carer. Through exploration in order to really understand this goal several other goals emerged. The client wanted adequate support for his partner but he also wanted support for himself. After exploring his role of carer it became apparent that one of his goals was to restore some balance to his role of carer and his role of being a partner in the relationship. He felt that his role of carer had taken over and he wanted to be his partner's boyfriend as well as someone who physically and psychologically cared for him. Another goal that felt contradictory emerged through exploration. The client wanted support for his partner and wanted to be more of a boyfriend than a carer but he also wanted to monitor and in a sense control his partner's care.

We both agreed in one of our earlier sessions that this was an enmeshed relationship and the client wished to step back slightly from this enmeshment. I was congruent with the client about the presence of the two contradictory goals not in order to discount them, but to explore what they both meant to him. In time my client taught me that he actually very much wanted to 'step back' from the enmeshment but felt he couldn't do this until someone else became 'expert' on his situation. This led us to one of the client's main goals in our therapy sessions; he wanted to be listened to, heard, understood and he wanted to teach someone else how to be as 'expert' and knowledgeable about his situation as he was. He simply didn't feel people were 'getting it'. This is a man that has lived with HIV for over 10 years, been through situations where he was told he had 6 months to live, who has been through periods of great ill health and has become an 'expert' on what he needs. However, he wasn't prepared to allow other people to care for him until they had allowed him to teach them about his expertise.

Another central goal of this client was to explore and process major life events that he felt had affected him in some way. Some of these events brought up such themes as death, anxiety, loss and injustice. Therefore this client's goals started out being very much concentrated on others and as these initial goals were accepted and explored and more shared understanding was created the therapeutic goals became more about him.

The course of therapy

As stated previously the client's first goal was to find support for his partner. We explored what this goal meant for him. The client wanted to concentrate on his own health and his own needs but he made it quite clear that this was very difficult unless he felt his partner was being taken care of. We used the person-centred model in order to explore and process this goal. The person centred model advocates that through using six core conditions the therapist and the client can create an environment where the client is encouraged to operate from an internal locus of control (Rogers, 1957). The internal locus of control is seen as part of the client's true 'existential self' (Mearns and Thorne, 2007). The six core conditions help to create an environment and a relationship where positive therapeutic change can happen (Rogers, 1957). The three main core conditions are unconditional positive regard, congruence and empathic understanding (Rogers, 1957). In our first sessions B made it clear that he wanted someone to listen and truly understand. B also made it clear that he wanted to direct the sessions in order to fully explain his sense of urgency, the situation he was in and what he wanted from the sessions.

Once all aspects of this initial goal were explored and the goal was defined we began brainstorming together about what tasks B might help meet this goal. The main tasks we identified were:

1. Trying to make sense of what sort of support would B feel was adequate for his partner.
2. Create a shared understanding why this goal is so important to B and how this goal developed.
3. Involve the service I was working for (CASCAID) in order to talk to other professionals about B's needs.

4. Explore what life is like for B without the support he wanted for his partner.
5. Explore his relationship with his partner.

It seems that the process of identifying and clarifying goals and tasks more goals were identified. I will explore these new goals at a later stage of this case study. Therefore even though the pluralistic framework gives the therapist and the client a clear way of working the three domains are not mutually exclusive and we sometimes ended up working within the three domains at the same time. I also found that by working in one domain other aspects of another domain were created. The methods we chose for working with these tasks included:

1. Exploration and discussion about the client's relationship with his partner.
2. Clarification about client's experience.
3. Communicating unconditional positive regard.
4. Trying to understand the client from their point of view.
5. Discuss the client's situation with my supervisor and the service.
6. Think about and explore the systems around B including his partner.

B wanted our therapeutic space to be somewhere he felt safe enough to explore some difficult parts of his life and he didn't want to be judged while he was doing it. We both discussed the options of how we would work together. B did not feel it would be helpful at this stage to use methods such as CBT to explore his thoughts and begin to challenge them. He wanted his thoughts to be respected and accepted. He felt he had plenty of people that wanted to 'tell him what to do' and he wanted our therapeutic space to be different. At the end of our time together when I asked B what his experience of our time together was like he explained that it was these beginning sessions that gave him hope. He suggested that because our relationship began from a position of acceptance and concentrated on his goals he felt more able to engage with me as a human being rather than just another 'professional' that he had to fight with to get what he wanted. When using the person-centred model I tend to work from Rennie's (1998) theory concerning the directive and the non-

directive position of the therapist. More specifically I am mostly non-directive when it comes to the client's content but I will become more directive when it comes to the client's process. This is in order to facilitate further processing of how the client makes sense of his content and it is also a way of challenging the client from within their frame of reference (Rennie, 1998).

I also used the systemic model to think about B's situation. The first element of his life that he brought to therapy was his relationship with his partner. He also discussed challenging relationships with many of the professionals he had to see on a regular basis. B also discussed past traumas that involved the people and the company he used to work with. Bor, Miller and Goldman (1993) provide an overview of systemic counselling specifically for HIV positive clients. It has been suggested that 'medical or physical problems have implications for relationships, whether these are between family members, lovers or health care providers. They can also affect people's view of themselves' (Bor, Miller and Goldman, 1993:5).

In order to meet B's goals I also involved the service I was working for (CASCAID) in order to discuss how we might all meet the needs of this couple. I discussed the case with my supervisor and explained some of B's concerns. During this time B and his partner set up a meeting with CASCAID in order to discuss their needs. We agreed to discuss this meeting in our sessions and create a plan for how B wanted to operate in the meeting; exactly what his needs were and what an acceptable outcome of the meeting would look like. This will be discussed in more detail later in this case study.

B's second goal developed through the exploration of the first goal. He wanted to find support for his partner but one of the reasons he wanted this support was so he could create more balance between his roles of partner and carer. He wanted to be more of a partner.

The tasks we identified to meet the goal of creating more balance between B's partner and carer roles within his relationship were:

1. Exploration of both roles and making sense of what they mean to B.

2. Creating a shared understanding of what this ‘balance’ may look like.
3. Making sense of how the roles became unbalanced.
4. Staring to find space and time to write again.
5. Problem solving and planning possible new ways of interacting with his partner.
6. Preparing for a meeting with CASCAID about Anthony’s needs that they will both attend. Preparing to take the role of partner rather than career in the meeting.

In the session following the meeting we explored the outcome. B was both pleased and surprised. CASCAID agreed to support Anthony in a way that felt adequate to both of them and B discussed that he remained in the role of partner and that this felt great.

During one point in the therapy it became challenging for me to ‘be with’ some of B’s choices. My honest feelings that I was bringing to supervision were that this relationship felt destructive for both B and Anthony. I very much cared for my client and felt a deep sense of empathy for his position but as this sense of care and empathy grew so too did my feelings of wanting to protect him. These feelings translated to a time in our therapy where I found myself becoming more directive and I was encouraging B to consider the ‘unacceptable’ nature of some elements of the relationship. Although B expressed that this was helpful to consider he was picking up through our time together that I may have had feelings about whether or not they should be together and he found this very unhelpful. B became resistant and frustrated with me and at this time it seemed that I was another professional he had to ‘fight’ to get what he wanted.

B had faced relationships in the past that were not honest and others that had ended with a sense of injustice. I decided to be congruent about my feelings. I told B that I was finding it challenging to accept all of his choices in his relationship and yet I wanted to provide the support and respect he was so clearly asking for. B started to explain to me that he was in the same position. He wasn’t sure about his decisions and yet he knew he wanted to be with his

partner. We continued to explore both of our feelings and during one session we explored what it would be like for B to leave his partner. The following session B arrived in the room with a sense of clarity and he began explaining this clarity to me. He said that our last session made him realize that he did have choices and in fact it was his choice to stay with Anthony. We then discussed where we both stood in our feelings about this and what this meant for our relationship and our work together. I agreed to respect his choice to stay with Anthony however B agreed to respect my choice to be concerned about him. This felt like a turning point in our therapy. Our relationship had been tested and it felt stronger as a result of this test. We didn't have to completely agree in order to work together towards B's goals but I did have to accept B's autonomy and B wanted to take the responsibility for his choices. McLeod (2007) has suggested that 'challenge and disagreement' can be an important part of the therapeutic process and dialogue between the therapist and the client (McLeod, 2007:240).

Through exploration of this goal, two contradictory goals became evident and we decided to work with both of them. We used similar tasks and methods in order to work with these goals, as they seemed to be 'two sides of the same coin'. It felt important to acknowledge both of them as very important to the client. This is where the client was; he seemed to want both and he was struggling with ambivalence towards this dichotomy. At first I thought that the client didn't want to reduce his role as carer because he didn't want to reduce his level of control over his partner's care due to the relationship being so enmeshed. I brought this hypothesis to my client many times in many different ways and his frustration with me was clear. B suggested that he was someone who enjoyed being in control and certainly there were aspects of this with his partner but there was much more to his situation than my rather simple hypothesis. B truly believed that the only thing standing between him and his partner having the relationship they wanted was the right kind of psychological intervention and support. B and Anthony's relationship may have been enmeshed and dysfunctional but they were dealing with extraordinary life stressors on their physical and mental health, on their finances, on their social life and on their careers. I wondered if all of this had

happened to me and my partner would I want to find a solution? How controlling would I become over his level of care? Would I know when to step back? Yes I would want to find a solution and in the meantime I'm not sure I would know when to step back.

Once I finally understood B's situation and started to have a more authentic empathy for his position in this situation our work with these two contradictory goals became much more authentic also. The two goals we identified were:

1. That B wanted to be Anthony's carer because he was scared if he let go that others would not provide the care that he felt Anthony needed.
2. B very much wanted to step back from being his partner's carer, as he wanted to enjoy being his partner. He wanted to let go.

An overarching goal then emerged through our exploration of the two contradictory goals that B presented. Even though B wanted to be taken seriously and accepted as an expert on his experience by other professionals, including me, what he really wished for was that someone else would become an expert with him. He wanted to 'train someone else up' so they could be up to speed with his experience. This was difficult and frustrating for B. Sometimes he would arrive in hospital and would know what was wrong with him, what medication he needed and how much he needed before the doctors or the specialists would. We discussed the doctor's and the specialist's position and explored the possibility that they were simply trying to provide B with the best care however; he explained that it is still frustrating to have to explain his long and complex medical history each time. He also faced frustration with a GP who questioned his pain medication. B frequently experiences high levels of pain for prolonged periods of time. He explored feeling judged and like he had to argue his case while being in debilitating amounts of pain. B later changed GP's and feels much more comfortable with his new GP.

Another goal that B identified was that he wanted to explore and process traumas he had experienced in the past. This was a section of our therapy that felt very different to the other sections as B really worked hard to

concentrate on himself and his own needs rather than the needs of others. We had identified previously that this was sometimes difficult for B to do.

During the course of therapy we took a brief amount of time to explore B's childhood experiences and his relationship with his family. B had experienced therapy before that concentrated on these areas of his life and he felt that he wanted to explain these experiences and relationships as part of his 'narrative' but he didn't feel he needed to spend a great deal of time on them.

We did spend some time exploring B's relationship with his father, as this was something that still confused and upset him. The methods we used to explore this relationship were the person centred model and we spent some of the sessions brainstorming about creative ways to understand and process some of B's feelings about his father. During one of our sessions B seemed quite emotional and he explained that father's day was a couple of days away and this reminded him that he didn't have the father figure he wanted. I put myself in the position of 'student' and B began 'teaching' me what this was like for him. Using the person centred model I took a non-directional stance with the content of what B was saying however, I was more directive with B's process in order to facilitate a deeper level of processing and understanding (Rennie, 1998). We then started brainstorming about what B could do this father's day. B explained that he usually sent a card to his father and when he still didn't hear from him he felt he re-connected with a large amount of stagnant hurt inside him. B decided he still wanted to send the card this year but we both agreed that B would send it without expectation of anything in return. The sending of the card was B's choice and therefore we explored the fact that perhaps he could also choose his level of expectation of what might or might not come from it. We also explored perhaps reaching out to a close friend on this day and making sure B treated himself with love and respect. We agreed that this father's day B would go out for tea and cake with a good friend. B wrote his father a father's day card and commented that it did feel different and almost empowering attempting to write it without expectation.

Part of our time together was spent exploring and processing experiences that

contained the theme of loss. A method that became important during this time was our relationship where the client was viewed by me as expert of his experience and therefore the expert in the room. Some of the losses that B had experienced were way beyond my own experience of life and death and I often felt humbled being in the same room as him. Therefore B taught me what these experiences were like.

Existential theory from Laura Barnett (2009) likens a HIV diagnosis as like a 'mirror to life' as it can push the diagnosed person into a process of reassessing and questioning what life means; or more specifically, what their life means. Barnett (2009) suggests that she sees 'each person as having to construct his or her own meaning in a world that lacks intrinsic meaning' (Barnett, 2009:64). Furthermore Barnett (2009) advocates that the therapist attempts 'to understand and appreciate the various stances which each client adopts towards themselves and the world' (Barnett, 2009:64). In this attempt to understand and accept the client with this level of depth it has been suggested that it is important for the therapist to take a stance of 'unknowing': or a stance that promotes acceptance of many different views about life and death (Barnett, 2009). Therapist holds the tension in the 'uncertain certainty' that we will all die, but we don't know how or when (Barnett, 2009). In this sense the therapy becomes collaboration between the therapist and the client as they both explore the client's world together.

During one session B described a time in his life where he was very ill in hospital. His boyfriend at the time was in the same hospital and was facing his mortality. B was there with him when he died. Shortly after his boyfriend's death B was told that by the doctors that he had six to a year months to live. At the same time B was told by his employers of ten years that he no longer had a job and for other reasons due to his dismissal, he could not collect his pension. B was furious, confused and found the entire situation incredulous.

B started making preparations both practical and personal in nature. He described saying goodbye, making peace with his life and making peace within himself. Barnett (2009) has suggested that 'the significance of our

mortality as recognized existentially is that it may foster an attitude of authenticity and thus contribute to reducing fear and anxiety, allowing growth, renewal and vitality for life' (Barnett, 2009:61). B said that he certainly didn't want to die but through the act of making peace with his life and facing his mortality in a very open way he found a sense of peace with the knowledge he was going to die. Existentially, having your body and your physical being 'fail' you and lead you further to your death can 'threaten our worldview and our whole world in all its dimensions' (Barnett, 2009:63). B described in our sessions some of the 'knowledge' that was created through his interaction with death. He explained the importance of love and being loved. He described that he decided he never wanted to 'wait' again to do something like travel or have a new life experience; he decided he wanted to be more fearless in the way he lived. He also described that his dislike of injustice or things in the world that felt 'unfair' increased in strength and volition.

Barnett (2009) also identifies that facing your own mortality or having a life threatening illness can 'highlight the existential alone-ness of the individual' (Barnett, 2009:62). Barnett (2009) explains that in her own client work she has found that sometimes a client's reaction to this existential alone-ness can manifest itself in an increased desire to 'merge with a partner, to be rescued by love and intimacy' (Barnett, 2009:62). This made me think about B and Anthony's relationship and B's frustration with people not understanding their bond. It seemed that B's experience of death and illness had perhaps made love an extremely important element of his life. This was an element of B's relationship that we challenged however it was important to do this from within B's frame of reference and within the context of his goals. He didn't want to leave Anthony; he wanted to create more balance in his relationship and this is what we worked towards.

Grounded theory analysis and discussion

After the 'line by line' coding of the transcripts was completed, I did a grounded theory cluster analysis that is shown diagrammatically in Appendix 2. The cluster analysis generated a visual map of my data and the themes

that emerged. On the basis of these themes, the following four processes were identified:

1. Understanding the road to the therapy room: what the client brings.
2. Creating shared understanding of the client's goals: what does the client want?
3. Becoming the client's student and challenger: creating a balanced relationship where the client is expert.
4. The process of processing.

Writing the following memos about each process allowed me to clarify, refine and make connections between the themes. This enabled me to further identify and define the four key processes. Direct quotes from the transcript are not included in the main body of the text due to word count restrictions.

Please refer to Appendix 3 for a more detailed description of the processes and sections of the transcription (including direct quotes) that support the following memos.

Process One

UNDERSTANDING THE ROAD TO THE THERAPY ROOM: WHAT THE CLIENT BRINGS.

This process can be defined as a period where shared understanding between the therapist and the client was created. Because this client has been HIV positive for 10 years there were many experiences that needed to be understood in order to create a comprehensive list of the clients goals for therapy in accordance with the pluralistic framework. Cooper and McLeod (2007) stress the importance of creating shared understanding through collaboration with the client in order to create goals with the client that are specific and important to them.

This process took longer than I expected with this particular client lasting six of the twelve sessions that were recorded. As this process continued it became apparent that this process was actually one of the client's goals: to be

heard, understood and accepted. I feel that this goal was of primary importance to this client. Due to some of the experiences that he had with 'professionals' such as GP's and psychologists, he felt that he had not been truly heard for quite some time. Additionally, he felt his expertise about his experience of being HIV positive was not being effectively utilised or respected by professionals. Therefore this client arrived in my therapy room angry, frustrated and with little hope that I would really listen to him. Due to the importance of collaboration in pluralistic therapy the client and myself were able to take our time and go through this process of creating shared understanding in order to create goals that the client felt were relevant to him. In our second session he suggested that this process created hope during a time where he felt entirely hopeless.

The themes that emerged from the transcripts were:

Identifying client's existing coping strategies.

By exploring the client's experiences the coping strategies that the client had developed emerged from the sessions and we highlighted and explored these strategies.

Communicating 'I am expert'

The client took time in almost each session to communicate his expertise. He communicated this through sharing his knowledge with me about his experience of being HIV positive and the contextual details of his life.

Exploring invisible needs.

This involved exploring the needs of the client that were not obvious and some that the client felt were hidden. These invisible needs included pain, HIV and emotional needs. The client felt that because he didn't look unwell sometimes his needs were invisible to others including his partner, friends and professionals such as his GP.

Exploring experience of professionals.

This client had regular contact with several different professionals including doctors, psychologists and HIV specialists. This regular contact meant that B's experience of being involved with these professionals was a significant part of his life. We discussed his experiences with these professionals by exploring specific times in his life where these experiences had affected him in some significant way.

Creating shared understanding.

By exploring who the client is, what his experiences were, what these experiences meant for him and his current situation we created a detailed 'pool of knowledge' about the client. I then summarised and reflected back this collection of knowledge to the client to invite him to correct or adjust my understanding. The eventual outcome of this exploration, summary and adjustment was that we both had the same 'data' or 'pool of knowledge' to work from.

Exploring the client in context.

We explored the context in which the client lived his everyday life by discussing the home he lived in, his relationship with his partner, family and friends and how he structured his day. This contextual information added to our 'pool of knowledge' about the client in a more detailed way. This added insight into our shared understanding about what it was like to 'be' B.

Exploring traumatic experiences.

The client's traumatic experiences had a significant affect on who he was and how he made choices in his life therefore in order to create shared understanding we explored these experiences.

The information that emerged from these themes allowed this first process to be created. These themes were not mutually exclusive and they did not occur sequentially apart from Process One, which did occur first. They interacted with one another often emerging and then re-emerging in the sessions. For

example while we were exploring the client's traumatic experiences we would sometimes begin identifying the strategies he used to cope with these experiences and then this may move to an exploration about some of the client's 'invisible needs'. Additionally, even though the theme of 'communicating I am expert' occurred overtly I also suggest the client was actually communicating his expertise within all of the themes in a more covert way.

The pluralistic framework advocates that a shared understanding about what is important to the client must be created in order to then go onto the next step of collaborating with the client in order to set the client's goals (Cooper and McLeod, 2007). In relation to this specific client Process One was important in order for us to set specific goals however, it was also important to truly understand the client's experience of being HIV positive. Due to this specific client being HIV positive for many years his experiences were vast and complex. Additionally, due the fact that the client had several experiences where he felt he was discriminated against and treated unfairly, Process One allowed the client to start working on one of his main goals straight away; the goal of being heard, understood and respected. It was also clear from the transcripts that collaboration with the client created a sense of respect for the client's experiences and the client's expertise. This collaborative relationship later lead us to being able to create a specific, 'bespoke' relationship between me and the client that I will explain in more detail in the section concerning Process Three.

The methods used that emerged from the transcripts were:

- Being transparent about the therapeutic process.
- Being congruent with the client.
- Being authentic and genuine.
- Trying to understand the client from their point of view.
- Exploration of client's world.
- Collaborating with the client.
- Staying with the client.
- Communicating about the patterns of our communication.

- Active listening.

It was the mixture of these methods that helped to facilitate the creation of Process One and gave us the ‘tools’ to work with the themes within this process.

Transparency in the transcripts involved me (the therapist) being open and clear about what it was that we were doing. This sometimes involved explaining a concept in psychology or a specific counselling model. It also involved being transparent as a person. This transparency meant that I would show the client if I was saddened, confused or in some way affected by what he was saying. This transparency helped us to create Process One as it allowed me to be open and honest about my understanding of the client and how his material ‘sounded’ and ‘felt’.

Another part of being transparent about what we were doing was the method titled ‘communicating about the patterns of our communication’. This is also sometimes called meta-communication and can be defined as ‘talking about talking’ or ‘communicating about communicating’. During Process One the client and I would talk about the way in which we were communicating and whether it was effective for what we were trying to do.

The method titled ‘staying with the client’ was used to ‘give the client room’ to explore his experiences. In a fictional book call ‘The art of racing in the rain’ the author describes the skill of truly listening and understanding someone (Stein, 2009). He suggests not interrupting with your own material while someone is telling their story; he likens this to ‘stealing’ someone’s narrative while they’re talking. Therefore I stayed with the client while he was telling his story without interpretation and with minimal interruption. The idea was not to ‘steal’ his stories.

The method of ‘Active listening’ was an important part of ‘staying with the client’ and a vital method within Process One. I define active listening as listening with the intent to hear and understand. It requires the therapist to

truly be in the ‘here and now’ with the client with the intent to listen to what the client is saying, what they aren’t saying, what their body is saying and maybe what they are frightened to say. The therapist makes a commitment to completely focus on all aspects of what the whole client is saying. This involves far more than only listening to the client’s words.

For this specific client the core conditions of congruence and empathy seemed to frequently occur together in the transcripts (Mearns and Thorne, 2007). I feel this was because in order for this client to truly experience empathy from me he needed me to be authentic with him first. Due to his previous experience of ‘professionals’ he was not prepared to put his trust in someone with a ‘professional mask’ on. In order for us to progress to the next process, the client required me to go through this initial process as a human being first, and a ‘professional’ second. It could be suggested that pluralisms’ emphasis on collaboration with the client and truly understanding the client’s needs and goals allowed this client to feel ‘in charge’ of creating what his therapeutic experience would be.

This client was in crisis when we first met and I felt a sense of urgency during this process to be there for the client but also effectively utilise the pluralistic framework. Part of the framework consists of clearly setting goals in each session and then clearly identifying (with the client) the tasks and methods that can most effectively meet the client’s needs. I feel we identified many of the client’s goals in this beginning process however, not all of them were clearly identified and stated within these initial sessions. Additionally, it seems that many of the tasks and methods used were not clearly identified during this initial therapeutic process. They were there, but they were not necessarily said out loud and systematically worked through to the end goal. This was the first client I had worked with using the pluralistic framework and I feel my inexperience with this framework was apparent during this initial process. It felt at times challenging to take the time in the session to identify the goals, tasks and methods that we were working on. During my analysis I started asking questions such as, how could I have made this process more effective? Through my analysis and through reflecting on my work I feel that I

could have made this process even more effective for the client by 'naming' what was going on in the therapy more as it was happening in the 'here and now'.

Process Two

CREATING SHARED UNDERSTANDING OF THE CLIENT'S GOALS: WHAT DOES THE CLIENT WANT?

This process is defined as a period of identifying and creating a shared understanding of the client's goals. The process involved the client exploring and 'teaching me' about his life and then both of us collaborating to identify his goals. Again this theme of the client being an 'expert' occurred within the transcripts. For parts of this process it felt like the client was telling several different narratives about his life and then I was focusing the session, slowing down the pace, and inviting him to work with me to identify what he wanted and what his goals were from these narratives.

The themes (these themes map onto the pluralistic framework in the form of therapeutic 'tasks') that emerged from the transcripts were:

<u>Accepting the client as expert.</u>

Accepting the client as expert can be defined as the therapist attempting to bracket their own ideas about what the client is saying and treating the client's material as something that is 'knowledge' or 'truth' for the client. This stance also involves a belief that the client knows more than therapist about the experience of being HIV positive.

<u>Exploring the concept of a space to be 'messy'.</u>

One of the client's goals for therapy was to create a place where he could be sad, unwell, or angry and the client defined this as a space to be 'messy'. Therefore we explored what the word 'messy' meant to him and what this would look like.

Exploring choices.

We discussed the client's choices in relation to his partner. We also discussed the concept of choice and what having choices meant to the client.

Exploring wanting to be understood.

One of the client's goals was to be understood and therefore we explored this concept. We also explored why it was so important for him to be understood.

Exploring our relationship.

This theme can be defined as discussing the relationship between me and the client and whether it is providing what the client needs. It also involved exploring parts of our relationship that were similar or in some way mirrored other relationships in the client's life.

Exploring the concept of balance.

The client wanted more balance in his relationship, he wanted more of a balance between his own self care and the time he spent caring for others and he wanted a balance between his pain and the side effects of his medication. Therefore this theme can be defined as the therapist and the client discussing the concept of balance within these areas and what balance would look like.

Exploring contradictory goals.

A couple of contradictory goals were highlighted by the client and in accordance with the pluralistic framework we discussed them both. The two main contradictory goals were that the client wanted control over his partner's care but he also wanted to step back from being so involved in the care of his partner.

The methods used that emerged from the transcripts were:

- Challenging the client.
- Communicating about our patterns of communicating.
- Normalising.

- Focusing the session.
- Being confused with the client.
- Trying to create an authentic relationship with the client.
- Creating a relationship where the client is the expert.
- Allowing the client to teach me.
- Checking and clarifying.
- Setting goals.
- Brainstorming with the client.
- Communicating unconditional positive regard.
- Being congruent and authentic.

The method of 'challenge' in Process Two can be defined as the therapist being congruent with the client in order to gently challenge. If I felt that there was a disparity between what the client was saying and what he was communicating through body language then I would mention this to the client. This method also involved challenging the client to explore something from a different perspective to see how it looked.

One of the client's goals was to create a space that was for him as well as a space he could discuss his partner's care needs. However I found after a couple of sessions that most of our time was taken up with the topic of his partner and very little time was spent on B. Therefore I suggested that we spend a certain amount of time focusing on his partner and then the rest of session was devoted to B. The method of 'focusing the session' involved putting a 'time boundary' around how long the client could discuss his partner.

The method of 'normalising' can be defined as helping the client to see an event or a situation in a more realistic or balanced way. For example, while discussing the concept of balance the client would often say that he couldn't understand how he could let things become so unbalanced and that there must be many people out there that are doing a much better job of dealing with life than him. Therefore we discussed what a challenge being HIV positive is and how it is completely understandable that sometimes things

would become unbalanced; we attempted to normalize his thoughts about how he felt he should be able to cope 100% all of the time.

Another one of the client's goals was to be given the space to explore his own material, be respected as an expert and not be told what to do or given 'advice'. Therefore the method of 'being confused with the client' was used to meet this goal. 'Being confused with the client' can be defined as taking an 'unknowing' stance with the client's material. This involves not having all the answers and instead exploring the material with the client.

The method of 'checking' was also an important aspect of Process Two. 'Checking' takes the form of asking the client questions about where we are now? What are we doing now? Is what we are doing helpful? Checking also involved checking the client's goals and making sure that we were 'on the same page'. By asking these 'checking' questions we were able to 'name' and define what the client wanted from the therapeutic experience and establish his goals.

During Process Two the method of 'brainstorming' also occurred within the transcripts. This method involves the client and the therapist introducing and exploring ideas and concepts that may be helpful to the therapy. Cooper and McLeod (2007) have described trying to establish the client's goals for therapy as a period of 'brainstorming' with the client. Cooper and McLeod (2007) stress the importance of finding out what the client 'wants' as opposed to what the client may 'need' in order to establish what goals are 'already there'. This specific client seemed to have more 'life goals' than specific goals. However, throughout this process I noticed that some of the client's goals were things that he wanted to explore but not actually meet just yet, some of the goals were contradictory and some of them felt overwhelming and 'impossible to me'. However, these were the goals that the client wanted and therefore this was our starting point. For example, one of the client's goals was to cope better within a relationship that he felt was sometimes abusive. As a therapist I accepted his goal. However, I used challenge to really understand what this

goal meant and I also used congruence to let the client know how I felt about this goal.

The analysis of the transcripts suggested that this was a very active, quite 'loud' process where I became more directive, information seeking and challenging as a therapist. In trying to use the pluralistic framework in order to establish the client's goals it seems I was using a more varied counselling skill set in comparison to Process One.

This specific client was in crisis and his needs were varied and complex and I feel this is reflected in my choice to use a variety of different skills in order to gain a clear understanding of the client's wants. When I began analysing this process using clustering in order to get a 'visual' understanding of what occurred the page itself was 'full and busy' in comparison to Process one which was slightly easier to organise and seemed 'neater' on the page.

Therefore this process was a period where I tried to gain clarification for the structure of this client's goals as well as the goals themselves. However, again I feel my inexperience as a pluralistic therapist came through. I identified some of the goals in the sessions but some of the goals we were working on I did not identify until my analysis of the transcripts. Is it possible that through analysis a therapist is able to identify the more subtle undercurrents of a therapeutic encounter or is it that I missed the opportunity to 'name' these goals in the session in order to work through them and then be able to track these goals and 'name' when they are achieved? At this point of my analysis my answer is that I don't know. However, this is one of the questions that I will continue to ask my data.

Process Three

BECOMING THE CLIENT'S STUDENT AND CHALLENGER: CREATING A BALANCED RELATIONSHIP WHERE THE CLIENT IS EXPERT.

This process can firstly be defined as a relational process where the client is in the role of a teacher and the therapist is in the role of a student. This process included subtle changes and re-evaluation of the client's goals and actively working on the therapeutic tasks to meet these goals. I also feel that this process met one of the client's goals which was to be valued as an expert of his experiences. During this process although my role was mostly being the client's student, it was also peppered with situations where I challenged the client on what he was teaching me. I wasn't challenging so much the content of his experiences but more his processing of them or what he had learnt as a consequence.

The themes that emerged from the transcripts were:

<u>Processing traumatic experiences.</u>

This theme can be defined as the therapist and the client discussing the traumatic experiences that the client has had and attempting to understand how they have affected the client and what they mean for the client.

<u>The pupil challenging the teacher.</u>

This involves the therapist challenging the client in order to check whether a different perspective is possible or more helpful for the client.

<u>Understanding the client systemically.</u>

This theme can be defined as discussing with the client the different systems of people that he is in regular contact with and how he interacts with these systems. Such systems included his group of friends, his family and the professionals he had to see such as his GP and pain medication specialist.

Defining goals and tasks

Defining goals and tasks is where the therapist and the client 'name' and define what the client wants from therapy and what tasks might be more effective to meet these goals.

Understanding experience of HIV.

Understanding the client's experience of being HIV positive can be defined as the therapist actively listening to the client's experiences, being curious and asking questions and helping the client to explore his experience in order to facilitate a depth of understanding.

As I created a visual analysis of this process through clustering it became apparent that there were very few sections that were naming what I was doing as a therapist and most of the page was taken up with what the client was teaching me and how we worked on this together. Again, very simple counselling skills seemed to be used during this process with an emphasis on collaboration and challenge.

The methods used that emerged from the transcripts were:

- Communicating about our patterns of communication.
- Challenge through congruence.
- Inviting the client to process.
- Collaboration with the client.
- Exploration of client's world.
- Active listening.
- Checking and monitoring the therapeutic experience and our relationship.
- Trying to understand the different 'systems' and interpersonal relationships in the client's life.
- Working in the 'here and now'.
- Trying to understand the client's ideas about mortality.
- Working from within a relationship where the client is the expert.
- Allowing the client to 'teach' the therapist.

One of the consequences of this process was that quite a specific relationship was created based on the client's needs. This relationship allowed the client to be the expert in the room, which in turn seemed to create an environment where the client's experiences and expertise were valued and respected. Once the client felt respected and empowered in this environment he seemed to welcome challenge more readily. He also became more open to invitations from me to process his experiences. The method titled 'invitation to process' can be defined as a question or a statement that invites the client to explore how he feels about the experience he is discussing in order to process what this experience means to the client.

Through my analysis of the transcripts it became apparent that this process was happening throughout our twelve sessions together. He would teach me, we would create an environment where he felt respected and empowered and then I would challenge him; often through the use of congruence. It could be suggested that this process was key to our work together.

On reflection, in accordance with the pluralistic framework, the relationship that was created through this process could be seen as the main method used in our therapeutic encounter. Cooper and McLeod (2007) have suggested that methods are 'the specific, practical ways in which the therapist and client fulfil therapeutic tasks, and can be broken down into 'client activities' and 'therapist activities'. For example, one of the client's goals was to be understood and taken seriously by a 'professional'. One of the tasks used to achieve this goal was exploring significant life experiences of the client. The overarching method used to complete this task and achieve this goal was the relationship we created through the process of me being the client's student. As discussed previously, there is a vast amount of literature that suggests that the therapeutic relationship has a significant impact on a positive outcome in therapy.

I am reminded of a narrative by Herman Hesse (1969) about a relationship between two healers. The two healers met and spent their lives together but only came to discuss some of the most important parts of their relationship

and how they felt about each other when one of the healers was dying (Hesse, 1969). I didn't 'name' Process Three in the sessions. It was only through the analysis of the transcripts that I became aware of its significance and additionally aware that it was possibly the main method we were using to meet the client's goals. Cooper and McLeod (2007) state that it is an important part of pluralism to 'name' what is going on in the sessions in order to further encourage collaboration with the client. Perhaps this process may have had an even greater impact if I had actually said to the client, ' It feels like maybe an appropriate method we could use to achieve your goal would be for me to become a student of your experiences and you become my teacher, how does that sound to you?' I guess I wonder what the impact of 'naming' of this process might have been.

I can see through my analysis why Cooper and McLeod (2007) stress the importance of being transparent with the client about each process in order to collaborate with the client and demystify the therapeutic process. However, in the case of this client, it seems that I needed to be far more reflective about my work as a pluralistic therapist. This process was occurring in the therapy organically and naturally but I was not necessarily completely aware of it until I analysed the transcripts.

Perhaps as a pluralistic therapist it is important to take the stance of a scientist-practitioner and reflect on what methods you are using both consciously and unconsciously. Reflection is obviously an important skill for any therapist but in order to use the pluralistic framework it seems that deep reflection is hugely important. Additionally, it could be suggested that perhaps a more formal analysis of my session notes might have been useful in order to be more conscious and transparent about the methods that were being used.

Process Four

THE PROCESS OF PROCESSING

This process can be defined as the processing of significant life events and

emotions. This process can also be defined as a period where we processed some of the changes in the client's goals, life circumstances and some more internal changes such as his way of thinking about things. We also took time to process the impact our relationship.

The themes that emerged from the transcripts were:

Processing relationship with partner.

This involved discussing the client's relationship with his partner and what this relationship meant to him. It can be defined as attempting to makes sense of the client's relationship with his partner.

Processing the need for balance.

Creating balance was one of the client's goals. Therefore we explored why the client needed this balance and what this balance might look like for the client.

Processing the concept of expert

We attempted to make sense of the concept of expert in order to better understand the client's needs and what these needs meant to him. This involved processing the concept that the client was an expert of his experiences but that he also wanted someone else to be in this role of expert as well.

Processing the experience of life and death

Through discussing the client's experiences of death we tried to make sense out of what he had experienced and the 'lessons' he felt he had learnt. We also discussed and explored what meaning this had for the way he now lived his life.

Reviewing our work together

Reviewing our work consisted of summarising our therapeutic experience and exploring whether the client's goals were met and whether any new goals had emerged.

The methods used that emerged from the transcripts were:

- Summary.
- Challenge.
- Working from within a relationship where the client is expert.
- Allowing the client to 'teach' the therapist.
- Working in the 'here and now'.
- Reflecting the client's feeling back to them.
- Being congruent.
- Being authentic and genuine.
- Being transparent about the therapeutic process.
- Communicating unconditional positive regard.
- Trying to understand the client's world and what it's like to live in this world.

Again it seems that one of the main methods used was 'our relationship'. This method allowed the client to be respected in the position of expert about his experiences. This was done through the therapist being in the role of student and the client in the role of the teacher. I suggest that from trying to create a shared understanding in Process One, and attempting to reach a relational depth in Process Two that this very specific relationship was created and then able to be used as a method to reach the client's goals.

This process seemed to be centred on processing the client's main goals and reviewing our work together. One of the clients goals was to create more balance in his life; more of a balance between his role of partner and carer within his relationship, more balance with his pain and the side effects from medication and more general balance within his quality of life. During this period it also became apparent that one of the client's main goals; to be seen, heard and respected as an expert of his own life, was also shown to have another side to it that required balancing. The client did want to be respected as an expert on his own life however, he also very much wanted someone else to take the time to be his student and become an 'expert' with him.

He very much wanted to collaborate with professionals but he sometimes found this quite challenging when he felt they were not collaborating at a high enough level with him. Therefore it appeared that sometimes the client would come across to some people that he wanted complete control and did not want to step back and let others help him. However, this was not the case. He desperately wanted help. But he knew the exact kind of help he wanted and was not prepared to accept what he felt was inadequate or misinformed care and support.

Through my analysis I am struck by the fact that even at this final stage of our therapeutic journey the goals of the client are changing, becoming more defined and in some cases new ones are emerging. Through this process of processing our work together an even deeper understanding of what the client wants emerged. Therefore it could be suggested that when working pluralistically it may be important to 'name' and explore the new goals, or the deeper understanding of 'old goals' that emerge through the processing the sessions at the end of therapeutic journey. It seems that the goals of this client emerged throughout the entire process of therapy. Additionally, some goals changed, developed and some goals became of higher importance and some less so.

I feel this was one of the challenges for me as a pluralistic therapist. At times it was difficult to 'name' all of the client's goals that were being worked through and therefore difficult to also name the tasks and methods that would most effectively lead to these goals being met. Through this analysis I have found that some of the seemingly most important goals of the client were not explicitly 'named' by the client or me. Additionally, some of the methods and tasks we were using to meet these goals were not explicitly named either. What I have found thus far is that these 'hidden' goals, methods and tasks seem to be mostly to do with our relationship or the specific type of relationship we had. It is more than possible that this occurred due to my lack of experience as a pluralistic therapist or perhaps this was an area of our work that I didn't give adequate reflection. It was through my analysis of the transcripts that these elements became obvious and therefore perhaps a

similar form of analysis earlier on in our work together may have highlighted these 'hidden' goals, tasks and methods sooner. Again, I wonder what the impact would have been if these 'hidden' goals, tasks and methods were 'named' and worked with explicitly in the sessions?

I continue to ask my data whether this concept of 'hidden goals, tasks and methods' is relevant to the other two cases? At this stage I wonder whether it would be important for a pluralistic therapist to 'study' the therapeutic relationship and attempt to 'name' what sort of relationship it is as a method to meeting some of the client's goals. The literature certainly suggests that the therapeutic relationship can be a significant part of a positive therapeutic outcome. Therefore perhaps it would be helpful for a pluralistic therapist to be fully conscious that the relationship may an important part of the method section of the pluralistic framework. On a larger scale, I also wonder whether this could lead to 'naming' the sorts of relationships that would be most helpful for different sorts of clients? This is not to take away from the unique nature of each therapeutic relationship and somehow create a step by step 'relationship manual'. But perhaps it would allow more effective comparison between case studies of clients in order collaborate therapists thoughts about what sort of relationship was most effective for which client group?

This process also included reviewing and processing our time together. This review explored any changes that had taken placed and it also included a review of the struggles that were still there. We also reviewed the client's experience of being in therapy.

Conclusion

These memos show three main processes at work that fit within an overall process of becoming the client's student and challenger. This overall process (becoming the client's student and challenger) was the like the 'container' for the therapy and the other three processes. Figure 4.1 visually shows the process between B and pluralistic therapy.

For a summary of the client's feedback, including sections of the transcripts, refer to Appendix 4.

Figure 4.1: The process between client 'B' and pluralistic therapy

Case Study Two: Client ‘Matthew’

The client

Mathew was born and grew up in the UK. Both of his parents are Caribbean and his mother moved to the UK in the 1940’s and his father in the 1950’s. Mathew has one brother and there is a fifteen-year age gap between them. Mathew describes their relationship as distant and at times confrontational. Mathew suggests that he felt loved by both of his parents but he never felt they really understood him; particularly his father. Mathew suggests that when he was growing up he got the impression that ‘children should be seen and not heard’. He felt it was very important to his parents that he be presentable and well behaved at all times as they felt it reflected on them as parents.

Mathew was sent to boarding school at age nine. He felt at the time that his parents were ‘sending him away’ and felt a sense of rejection from them. Mathew was the only black child in his class at school and he reported that this experience made him feel a mixture of anxiety, pressure and also a feeling that he was ‘special’. After a period where he was bullied he decided that the way he was going to deal with it was to ‘put on mask’ and hide his ‘fragile self’ away. This mask was confident, witty, sharp and capable. After a period of time Mathew became very popular at school and had a wide circle of friends.

When Mathew left school he reported that he felt his identity and presentation was often confusing to others. He was a black child, with what he describes as a ‘posh English accent’, he was well educated at an English boarding school and he had been influenced by Caribbean culture.

Mathew’s father died in the early 1990’s. Mathew’s mother died in 2008 and had lived with dementia for many years previously to this. Mathew and his brother looked after their mother during this time.

As an adult Mathew worked in a professional role in the financial sector and also within the IT sector. However, he reports that he was always searching for where he fitted in and never really felt that his skills and talents were utilised properly. Mathew has also worked in the theatre for many years and the most frequent character he uses on stage is called 'Raven' (name changed for the purpose of confidentiality). There was a period in Mathew's adult life where he considered gender re-assignment. For a period of three years Mathew lived as a woman in preparation for gender re-assignment surgery.

From the first time Mathew 'put on a mask' in boarding school he felt that there was a side to his personality that was fragile, timid, quiet, submissive and shy and then another side that was witty, strong and assertive. These two different sides became more defined in Mathew's mind throughout his adult life and he believed the 'strong' side of his personality was the female character he created called 'Raven' and that the 'submissive' side of his personality was Mathew. Mathew later decided that he did not want to go through with the gender re-assignment surgery.

In the same year that Mathew decided against gender re-assignment he attempted suicide through taking an overdose of tablets. Prior to this suicide attempt Mathew had recently lost his job and was experiencing major financial stressors. During this time Mathew's mother was also very ill and required full time care that was provided by Mathew and his brother. Mathew described this time as the end result of things in his life building and building until he felt so overwhelmed with everything he had to do that he felt he had nowhere to hide and no soft place to fall.

Mathew was diagnosed with HIV in early 2006 when he was 47 years old. When Mathew was first diagnosed he informed medical staff that he did not want to know his CD4 count or his viral load at any stage as he thought this would cause him unnecessary concern. However, in 2008 Mathew's CD4 cell count had dropped to the point where medical staff felt it might be time to start antiretroviral medication in order to control in the virus. Mathew suggested

that this was a very difficult time for him as taking this medication meant being reminded on a daily basis that he was not well and his coping strategy for dealing with the diagnosis at this stage was avoidance. He began using antiretroviral medications in 2008 with varying degrees of adherence.

Mathew currently lives alone in rented flat in the UK. He has a supportive group of close friends and a wider group of acquaintances. At the time of writing this case study Mathew is involved in the performing arts. Mathew arrived in our therapy room motivated and open. His presentation in our initial sessions suggested he was an intelligent, psychologically minded man who had developed some creative and complex strategies for coping that simply were not working for him anymore.

Assessment of the client's goals

The client arrived in the therapy room with quite specific goals; one of these goals evolved over the course of therapy. For the purpose of this study I will discuss the client's main goals for therapy. The client's main goals were about his anxiety. He wanted to understand this anxiety, the genesis of it and how to cope with it more effectively. Mathew also wanted to re connect with his brother in the hope that they're relationship might improve. He wanted to be more assertive within this relationship and he wanted to be able to tell his brother how he felt. Lastly, Mathew arrived in the therapy room with the goal of understanding the different parts of his identity. At first Mathew wanted to 'get rid of' the persona he named 'Raven' and move 'Mathew' to the forefront. Through our exploration of these two personas we found that Mathew actually didn't want this goal at all; he felt he should want it. What he really wanted was to integrate both personas as he truly felt that both were different parts of him that should be understood and accepted. The client also wanted to develop ways to prevent feeling overwhelmed, feeling suicidal and becoming unwell.

Course of therapy

The most immediate goal that Mathew had for therapy was to manage his anxiety more effectively. Therefore we began to explore his experience of

anxiety, how it was affecting his everyday life, how he was currently coping and how he wanted his coping skills to change. Mathew explained that he frequently felt overwhelmed by life's stressors and his strategy to cope was to avoid these stressors and pretend they weren't there. The outcome of this behaviour was that after a period of time of avoidance Mathew would feel completely overwhelmed as the different stressors piled up around him. He explained that there would be a mountain of bills he hadn't taken care of; that his flat would be a mess and that he would miss important meetings that he had to attend. Consequently Mathew would feel like he simply couldn't cope with everything he had to do and he would avoid life further by shutting himself away from friends and family.

We mainly used the person centred model to create shared understanding about Mathew's experience of anxiety and how he wanted his coping skills to change (Mearns and Thorne, 2007). I was trying to create an environment of acceptance so Mathew felt he could trust the space and explored his experience. The person centred model suggests that when the therapist takes a non-directive stance and allows the client to lead the therapy that the client is encouraged to operate from their 'internal locus of control' (Rogers, 1957). By encouraging the client to operate from an 'internal locus of control' the therapist is encouraging the client to speak from their 'true self' or the self that is not influenced by others conditions of worth (Rogers, 1957).
The initial goals that we identified were:

1. Mathew wanted to understand his anxiety in order to feel more in control of it.
2. Mathew wanted to create new coping skills to manage his anxiety.
3. Mathew wanted to be able to go to job interviews and manage his anxiety.

While exploring and attempting to understand Mathew's anxiety he explained that he felt that the thoughts he had while he was anxious had a negative effect on how he would react to a situation. I decided to introduce Mathew to the cognitive behavioural therapy model (CBT) to see how he felt about it and whether it might be helpful to explore these thoughts further (Trower, Casey

and Dryden, 2005). CBT advocates that a person's thought processes can affect their emotional and behavioural responses and therefore by adjusting the thought process then the emotional and behavioural responses can be adjusted also (Trower et al, 2005). We also began to explore what a normal day looked like for Mathew. As Mathew explored a normal day, starting from waking up in his house, it became apparent that his anxiety began as soon as he opened his eyes in the morning.

More specifically, Mathew's first destination in the morning was his bathroom. Just under the bathroom mirror was a half tiled wall and on the floor beside the sink was a pile of tiles waiting to be put up to finish the job. Mathew suggested that this pile of tiles mocked him every morning reminding him that he felt he was useless and not incapable of doing anything right. During this discussion about an average day in Mathew's life it also became apparent that Mathew enjoyed being creative, he loved cooking, he was a voracious reader and loved playing video games that were based on characters that had to go through complex journeys in order to meet their goals. After this period of exploration we had both decided on some tasks that might help us to work towards Mathew's initial goals:

1. Discussing situations where Mathew has been anxious.
2. Creating behavioural experiments to encourage self-care.
3. Problem solving and creating new strategies to increase quality of life.

The methods we used to do these tasks were:

1. Using thought records in order to explore Mathew's anxiety and create alternatives.
1. Mathew would put up the tiles in his bathroom.
2. Mathew would cook something he loved once a week and we could spend some time discussing this recipe in the session.
3. Being authentic and genuine with the client.
4. Encouraging the client to be authentic.
5. Working in the 'here and now'.
6. Feeding back to the client about how they are in the session.
7. Being congruent with the client.

8. Reflecting back to the client the therapist's experience of the client.

At this stage in our therapeutic relationship I felt that being congruent with Mathew was important. Mathew was an extremely polite man and I was wondering if this politeness was stopping him from really showing how he felt in the 'here and now' in the room. Therefore I started to reflect back to Mathew when I felt there was incongruence in the room. Mathew very openly discussed with me that he has been putting on 'masks' all his life and that he would really appreciate it if I noticed a mask appearing in the sessions that I mention it. I agreed to do this. Through me being congruent in the session it seemed that Mathew felt like he had 'permission' to be open and congruent also.

Mathew came in the following session and mentioned that he had tried to go to a job interview and didn't make it because of his anxiety. We decided to use a thought record to go through the situation, check Mathew's thought processes and see if there were any alternatives. Mathew was waiting for a bus to go to his job interview but after a period of time waiting at the bus stop it became apparent that the bus was late. Mathew said that he started to become 'panicky'. He said that some of the negative automatic thoughts that were going though his head were, 'everybody is looking at me and thinking I am mad', 'I am going to be late for interview, they are going to think I am incapable', 'I should be able to do this', 'I can't do this' (Padesky and Greenberger, 2009). Mathew's physiological reaction was that his heart rate increased, he started sweating and his breathing became shallow. Mathew's behavioural reaction was that he left the bus stop and started walking home. He reported that with each step his physiological symptoms reduced and he started to feel better. However, when he got home he felt that all the thoughts he had at the bus stop were proved to be true and he felt sad and tired.

Mathew discussed that he felt it unacceptable to show true emotions to other people or for him to look like he wasn't coping. We established this might be a possible belief that Mathew held; namely that it was unacceptable to appear not to be coping as this meant that he wasn't a capable person. We decided

to explore this belief further at a later stage. We then started to explore possible alternative thoughts such as 'I can do this, but I need a moment to breathe'. Mathew suggested that there was a convenience store right by the bus stop and he felt that if he had walked there and taken a moment to slow his breathing that he might have been able to go back to the bus stop and get the next bus. Therefore we created a plan if this sort of situation happened again:

1. Mathew would walk to somewhere he felt was 'safe'.
2. He would then use some relaxation breathing techniques to slow his breathing.
3. He would try and recognise and monitor his negative automatic thoughts to see if there were alternative thoughts that might be more helpful.

Through this exploration we created a tentative hypothesis about Mathew's anxiety. We thought that Mathew's beliefs about himself, his abilities and how he 'should' be meant that he would avoid situations and projects that he felt were outside of his capabilities. By avoiding these situations and projects Mathew was proving to himself that in fact his assessment of his capabilities was correct. The outcome of this was that he wasn't able to do the things he wanted to do and that sometimes life would 'pile up' around him leading to a situation where there really was an overwhelming amount for him to do. Mathew also reported that during this overwhelming time he would frequently become unwell with a serious of colds that were very difficult to recover from. This was a highly collaborative section of our work together and felt like two scientists working together towards a common goal. We were both bringing in our thoughts and theories in order to meet the client's goal of truly understanding his experience of anxiety.

In one session I invited Mathew to explore a possible task that might help us to further understand the general anxiety he experienced in his everyday life. We created a task where Mathew would finish the tiling project in his bathroom, he would time how long it took to do and then we would process his experience in the next session. Mathew came in the following session and

we reviewed the task. Mathew said that it didn't take him very long to do, that it wasn't beyond his capabilities (in fact he was very good at it) and that when he was finished the task he felt a sense of accomplishment and peace. He said that every morning when he went to his bathroom and saw the tiles they no longer made him feel useless; in fact he felt a sense of joy. He said that the thought that went through his head when he saw the tiles was, 'I did that'. Mathew continued to finish 'tasks' around his house throughout our therapy sessions and we continued to process his experience of these tasks. According to CBT by creating experiences where the client is able to challenge their beliefs new thought processes and beliefs can begin to be created as the 'old beliefs' are proved to be incorrect (Trower et al, 2005).

After this initial period where we explored Mathew's experience of anxiety, created a tentative hypothesis and then created tasks to help us meet his goals Mathew introduced another goal. Through our exploration it became apparent that Mathew lacked faith in his abilities. Mathew explained this further by suggesting that he didn't really feel he knew his capabilities. He suggested that he had been 'putting on masks' as a way of coping for so long that he didn't know what was real or what was pretend. We identified Mathew's goals as:

1. To understand the function of 'putting on a mask'.
2. To integrate the different parts of his personality.
3. To be more assertive.

We used the person centred model to explore the first time Mathew decided to 'put on a mask' as a way of coping. At this stage I was influenced by Rennie's (1998) thoughts about the person centred model in that I took a non-directive stance in response to the content of what Mathew was saying however, at times I would become directive in order to facilitate processing. This was in order to work towards Mathew's goal of understanding the function of his coping strategy of putting on a mask. Mathew explained that when he was sent to boarding school he was the only black child in his class. He was bullied for about a week and he decided that he had had enough. Mathew decided to create a character that was strong, witty and assertive

with a wicked sense of humour. He came to school the following day and let this character loose on the bullies. Mathew described himself as saying some cutting, clever and extremely humorous things to his bullies making all the other children laugh. Mathew became one of the more popular boys in school after this time and he wasn't bullied again. I felt Mathew's strategy for coping was creative, brave and skilful. I was congruent with Mathew and let him know how I felt about hearing his story. I also used existential therapy to assist further processing about this story through 'noticing' the client while he was telling this story. I explained that he seemed to sit up 'taller', his speech became louder and he was gesticulating with his hands. Mathew replied that the story made him feel good about himself in that he had overcome adversity and challenge.

In Mathew's adult life this character was given a name; 'Raven' and a job. Mathew used this character in his stage performances. Raven was female, assertive, strong and extremely capable. When I asked him to describe Mathew he suggested that he was quiet, shy, unassertive and not able to cope with life. We decided to spend some time exploring who Mathew is and what his strengths are. We also decided to explore Raven and who she was. During our exploration I asked if Raven was HIV positive; Mathew replied that she wasn't and she was always one hundred percent well.

We created a tentative hypothesis concerning Mathew's identity. We decided that this character might have been created as a way of hiding parts of Mathew's 'fragile' and 'unacceptable' self away somewhere safe while other 'stronger' parts of Mathew could be in the forefront and 'take the blows' so to speak. These 'fragile parts' included being HIV positive. Something that Mathew found difficult to accept and Raven didn't have to deal with. We also created another hypothesis that perhaps by creating Raven it gave permission to those parts of Mathew to come out that perhaps was not valued in his childhood. Mathew recalls that as a child he felt he should be 'seen and not heard'. We hypothesized that perhaps Raven didn't have to listen to these conditions of worth and she was free to act how she wanted to. After a long pause in one of sessions Mathew suggested that if these hypotheses are true

then all of these parts, capable and fragile, are all parts of him. We then decided that our sessions would be about working towards accepting all parts of Mathew.

Through the exploration of the two different personas that made up Mathew we began to explore the time in Mathew's life where he became completely overwhelmed and decided to take his own life. We explored Mathew's experience of suicide. Mathew explained that basically everything around him had piled up and he felt too tired and too sick to keep waking up every morning with a feeling of complete hopelessness. He described feeling like there was no way out.

We both continued to 'notice' Mathew in the sessions and created an environment where all parts of Mathew were allowed. I would mention when Mathew was sounding assertive as well as when he wasn't. We would explore and accept when he was joyful as well as down or angry. I believe a consequence of this piece of our work was that Mathew started to bring in and express a wider range of emotions and his very tentative, 'overly polite' self seemed to make less of an appearance. It felt at this time that we were often working at a relational depth as we were both getting to know and accept Mathew at a much deeper level than before.

Mathew then led the therapy into working on another goal that became apparent through our exploration of previous goals. Mathew felt that he sometimes found it difficult to take care of some of his physiological needs that occurred due to his HIV status. He wanted to create some space and time where he could take care of himself. Mathew explained that he didn't ever feel like he could relax or take time off because there always seemed to be an endless pile of things to do. We linked this with our previous theory and added to it; Mathew's avoidance strategy to things he felt was beyond his capabilities meant that things would sometimes 'pile up' creating additional feelings of being overwhelmed. As a consequence Mathew would sometimes become unwell but didn't feel he deserved to take time out for himself due to the fact he felt it was his own entire fault. I decided to use the 'miracle

question' from solution-focused therapy to invite Mathew to explore what he really wanted (Miller et al, 1996). The theory behind solution-focused therapy is to invite the client to concentrate on possibilities rather than just problems in order to create an environment where change seems possible and hope is created (Miller et al, 1996)

The miracle question is where you ask the client to imagine that they wake up one morning and a miracle had occurred. Their life was exactly how they wanted it to be. You then ask the client to discuss 'that day' with you starting from getting up in the morning. You ask the client to explain as much detail as possible. When I asked Mathew this question he described what would be a 'miracle day' for him. The day included getting up and his house was in order, all his bills were organized and paid, that he had no appointments to go to, that he was HIV negative, that he was full of energy and that he planned to go to the park and have a picnic and lye on the grass and read for the rest of the day (Miller et al, 1996).

Out of this solution-focused exploration we agreed on some appropriate client activities to meet the client's goal. These activities included

1. Cook a lunch from home and pack it in a picnic basket.
2. Take a book and his hamper to the park and read for the rest of the day.
3. If he finds that his mind wanders onto anxiety provoking thoughts about what he 'should' be doing he will use the relaxation breathing techniques from previous sessions and 'notice' his surroundings to bring him back into the 'here and now' moment.

We then reviewed these activities in next session. Mathew reported that he read in the park for the whole afternoon and he didn't have any anxiety provoking thoughts because all the things he needed to do that week were done. As our therapy progressed Mathew decided to sometimes take an afternoon off and indulge in his love of cooking, other days he would play computer games and on other days he would take time out to go out with

friends. It was Mathew who continued to create and use these activities outside the sessions.

By the end of our sessions Mathew had gone to a job interview and got the job. He took on the role of director of a play. In our final session I asked Mathew how he felt about our ending and he felt that it was the right time to leave because he wanted to try out his new coping strategies on his own. Mathew reported that sometimes he still felt overwhelmed and experienced high levels of anxiety and sometimes he still used some avoidance techniques in order to cope. But in addition to this experience sometimes he felt he was coping and he was able to create joy and peace in his life. We decided that this was good enough. We decided that frankly Mathew didn't have to cope perfectly all the time and that the reality was that some days might be challenging. Mathew suggested that he did feel better equipped to deal with these challenging days when they came.

Grounded theory analysis and discussion

After the 'line by line' coding of the transcripts was completed, I did a grounded theory cluster analysis that is shown diagrammatically in Appendix 2. The cluster analysis generated a visual map of my data and the themes that emerged. On the basis of these themes, the following five processes were identified:

1. Creating shared understanding of the client and the client's goals.
2. Creating Tentative Hypotheses: Two scientists working together towards a common goal.
3. Creating and doing tasks.
4. Reviewing our work including the Tasks: Where are we now?
5. Exploring Different Paths.

Writing the following memos about each process allowed me to clarify, refine and make connections between the themes. This enabled me to further identify and define the five key processes. Direct quotes from the transcript are not included in the main body of the text due to word count restrictions.

Please refer to Appendix 3 for a more detailed description of the processes and sections of the transcription (including direct quotes) that support the following memos.

Process One

CREATING SHARED UNDERSTANDING OF THE CLIENT AND THE CLIENT'S GOALS

This process can be defined as a period where the therapist and the client worked together to create a shared understanding of what the client wants out of therapy and who the client is within the context of their life and experiences. Cooper and McLeod (2007) advocate creating shared understanding between the client and therapist in order to identify and define goals that are relevant for the client. However, this client arrived in the therapy room with quite specific goals and he seemed motivated and ready to start to work towards them. Due to the fact that the client had already identified several of his goals before our first session part of creating this shared understanding between us involved him discussing his goals for therapy almost immediately.

The themes that emerged from the transcripts were:

<u>Exploring anxiety and loss.</u>

This involved discussing the client's experience of anxiety and loss and how they were affecting him.

<u>Exploring current coping strategies.</u>

An exploration of how the client currently copes with stressors and whether this is helpful or not.

<u>Exploring the client's 'wants'.</u>

Discussing what the client wants from the therapeutic experience and the goals he has for therapy.

Exploring thought processes and beliefs.

While discussing some of the client's past experiences with anxiety we also explored some of the thoughts that the client had during these experiences and the beliefs that may lie underneath these thought.

Trying to understand the client within the context of their world.

Attempting to understand what it is like to be the client on a 'day to day' basis and the world in which they live in.

Due to the fact that the client entered the room with some quite specific goals for therapy the creation of shared understanding was based around these goals and this was reflected in the analysis. The client also had quite a clear idea of the coping strategies that he used to cope and how he wanted to change the strategies that were no longer working for him. One of the consequences of this process was I began to understand the client's inner world, and this inner world within the context of his external world, and what parts of these two worlds he wanted to change.

The methods used that emerged from the transcripts were:

- Collaboration with the client.
- Noticing the client's body language.
- Exploring 'here and now' awareness.
- Reflecting on the client's body language and voice and communicating this to the client.
- Making links within the client's narrative.
- Unconditional positive regard.
- Working from within the client's frame of reference.
- Trying to understand the client's world and how they feel in it.
- Being mostly non-directive.
- Exploration of negative automatic thoughts.
- Challenging thoughts and beliefs.

This process was an invitation to the client to enter into a collaborative relationship where his goals were central to the therapeutic process. This collaboration consisted of discussing and exploring the client's aims for therapy and how we might work together towards the realization of these goals. It also involved creating a consensus about the tasks and methods that might be most effective to use.

As identified by the analysis, the counselling 'tools and methods' used were mainly humanistic in nature and I took a mainly non-directive stance within our relationship at this stage (Rennie, 1998). This choice was made so as to give space for the client to explore his goals as they were at the time of entering therapy. Cooper and McLeod (2007) suggest that it is an important part of pluralistic therapy to work from what the client truly wants rather than what the therapist might think the client needs.

During this process the client discussed that his thought processes would often lead to periods of anxiety and stress. Therefore we explored some of the Cognitive Behavioural Therapy (CBT) methods that identify and challenge thought processes. We also used the method of 'making links' in order to explore possible connections between the client's thoughts, feelings and behaviours and his current coping strategies.

Existential therapy such as noticing and recognizing the client in the 'here and now' was also used as a method to reach the client's goals (Yalom, 1980). This translated to commenting on and exploring how the client was in the therapy room and within our relationship. This method contributed to a deeper level of shared understanding between us. For example, it led us to exploring such things as why this client sometimes appeared happy in the sessions when he was discussing something that was upsetting for him or when he was feeling down.

This process of creating shared understanding of the client and his goals established a collaborative working relationship and allowed me to begin to enter into the client's frame of reference. It also allowed us to being to further

define his already specific goals and identify goals that were there but not yet fully formulated by the client.

Process Two

CREATING TENTATIVE HYPOTHESES: TWO SCIENTISTS WORKING TOGETHER TOWARDS A COMMON GOAL.

This process can be defined as collaboration between the therapist and the client to make sense of the client's experience of the world and create hypotheses based on both of our expertise and knowledge. The hypotheses were tentative, flexible and being continually reviewed and changed. This was a very 'active' process where lots of ideas where explored. This process also helped us to really define the client's goals in a much more specific way. For example, by creating hypotheses about the client's anxiety and stress we were able to identify goals such as 'I want a different coping strategy when I am anxious because I don't want to use avoidance tactics anymore'. At a later stage when we were designing tasks in order to reach the client's goals this specificity assisted us to create tasks that were truly relevant to the client.

The themes that emerged from the transcripts were:

<u>Reviewing and recognizing.</u>

Reviewing and recognising existing coping strategies; the parts of the strategies that work and the ones that the client would like to change.

<u>Checking.</u>

Checking involved asking the client if the hypothesis felt right or whether it needed to be adjusted. It also involved checking with the client to make sure we were working towards his goals in an effective way.

<u>Making links and identifying patterns.</u>

After reviewing and recognising the existing strategies for coping we began to make connections between the client's thoughts, feelings, behaviours, life experiences and the ways he chooses to cope.

Exploring experience.

Discussing the client's past and present experiences that have had a significant affect on how he lives his life and the choices he makes.

Processing emotions.

Attempting to 'make sense' of the client's experiences through exploration of past and present events.

Identifying thought processes and beliefs.

Discussing significant events in the client's past and present and attempting to locate the thoughts he was having during these events that lead to particular behaviours. This also involved exploring possible beliefs about the self, the world and others that the client may have.

The methods used that emerged from the transcripts were:

- Communicating unconditional positive regard.
- Being congruent and genuine with the client.
- Working within the client's frame of reference.
- Reflecting feelings back to the client.
- Trying to understand what it is like to live in the client's world.
- Summary.
- Reviewing and recognising.
- Checking.
- Making links and identifying patterns.
- Identifying thought processes and beliefs.
- Challenging thought processes and beliefs.
- Teaching the client to recognise thought patterns in particular situations.
- Reviewing a particular anxiety provoking situation and looking at what can be done differently.

When analyzing this process I noticed that the themes and the methods were quite similar. It also became apparent that the client and the therapist seemed to both being using the same methods. For example, we were both

reviewing and recognizing the client's coping strategies, making links and identifying patterns and we were both identifying thought processes and beliefs. It could be suggested that we were both being therapists or 'scientists' working towards a common goal. I feel a consequence of this process was that the client became very involved in the therapeutic process. I also feel this was an empowering process for the client evidenced by his exploration of his own hypotheses and recognition of some of his existing coping strategies that worked for him. One of the client's goals was to be more assertive and I feel this process allowed the client to begin working towards this goal.

One of the consequences of this process is that we created several working hypotheses about the client's anxiety, stress, his identity and his experience of suicide. These hypotheses were an amalgamation of counselling psychology theory, the client's data about his experiences and data that we collected during the therapy through exploring the client's patterns of behaviour and making links between these patterns and the client's experience.

This was a highly collaborative process that in a way allowed us to create several formulations about the client's current internal and external world based on data from the client, data from my knowledge of counselling psychology and the data we collected through the process of therapy.

Process Three

CREATING AND DOING TASKS

This process can be defined as a period where tasks were identified and/or created through collaboration between the therapist and the client and then these tasks were carried out either within the therapy room or outside of the therapeutic space. The purpose of these goals was to work towards the client's goals. During this process I was at times more directive than I had been during the other processes that occurred during therapy. Some of the tasks were suggested by me but usually after a period where we would both

be ‘brainstorming’ about the client’s goals and how he would like his life to be. This was a creative and collaborative process.

The themes that emerged from the transcripts were:

Creating the ‘Tiles Task’.

Discussing a task where the client would put up tiles in his bathroom that had been on his bathroom floor for some time.

Creating the ‘One Day Task’.

Discussing a task where the client would take a book and a lunch that he had made to a park for the afternoon.

Brainstorming.

Exploring, exchanging and discussing ideas for the tasks and how they might work. This theme also involved exploring different parts of who the client was and possible hypothesis about the client’s identity.

Exploring hypotheses.

Possible explanations concerning the client, his identity, coping strategies were explored in order to create relevant tasks and methods with the client.

The methods used that emerged from the transcripts were:

- Exploring possible creative solutions to problems.
- Using the ‘Miracle Question’.
- Creating hypotheses with the client.
- Challenge by using congruence.
- Brainstorming.
- Checking.
- Communicating unconditional positive regard.
- Trying to understand the client from their point of view.
- High level of collaboration with the client.
- Creating time and space for the client to have enjoyable experiences.
- Teaching the client about possible methods of self-care.

Parts of this process happened within the therapy room and other parts of this process occurred outside it. The 'meditation task', the 'tiles task' and the 'one day' task were all created and explored in detail within the therapy room before the client carried out the tasks outside of therapy room in the context of his day to day life. The outcome and experience of doing these tasks was explored within another identified process that shall be explored later in this document.

During this process I became more directive in the sessions as I suggested some of the tasks and then invited the client to explore the suggestion and adjust the task so it felt relevant and personal to him. However, the client was also involved in suggesting tasks, particularly tasks for us within the therapy room. The client wanted to explore the different parts of him or his different 'personas' in order to meet his goal of identity integration. The client also wanted to continue to explore, redefine and create hypotheses particularly about his anxiety in order to meet his goal of understanding and feeling more in control of his anxiety and better able to cope with stress. This was quite a creative process where ideas were created, tested and possible solutions to problems were explored. I feel the solution-focused approach to therapy helped facilitate this creative process of focusing on possible solutions based on hypotheses that were created through collaboration between the client and the therapist.

Through the analysis of the transcripts I feel one of the consequences of this process was that the client started to feel a sense of hope that maybe he could find different ways of coping that would be effective. Pluralism advocates 'checking' with the client to make sure that the therapist and the client are truly working towards the client's goals and are 'on the same page' (Cooper and McLeod, 2007). This is to make sure that the therapy is relevant specifically to the client but also as a way of tracking progress. This tracking allows the therapist to check with the client that their 'wants' are being met but it also allows the client to track any progress that might be being made. Cooper and McLeod (2007) also suggest that it is important for a task to have

a beginning, middle and end in order to allow for this same 'tracking' of progress.

Process Four

REVIEWING OUR WORK INCLUDING THE TASKS: WHERE ARE WE NOW?

This process can be defined as a process of reviewing the work we had done together concentrating on the tasks. We explored what it was like for the client to do the task? What it felt like to complete the task? We explored what we could learn from the task? We also explored 'where we are now' and if any goals had changed or new ones had developed? Within this process we also took the time to process difficult emotions and feelings that occurred as a result of the tasks.

The themes that emerged from the transcripts were:

<u>Review of 'Tiles Task' and 'One Day Task'.</u>

Discussing what it was like to complete the tasks, whether they were helpful and whether we had learned anything new from them.

<u>Reviewing where we are now with our hypothesis about personas and identity.</u>

Exploring the hypothesis concerning the client's identity that we had created in the sessions and whether they needed to be adjusted or changed.

<u>Reviewing where we are now with our hypothesis about anxiety and stress.</u>

Exploring our hypothesis about client's experience of anxiety and stress and whether we have a shared understanding about this hypothesis. Also a review of whether this hypothesis needs to be adjusted.

Processing feelings and emotions

Trying to 'make sense' of some of the difficult feelings that emerged in the session through creating these hypotheses and topics the client found challenging.

Reviewing goals

Inviting the client to explore whether we have met his goals, whether new goals have emerged or whether we need to adjust our definition of previous goals.

The methods used that emerged from the transcripts were:

- Communicating unconditional positive regard to the client.
- Focusing the client.
- Encouraging the client to explore our relationship.
- Encouraging the client to be genuine and authentic.
- Being authentic with the client.
- Being congruent with the client.
- Reviewing out work.
- Reviewing our hypotheses.
- Checking our work.
- Tracking our work: where are we now?
- Summarizing our work so far.
- Checking where we are with the client's goals.
- High level of collaboration with the client.
- Reflecting feelings back to the client.
- Paraphrasing the client's experience.

During this process I was non-directive when it came to the content of what the client was saying however, I was directive when it came to the client's processing. This is in accordance with Rennie's (1998) exploration of the person-centred model where he suggests that being directive in relation to the client's process can further facilitate processing of how the client makes sense of his world. This more directive person centred stance in relation to

process also allows the therapist to challenge the client within their frame of reference.

As mentioned previously Cooper and McLeod (2007) suggest that 'tracking' where the therapy is going and 'checking' with the client that the therapy is concentrating on the client's 'wants' it is an important part of pluralistic therapy. This reviewing process created a clear shared understanding between me and the client as to what our working hypotheses were, what we had done together as a consequence of these hypotheses, where we both stood now and what we needed to adjust or progress with to meet the client's goals. This process also involved a review of the goals. This process further defined some of the goals and it also changed some of them.

It was mainly the person centred model used to facilitate this process. This allowed the client to lead the sessions and explore and process our work in a non-judgmental and empathic environment (Rennie, 1998). We also used elements of Existential Therapy, in particular working in the 'here and now' within the sessions (Yalom, 1980). This manifested itself by me and the client discussing parts of our relationship and how the client presented in the room.

Process Five

EXPLORING DIFFERENT PATHS

This process can be defined as a period where the client and the therapist explored possible new coping strategies or lifestyle changes based on our hypotheses and what we had learned from the tasks and our exploration of the client's experiences. This exploratory process also allowed us to explore what coping strategies were working for the client and what strategies needed to be adjusted to meet the client's needs.

The themes that emerged from the transcripts were:

<u>Exploring different approaches to stress and anxiety.</u>

Discussing and creating possible new ways to cope with life stressors and specific situations such as going to a job interview.

Exploring new/old effective coping strategies and integrating them.
Integrating some of the client's 'old coping strategies' that he found helpful and adding them into the new coping strategies we were creating.

Exploring different approaches to integrating different parts of the client's identity.
Discussing possible ways that the client felt would be effective to integrate and celebrate the different parts of the client's identity.

The methods used that emerged from the transcripts were:

- Normalising.
- Communicating unconditional positive regard.
- Using congruence to challenge.
- Reflecting feelings back to the client.
- Exploring possible creative solutions to problems.
- Brainstorming.
- Collaboration with the client.
- Exploring the client's coping strategies: movies, reading, cooking and performing.
- Exploring new coping strategies: 'good enough', 'one day', and taking time out.
- Encouraging the client to think in creative ways.
- Encouraging the client to 'think like a therapist'.
- Teaching the client different pathways of coping.
- Creating a sense of hope.

This process involved piecing together all of our 'data' that we had collected and creating new coping strategies that were relevant to the client. Part of this process involved elements of managing the client's expectations through attempting to normalize some of the client's anxiety that even with these 'new coping strategies' he might sometimes still feel down, unwell or his needs

might change. Being HIV positive has been described as a continual process of adjustment and re-adjustment and therefore I would hypothesize that this process of exploring different paths may have to be repeated at a later stage as the client's needs and 'wants' change (Church, 1998).

Therefore I feel there are several differing consequences of this process. The first and most obvious consequence is that some new ways of coping are identified and explored. It seems that a consequence of this is that a sense of hope is created. However, I hypothesize that another less obvious consequence of this process is that the client has the experience of learning how to explore different paths even when there appears to be very little choice. I feel the experience of this process may have 'taught' the client that different pathways to coping can be found and the ways in which these pathways might be identified and explored.

I also feel that during this process our relationship was such that we were both in the role of 'therapist'. This particular sort of relationship seemed to feature in the other processes as well. I hypothesize that this may partly be due the fact that the client arrived in the therapy room with theories about his issues, clear goals and some hypotheses about the links between his thoughts, emotions and behaviour. Therefore it seems that I worked with the client in way that accepted and respected 'where he was' within his frame of reference. This may have be the foundations of our relationship developing into something that resembles two therapists or two scientists working towards a common goal.

I also hypothesize that because Pluralistic therapy advocates that the therapist works with the client's most immediate and relevant 'wants' and goals that this gives the therapist a clear pathway to working within the client's frame of reference from the first session; but it may also open a pathway to creating a relationship that is relevant to the client also.

Conclusion

These memos show the five main processes that emerged from the transcripts of the therapy sessions with Mathew. Figure 4.2 visually shows the process between Mathew and pluralistic therapy. It shows that the processes that occurred with Mathew were cyclical in nature and were repeated throughout the course of therapy.

For a summary of the client's feedback, including sections of the transcripts, refer to Appendix 4.

Figure 4.2: The process between Mathew and pluralistic therapy

Case Study Three: Client 'Peter'

The client

Peter was born and grew up in Africa with five other siblings. Peter's mother was African and his father was European. Peter describes his father as a very well respected man in his village. He describes his father as wise, fair and kind but distant and hard to read when it came to emotions. Peter suggested in our sessions that he was taught that emotions were tedious and something to be kept under control. Peter grew up with a strong sense of family, community and had a deep respect for his father. However, Peter always got the sense that his father was somehow ashamed of his 'African family' as he was never introduced to or given any information about his father's family in Europe. Peter describes his mother as someone he loved but she was unreliable and due to some of her behaviour she was not well respected in the village. The view of the village and what his elders thought of him was of extreme importance to Peter.

Peter left school when he was 21 and started a business that he ran for a period of seven years. During this period Peter married and had one child. His wife also had a child from a previous marriage that lived with them. Peter's wife was HIV positive however, she did not tell Peter at any time throughout their marriage. In 2005 Peter's child and his wife's child both died of HIV related complications. After both children had died Peter reported that his wife started acting very differently and started seeing other men. Peter describes this as a time of such intense betrayal and loss on so many levels that he finds it difficult to fully process and understand. In late 2005 Peter's wife also died of a HIV related illness. Peter stayed by his wife's side when she was in hospital.

Shortly after this time Peter's father died. This was a huge loss to Peter. His father spoke to him on his deathbed telling him to contact his European family amongst other words of advice. Peter felt so confused by his final interaction

with his father. He desperately wanted to for fill any and all of his father's requests however, he felt torn. He questioned whether his father really ever took the time to get to know him and therefore he questioned how relevant his requests were to his life.

Peter came to the UK in 2006 when he was 28 years old. This was also the same year he was diagnosed as HIV positive and he started using antiretroviral medication. He remarried and lived with his wife in the UK and they are still married today. Peter's wife is also HIV positive. Peter trained in the UK and he currently works up to seven days a week. In 2008 Peter started to experience symptoms that affected his quality of life. The symptoms Peter reported were:

1. Jerking of the legs and spasms in his muscles most of the time.
2. Weakness of voice all of the time.
3. Extreme fatigue all of the time.
4. Breathlessness most of the time.
5. Pressure at the back of the head some of the time.

The jerking of his legs began as a twitch and then continued to get worse. In some cases the jerking would be so severe that he would fall to the floor and his body would continue jerking for up to five minutes at a time. Peter suggested that he can also sometimes 'feel his voice disappear' and he has trouble speaking at the volume he used to. He also complained of feeling so tired that he would frequently fall asleep at inappropriate times, frequently while sitting down and sometimes while standing. Peter reported that sometimes he feels like he has to gasp for air as he feels the breath in his body running out. He also reported that he frequently feels pressure in the back of his head when his emotions were overwhelming. During this time Peter found it challenging to work but he continued to do so. At one time there were some concerns from one of his employers about his work performance. Peter spent some time in transition between jobs during this time before starting new employment.

In 2008 Peter was admitted to hospital for a day in order to investigate his physical symptoms. Some of the physical investigations were conducted more than once. Peter's doctors suggested that to the best of their knowledge, his symptoms did not correspond to any disease or syndrome that they could identify. His doctors suggested that this could be more psychosomatic rather than purely physiological in nature. Peter was quite sure that the doctors thought he was 'mad' and was making the symptoms up. However, he knew something was wrong; that the doctors couldn't find anything definitive and that he still wanted to work out what he could do to makes his symptoms go away. Peter's doctors suggested he worked with a psychologist.

Peter is now 32 and lives with his wife in a flat in the UK. He describes his relationship as very strained. He feels that his wife can sometimes misunderstand his symptoms for laziness or a desire not to communicate with her. Peter reports that he sometimes feels alone in the marriage and would sometimes like his wife to be more caring, loving and gentle with him. Peter is currently employed and works up to seven days per week, which works out to about 45 hours a week. Four of his siblings live in the UK and one of his brothers' lives in Africa. At the beginning stages of therapy Peter was very honest in telling me that he believed that his symptoms were the outcome of neurological issues that had not yet been picked up by the doctors. He did however want to remain open to other possibilities and was very keen to find answers.

Assessment of the client's goals

The client's goals remained fairly consistent throughout the course of therapy. For the purpose of this case study I will discuss the main goals within our therapeutic process. The client's most immediate goal was that he wanted answers and solutions to several different questions. He wanted to know the cause of his physical symptoms and how to make these symptoms to go away. A goal that is directly related to this first goal is that he wanted more control over his body and his emotions. The client also wanted answers about questions he had about his past particularly in relation to his father.

Some of the client's goals were relational in nature. He wanted to experience true empathy and kindness, he wanted to be 'understood from his point of view' and he wanted someone to bear witness to his life's narrative. The client also wanted to process these narratives of the past in order to make sense of them, process some of the difficult emotions they produced and then move on from these experiences.

The client also had two contradictory goals which were he wanted to accept he was HIV positive and that there would be times where he was unwell however, he also wanted to fight the fact he was HIV positive and did not want to accept that he may have times where he was not well. This is the one goal that changed during the course of therapy as the client moved to wanting to accept that having HIV might entail not being in perfect health all the time.

The course of therapy

Peter arrived in the therapy room very eager to find answers to his questions and solutions to his problems. I noticed from the first session that there was something that Peter said repeatedly; 'Are you with me?' I asked him about this statement and he told me that he felt truly alone with his problems and that he felt like everybody was telling him that he was making them up or that his problems weren't real. I decided to use the person centred model in a traditional, non-directive sense to explore Peter's 'wants' from therapy so we could create a shared understanding about these goals without me trying to influence the shape of his goals (Mearns and Thorne, 2007). Pluralistic therapy advocates that the therapist work from the immediate goals as they exist for the client in order to truly work towards what the client wants (Cooper and McLeod, 2007).

The goals we identified were:

1. To understand the cause of Peter's physical symptoms and make them go away.
2. To understand and process the past.
3. To experience the feeling of being truly understood and feel like he is not alone with his problems.

4. He wanted to fight the fact he has HIV and become well again.
5. He wanted to accept the fact he has HIV and cope better with being unwell.

The goal that Peter wanted to start on immediately was the first goal concerning his physical symptoms. We started to explore Peter's current physical experience. He had decided at this stage that the doctors that did all of the tests to try and work out if there was anything wrong physiologically must be incorrect. Peter thought it was a neurological problem. As we started to explore some of the details about Peter's current physical experience it became apparent that Peter wasn't sure and therefore we started from a position where we both decided we simply didn't know but we were going to try and explore the issue and see what we came up with. This position of 'not knowing' with the client felt like it was working towards Peter's goal of not feeling alone with his problems. A turning point in this exploration was when Peter described his physical experience like his body was 'scared all the time'. We began to explore the emotional element of this statement as well as Peter's current emotional and psychological experience.

During this period of exploration I was reminded of Rothschild's (2000) theory concerning traumatic stress and somatic trauma therapy. Traumatic stress is described by Rothschild (2000) as a 'normal reaction of the body and mind to an overwhelming event that threatens life'. Rothschild (2000) explains that sometimes after the traumatic event the mind might find it difficult to process what has happened and make sense of it. In a way, the traumatic event stays 'fresh' and has not been processed into the recesses of the memory; it is still very much alive in the persons mind. Therefore the brain continues to send messages to the nervous system telling it that it is continuing to experience something traumatic or will experience something traumatic that it must be prepared for. The theory is that the nervous system tells the body to prepare for three possible responses: fight, flight or freeze. The fight response may manifest itself in the body as a tightening of the muscles, flight might entail the body preparing to run and the freeze response is almost like your body disassociates from the experience and in a way, 'plays dead'. This continued

effort from the body and the mind to be in constant state of preparation for trauma can lead to traumatic stress and post- traumatic distress disorder (PTSD). Some of the symptoms can include extreme fatigue, feeling unsafe, muscular pain, feeling detached from oneself and others and anxiety (Rothschild, 2000). According to the DSM-IV Peter was not experiencing PTSD. Additionally there is some research that suggests it is problematic to diagnose HIV positive client's with traditional PTSD as their concerns are typically about the future and whether they will be able to cope with possible future traumas rather than the anxiety being anchored in experiences of the past (Kagee, 2008:1008). Therefore I felt a diagnosis of PTSD was inappropriate for Peter and would not be helpful for our therapy.

I did however; think it would be appropriate to start to explore Peter's symptoms as a somatic response to trauma. I therefore explained Rothschild's (2000) theory to Peter to see what he thought. Peter suggested that he felt he understood the theory and that it was the best possible explanation we had at the time. We created a tentative hypothesis that Peter had not fully processed the trauma of his children and wife dying from HIV. We decided that it seemed like Peter's body and mind were preparing for this sort of trauma and betrayal to happen again at any moment. We worked from the hypothesis that Peter was experiencing traumatic stress. This was a highly collaborative time and I feel that by encouraging Peter to create a hypothesis with me a sense of empowerment and hope was created. I also feel that by being transparent about Rothschild's (2000) theories that we were able to create a hypothesis that was much more relevant to the client based on a collaboration of theory from my knowledge and vital data about the issue from Peter.

In accordance with somatic trauma therapy, I suggested that we start monitoring Peter's mind and body responses in the sessions and that he monitor them outside of the sessions. The tasks we created to meet Peter's goal were:

1. Collecting data about any mind body connections.

2. Problem solving and creating new strategies concerning his physical and emotional issues.
3. Monitoring and analysing emotional responses.

From these tasks we created some 'client activities' in order to assist the tasks. These client activities break the tasks down further into practical things the client or the therapist can do:

1. Peter would fill in an activity schedule.
2. Peter would write down any data about when his thoughts or feelings affected him physically.
3. Peter would write in a journal.

I invited Peter to explore these activities. The activity schedule was used to give us a clear idea about what Peter's week looked like including sleeping habits and when his symptoms were occurring and how severe they were. Peter didn't find the activity schedule I gave him effective for him so he designed his own. The mind and body monitoring activity was something that Peter would note on the activity schedule and if he felt like further processing what he found through monitoring he would write in a journal that I provided him. I invited him to bring his journal into the therapy sessions at any stage that he felt it was relevant and helpful for him.

During this time of monitoring Peter and I discovered that when Peter became overwhelmed by emotions his symptoms occurred. For example, when Peter became angry his legs would begin to jerk and his muscles would ache. During one session we were exploring the death of this wife and children and Peter became so tired that he could not keep his eyes open. He fell asleep in the session. I let Peter take a moments rest in the session and when he came back into the room we explored his reaction to what we were discussing. He explained it was like his body didn't want him to talk about it. I was reminded by Rothschild's (2000) theory that if you decide to work with memories of a trauma then it is advisable to have a plan to 'apply the breaks' and take care of the client in the session. I invited Peter to try a grounding exercise in order to bring his mind and body back in the room and to take a break from the

overwhelming mind and body experience he was having (Rothschild, 2000). I asked Peter to put both his feet on the floor and breathe in through his nose and out through his mouth. After a few moments of doing this I asked him to look around the room and name the things that he saw (Rothschild, 2000). I then asked Peter how he felt about the grounding exercise and he said he felt refreshed and like he had had a nap. We then decided to continue exploring his traumatic experience but with the agreement that if it was becoming too overwhelming than we would take a moment and repeat the exercise.

We continued to process Peter's experience of falling asleep in the session. From our exploration it seemed his extreme fatigue was almost like his body and mind wanting to disassociate from what we were discussing. We decided to continue the monitoring of his mind and body throughout our sessions. Peter suggested to me in one session that he was interested in trying yoga or meditation to gain further control over his body and promote times of relaxation in his everyday life. Therefore we created the 'meditation task'. I gave Peter a meditation CD and we then monitored his use of the meditation CD and any effects that it had. Peter decided to incorporate meditation into his life as and when he needed it. He explained that meditation felt like his body and mind was on the same page and like he was in control in a relaxed and gentle way.

From our exploration and monitoring we felt the next step would be to concentrate on Peter's second goal of processing experiences from the past, concentrating on his experience of his family, the experience of his wife and children dying from HIV and his experience of contracting HIV. During this period of therapy Peter seemed to be describing a series of complex narratives. He explained that it felt good to speak to someone about his whole story. I felt that this 'bearing witness' to his narratives seem to be important to Peter and I took a non-directive stance so he could fully explore the content of his stories and share with me. I then invited Peter to take the 'curious investigator' stance of narrative therapy so we could further process Peter's narratives and try and make sense of them. Through this 'curious

investigator' led exploration it became apparent that Peter had developed several beliefs about himself, world and others as a result of his experiences.

In order to facilitate further processing I invited Peter to explore these possible beliefs further through using CBT and thought records (Padesky and Greenberger, 1995). I didn't feel using the thought record as they were was appropriate. We were working from the hypothesis that Peter's responses were 'normal reactions to abnormal situations' and therefore it felt insensitive to try and search for alternative thoughts or beliefs using a thought record. We did however, explore his possible beliefs, what these mean for how he lives his life and whether he felt these beliefs were helpful for him. Some of the beliefs included that people were either 'good' or 'bad' and that life choices were either 'good' or 'bad'. It became apparent that Peter felt ambivalence towards these beliefs as he felt he 'should' feel they were right for him, and yet he didn't feel they were right and relevant for him today.

When exploring Peter's beliefs I was reminded of the ego defence of 'splitting' described by psychodynamic therapy (Jacobs, 2004). This ego defence suggests that the client may put objects into 'good' and 'bad' categories as they find it difficult to integrate the fact that an object can have both 'good' and 'bad' qualities. Therefore I encouraged Peter to continue to explore his experiences so we could get a more 'three dimensional' view of his experiences in order to further facilitate and integrate his narratives.

At the end of our sessions we explored whether we had met Peter's goals. Peter felt he had a clearer understanding about his symptoms. Peter's symptoms had reduced in frequency but they had not reduced in severity. However, Peter felt he was better equipped to cope with these symptoms. In the case of Peter's goal of processing his traumatic experiences, Peter felt that really he had just begun to process the traumatic experiences in his life however; he did feel less scared about exploring them. This felt like perhaps instead of meeting all of Peter's goals we had created a clear path that may lead towards their eventual completion.

Grounded theory analysis and discussion

After the 'line by line' coding of the transcripts was completed, I did a grounded theory cluster analysis that is shown diagrammatically in Appendix 2. The cluster analysis generated a visual map of my data and the themes that emerged. On the basis of these themes, the following five processes were identified:

1. Are you with me? Travelling to 'planet Peter'.
2. Processing the narratives of the past.
3. Exploring and challenging beliefs.
4. Creating tasks.
5. Monitoring and checking and making links.

Writing the following memos about each process allowed me to clarify, refine and make connections between the themes. This enabled me to further identify and define the four key processes. Direct quotes from the transcript are not included in the main body of the text due to word count restrictions.

Please refer to Appendix 3 for a more detailed description of the processes and sections of the transcription (including direct quotes) that support the following memos.

Process One

ARE YOU WITH ME? : TRAVELLING TO 'PLANET PETER'.

This process is quite similar to the process of 'creating shared understanding' that has been highlighted in the other two cases. However, through my analysis I felt there were some differences with this client. One of the client's goals was to experience true empathy. He repeatedly said two phrases in our sessions; one was 'are you with me?', and the other was 'I want someone to understand me from my point of view'. During this process shared understanding was created but it was created through the therapist trying to 'step into the client's shoes' and walk around with him. To describe this process in a visual way, I feel that the client and I were sitting beside each other and he was taking me through what his life was like. The process of

‘creating shared understanding’ could be described visually as the client and I sitting directly opposite each other and the client sharing information with me as I am trying to make sure that I understand this information from within the client’s reference. I also feel that this process was about trying to ‘feel’ the client’s emotional world as well as bearing witness to the content of the client’s experiences.

The themes that emerged from the transcripts were:

Exploring emotional and psychological experience.
Discussing how the client experiences his emotions and thoughts in the present day.

Exploring experience of HIV.
Discussing how the client feels and thinks about of his HIV diagnosis. We also discussed the relationship that the client had with HIV and how he created this relationship.

Exploring physical experience.
Discussing the client’s physical symptoms and how they affect his quality of life.

Exploring identity and culture and family.
Discussing and exploring the client’s relationship with himself, his culture and his family. We explored his experiences of being part of his family as a child and in the present day and how this affects his choices and the way he chooses to live.

Communicating his goals for therapy.
The client shared with me what his ‘wants’, needs and goals for therapy were.

The methods used that emerged from the transcripts were:

- Communicating unconditional positive regard.
- Working from within the client’s frame of reference.

- Trying to understand the client from their point of view.
- Trying to understand what it is like to live in the client's world.
- Being transparent about the therapeutic process.
- Teaching the client about the therapeutic process.
- Being open.
- Being congruent and genuine.
- Using congruence to challenge.
- Creating a relational depth between the client and the therapist.
- Creating shared understanding.
- Grounding technique.
- Collaborating with the client.
- Monitoring any connections between the body and the mind.
- Monitoring thought processes and physical reactions.
- Working with the client in the 'here and now'.

Creating shared understanding was the method used to 'pool' all the information that was being explored in Process One. This was done through discussing and exploring the client's experiences and goals for therapy and making sure that we both had a good, shared understanding about the client and what he wanted.

Collaboration occurred several times in the transcripts. This method of collaboration involved a commitment on the part of the therapist and the client to work together towards a common goal. This was done through 'pooling' all of our ideas, thoughts, the client's experiences and my experience together in order to help the client to realize his goals. Collaboration also involved creating a consensus between us about what we were working on and the tasks and methods that were most appropriate to use.

The method of transparency in Process One can be defined as the therapist being 'out in the open' about what they are doing. This means I invited the client to become a 'scientist' with me by sharing psychological theory, or explaining a therapeutic model or sharing my hypothesis with the client. Transparency was a necessary element of collaboration. I was transparent

with the client so we could both work from the same material; he was sharing his experiences and so I shared mine as well. This creates quite a large 'pool' of data to work from.

This process is mostly about the client's present experience. It emerged and re-emerged at different times during the twelve sessions. I feel this could be explained by the fact that the client's 'here and now' experience was important to the therapy and important for me to understand in order to feel and convey a genuine empathy for Peter's experience. Additionally, Peter's physiological experience was frequently very much in the 'here and now'; it was something that he sometimes experienced during our sessions. 'Travelling to Planet Peter' was an ongoing process, as perhaps I truly understood one area, another area that needed to be visited and I needed to 'follow' Peter to get there.

Empathy and relational depth were key methods within this process of 'travelling to planet Peter'. At the point where Peter arrived for therapy the medical community had done all that they could to try and help Peter however, because all of the tests had come back with nothing definitive, Peter was left with uncertainty and fear. This process consisted of me trying to really 'feel' what it was like to be Peter within the context of his psychological, emotional and physiological life. I feel an outcome of this process was that even though I did not have answers for his questions I 'struggled' with these questions with him meaning that, at least in our therapy room, he was not alone with them.

Process Two

PROCESSING THE NARRATIVES OF THE PAST

This process can be defined as a period of the therapy where we attempted to make sense of some of the client's traumatic narratives. This particular client had experienced several different traumatic experiences in his life and he had never told his 'whole story' to anyone. Part of this process was bearing witness to the client's narratives and being with him as he shared his story.

The second part of this process was both of us trying to make sense of these experiences and trying to process some of the difficult emotions that accompany them. This process is in line with one of the client's goals; he wanted to make sense of his past in the hope that he could move on from it.

The themes that emerged from the transcripts were:

Exploring and processing the client's experience of his father.
This involved discussing the client experience of his father and his relationship with his father as a child, and as an adult. We then attempted to try and 'make sense' of the client's experience and what it meant for the client in his life today.

Exploring and processing the client's experience of watching his family die.
Talking about, discussing and exploring the whole narrative about the client's late wife and his children contracting HIV, becoming unwell and dying. We discussed how he had 'made sense' of this narrative and how this 'making sense' of it affected the way he lives in the present.

Exploring and processing the experience of contracting HIV.
Discussing the client's narrative about how he contracted HIV and how he 'made sense' of this experience. We discussed what impact this diagnosis had on his identity, how he lived his life, his relationships, his choices and his employment.

Exploring and processing the experience of growing up within his family and his culture.
This theme can be defined as the therapist and the client discussing and exploring the client's past experiences and how these experiences affect his life today. We explored the culture and the family that the client grew up in and the impact that this environment had on his identity, his relationships and choices in the present day.

The methods used that emerged from the transcripts were:

- Bearing witness to the client's life story.
- Collecting data about the client's life story.
- Communicating unconditional positive regard.
- Trying to understand what it has been like to live the client's life.
- Identifying possible beliefs as a consequence of the client's narrative.
- Being authentic and genuine with the client.
- Encouraging the client to be authentic.
- Trying to understand the impact of the client's narrative on his identity.
- Collaborating with the client.
- Grounding technique.
- Monitoring connections between thoughts and physical reactions.
- Working in the 'here and now'.
- Encouraging the client to be a 'curious investigator'.
- Monitoring mind and body connections.
- Respecting that the client is the expert in relation to their life story.

There were some complex narratives contained in this process. There was a high level of content followed by some challenging and emotional moments in the therapy where we attempted to process and make sense of these narratives. The method of 'bearing witness' can be defined as the therapist attempting to 'experience' the narratives of the client in an authentic and empathic way.

While Peter was explaining some of his narratives my stance was that of a 'curious investigator' trying to piece together all the parts of the story. Through asking direct questions I encouraged Peter to take this stance also so we both became 'curious investigators' together. This stance seems to be largely driven by Narrative Therapy which was used in order to understand the full 'richness' of Peter's narratives but also to understand what conclusions about life he has made as a result of these stories and what these stories meant to him and his identity (Payne, 2006). The narrative

about his experience of his culture and his family seemed to have a deep impact on Peter's identity and how he felt about this identity today.

This process was very interactive and seemed to have quite a physiological effect on Peter. During exploring and processing these very emotional narratives he would frequently become extremely tired and the symptoms he reported that were occurring outside the sessions started to happen in our sessions also. Therefore one outcome of this process was the creation of Process Five that I will explain in more detail later in this document.

Another outcome of this process was that we seemed to be left with quite a comprehensive idea about what seemed to be some of Peter's core beliefs about himself, the world and others.

Again this process did not just occur once, this process emerged and re-emerged over the course of therapy.

Process Three

EXPLORING AND CHALLENGING BELIEFS

This process can be defined as a process that leads on directly from Process Two. Through exploring and processing some of the narratives of the past it became clear to both of us that Peter had some very strong core beliefs about himself, the world and others and he wasn't sure if they worked anymore for him or even if they were true. Therefore during this process we explored his beliefs, where they came from and how they might have been created. We then challenged these beliefs to test how true they were for Peter and whether they fitted with his present life. This process could be explained as a period where we explored and challenged Peter's cognitive world.

The themes that emerged from the transcripts were:

Exploring and challenging beliefs about 'self', 'the world', and 'others'.

This theme involved using the data we had collected during Process Two and exploring the beliefs that had developed from the client's experiences. These included beliefs that the client had about himself as a man, a husband, a father, a son and member of his community. They also included the client's beliefs about how the world worked and how he felt about being a member of the global community. We also explored the beliefs that the client had about other people and relationships. We then challenged the beliefs to see if they were 'true' for the client and helpful for how the client wanted to live his life today.

Exploring and challenging beliefs about emotions.

Through Process Two we discovered that the client had several beliefs about emotions and how they should and shouldn't be expressed. Therefore we explored these beliefs and then challenged them to see if they were 'true' for the client.

The themes in relation to the methods being used that emerged from the transcripts were:

- Identifying core beliefs.
- Challenging core beliefs.
- Communicating unconditional positive regard.
- Trying to understand the client from within their point of view.
- Challenging the client.
- Being transparent and open.
- Encouraging the client to be authentic.
- Exploration of the client's world.
- Challenging ego defence: splitting.
- Communicating about our patterns of communication.
- Mind and body monitoring.
- Modelling that a relationship can contain tension.

Again this process occurred several times throughout the therapy but always seemed to proceed after Process Two took place. Through Peter's traumatic narratives there seemed to be several core beliefs that were created out of his experiences and his interpretations of these experiences. Peter's narrative about his culture seemed to be a great driver in all aspects of what he believed about himself, the world and others. Sections of this process almost sounded like a debate as we both challenged and tested his beliefs. Cognitive behavioural therapy, in particular questions from Padesky and Greenberger's (1995) thought records, assisted us to get a deeper understanding of what these beliefs meant to Peter and whether they were 100% true (Padesky and Greenberger, 1995).

During Process Two it became apparent that some of Peter's beliefs seemed to indicate the ego defence of splitting. People seemed to come into two categories for Peter; they were either good or bad. Additionally, Peter seemed to believe there were only two paths that you could follow in life: a good path or a bad path and there were clear consequences for both. Therefore during this process we attempted to explore and challenge this possible defence also.

Our relationship was certainly tested when this process occurred. Peter indicated that he wanted to challenge and at the very least understand these beliefs as he seemed to feel that some of them weren't working for him anymore and others caused him confusion, as he wasn't sure if they were true. However, challenging these beliefs was a difficult process for him. Most notably, it was emotional for him to challenge some of the beliefs that had been instilled in him by his father. It was these beliefs that he questioned the most and that he felt did not work for him anymore. I feel that without Process One of trying to 'travel to planet Peter' that this process may have been damaging rather than challenging for our relationship. It felt like because I had made a commitment to work from within the client's reference and felt a genuine empathy for the client that this process was able to happen.

Meta-communication was an important aspect of this process as I was able to check with the client whether what we were doing was helpful or on the right track. Through meta-communication we were also able to ask questions about how we were interacting and what this meant for our relationship. I feel this process tested our relationship however; it also strengthened it as we both decided that disagreement and debate could be a part of our therapeutic relationship. I feel an outcome of this process was that we were both modelling that relationships and experiences were not always just 'good' or 'bad'. I felt it modelled that relationships can contain tension and disagreement while also containing empathy and kindness.

Process Four

CREATING TASKS

This process can be defined as a collaborative and creative process where tasks were created in order to help meet the client's goals. I suggested the tasks however we explored the initial idea of each task and then the client added to the idea to make it more relevant to him and his life. These tasks were then monitored and processed using Process Five, as they were a part of 'tracking' the client and both of us collecting relevant data to help explore and create hypotheses in the sessions. This will be discussed in more detail in the next process.

The themes that emerged from the transcripts were:

<u>Inviting the client to explore an idea for a task.</u>

This involved suggesting a possible task to the client and asking him if he would like to explore it as an option.

<u>Exploring the task in session.</u>

We discussed the possible tasks in the sessions. We explored what the task would be, when the client might do the task and what it might feel like to do. We also explored what the client hoped to get out of the task and what it would feel like to complete it.

Creating the 'Journal Task'.

The journal task consisted of the client using a journal to explore and process some of his feelings outside of the sessions. The client also used the journal to monitor any links between his physical symptoms and his emotional experience.

Creating the 'Activity Schedule task'.

The activity schedule task consisted of the client monitoring his activities for one week, writing these activities down and also recording how he felt and what his energy levels were like.

Creating the 'Meditation Task'.

The meditation task was created to meet one of the client's goals of feeling more relaxed and having time that was just for him. I brought in a meditation CD and we decided that the client would use this CD as and when he felt he needed it.

The methods used that emerged from the transcripts were:

- Inviting the client to explore a task.
- Brainstorming.
- Collaborating on ideas about the task.

This process began as a kind of invitation to the client to explore some tasks that I designed to work towards some of the client's goals. This invitation was preceded by a collaborative exploration about the suggested task and how it might be most relevant to him and his life. For example, Peter wanted to feel more in control of his body and part of this control entailed being able to 'quieten' his body and create moments where he felt a sense of peace. I suggested the meditation task and provided him with a meditation CD. We then explored when Peter might do this task? How often he might do it? Where he might do it? What he expected out of it?

This process seemed to create a sense of hope for the client. It also seemed to create a sense that the client was able to 'do something' about some of his issues and an outcome of this seemed to be that the client felt a sense of control. The process of creating tasks seemed to open up options and choices where there seemed to be none. Brainstorming was a key method during this process. Brainstorming can be defined as the both the client and the therapist exploring and discussing ideas for tasks. This is quite a creative method that seems to generate 'possibilities'. A consequence of the method of brainstorming is that the client becomes very involved in the creation of what his therapeutic experience will be.

I also feel an outcome of this process was that even though we did not have all the answers about Peter's physiological symptoms we were still able to brainstorm about what might help and create practical ideas that he could try. I feel that in a way this process models that even in the face of uncertainty there may be ways to cope with and live with this uncertainty. As discussed in the literature, uncertainty can be a significant element of the experience of living with HIV.

Process Five

MONITORING & CHECKING & MAKING LINKS

This process can be defined as a multifaceted process with the aim of keeping track of the client's psychological, emotional and his physical experience during therapy. This process took place both in the therapy room and outside of it as the client continued to monitor his experience in his everyday life. It also involved making links between the data we were gathering during our time together and the client's present life and past experiences. One of the client's goals was that he wanted to know if there was a connection between his physical experience and his emotional experience. Therefore we gathered data that would allow the client and me to hypothesise about what we thought this connection was and if there was a connection at all.

Part of the data collection involved monitoring, and checking the tasks that were created in Process Four. We used this information to make further links and also monitor whether any of the tasks were working towards the client's goals. We also monitored his physical symptoms in the sessions in order to see if there were any links between content, emotions and the client's physical experience. This was also so we could make sure the client was taken care of in the sessions so we could add breaks where appropriate or take a moment to do a grounding exercise.

The themes that emerged from the transcripts were:

Hypothesis Creating and Testing.

Hypothesis creating and testing involved exploring possible hypothesis with the client and then checking both in and outside the sessions if these hypotheses felt accurate to the client.

Mind and Body Monitoring.

Outside the sessions the client would continue to monitor his physical experience and his emotional experience. In the sessions both the therapist and the client would check and monitor any physical reactions that the client had when discussing material that the client found challenging to talk about or that produced strong feelings in the client.

Mind and Body Links.

We would both check during the sessions to see if there were any links between the client's emotional experience and his physical symptoms. The client would also check whether any links existed outside the sessions by exploring these possible links in his journal.

Monitoring and checking tasks that were completed outside the therapy room.

Once the tasks were completed we would explore the client's experience of the tasks in the sessions. This was so we could create a shared understanding between us about any new 'data' that was generated by the tasks and whether the client felt they were effective.

The methods used that emerged from the transcripts were:

- Tracking and checking the work.
- Grounding Exercises.
- Meditation.
- Exploring hypotheses.
- Exploring tasks (activity schedule, meditation and journal).
- Communicating unconditional positive regard to the client.
- Trying to understand the client from their point of view.
- Being open and genuine with the client.
- Being transparent about the therapeutic process.
- Monitoring mind and body connections.
- Working in the 'here and now'.

This process involved the client and I collecting data both in the sessions and outside of the therapy room. Peter was monitoring his physical symptoms and emotions and was tracking any links he felt there was between the two. I was gathering data outside the session through reading Rothschild's book 'The body remembers' (Rothschild, 2000). I would then discuss some parts of the hypotheses in this book with the client to see if it was linking with his experience.

We would also do this in the session together. If Peter suddenly became tired or his legs started jerking then we would take a moment to explore the content of what we were talking about and how he was feeling. We would then talk about possible links between the data we were collecting outside the session and the data that was in the room. In hindsight this almost looks like a process of triangulation.

Monitoring and checking are both features of pluralistic work. I think these two elements of pluralism in the context of this process help to create a relationship between the client and the therapist where they are both 'curious investigators' and 'scientists' working towards a common goal. I feel that specifically for HIV positive clients this gives the client a chance to explore

what they think they want to do to live with HIV instead of gathering information purely from the medical community or other professionals. It seems to place some of the control and responsibility back in the client's hands in regards to their physiological and emotional experience.

Congruence seemed to be an important part of this process. I think congruence created a sense of openness that encouraged the client to trust in the process of therapy and in his own process. Transparency was also important as it allowed me to be transparent and open with the client about the information that I had collected outside the therapy room. For example, I shared with the client the concept of fight, flight and freeze reactions to stress or trauma. We then explored this information making links to his physical symptoms such as extreme tiredness and his muscles jerking. We then discussed this as a tentative hypothesis and we monitored and checked our hypothesis in the session and the client monitored this hypothesis in his everyday life.

We also checked the tasks that Peter completed outside the therapy room such as the meditation task. The meditation task was created in order to give Peter a moment where he could relax and thereby create a feeling of control over his body. This task eventually became a 'tool' that Peter used to cope when he was feeling particularly tired, when he had pressure in his head and when his muscles were jerking. Part of this process is also about monitoring, checking and making links concerning what 'works' or what is helpful for the client and exploring why.

Conclusion

These memos show five main processes that emerged from the transcripts of the therapy sessions with Peter. The first process discussed in the memos (Are you with me? travelling to planet client) was the driving force of the therapy and the other four processes. These processes did not always occur sequentially, they emerged and re-emerged throughout the twelve sessions. Figure 4.3 visually shows the process between Peter and pluralistic therapy.

For a summary of the client's feedback, including sections of the transcripts, refer to Appendix 4.

Figure 4.3: The process between Peter and Pluralistic Therapy

CHAPTER 5: SYNTHESIS AND DISCUSSION

This chapter is a discussion about the results from the case studies and recommendations of the specific goals, tasks and methods that are relevant to the therapeutic practice with clients who are HIV positive.

The synthesis and discussion will be explored using the pluralistic framework of goals, tasks and methods. An additional heading titled 'creating shared understanding' has been added as this was found to be particularly relevant for this client group when using the pluralistic framework.

Goals

For these client's the goals seem to be divided into quite specific goals (such as being able to go to a job interview), life goals (such as being able to create more balance) and relational goals. With this client group contradictory goals also seemed to feature.

By the term relational goals I mean what sort of goals or wants does the client have for the therapeutic relationship. It seems that these HIV positive clients had quite specific relational goals and ideas about what they needed from our relationship.

One of the specific goals when working with HIV positive clients that this research has highlighted was that the client wanted the therapist to understand their life experience from their point of view. More specifically, for the therapist to understand what it was like for them to live with HIV. It is recommended that if a client has been HIV positive for a period of years then this relational goal allows the client and the therapist to 'pool their resources' and make the best use of all of the 'expert' information in the room. Client B wanted to be heard and understood however, as the therapy developed this goal was further defined: he wanted to be respected as the expert in the

room. It seems there was a goal to 'teach' the therapist what it was like for the client to live with HIV. In the feedback sessions client B suggested that although he felt this analysis was accurate he added that it was also important for him for this relationship to be flexible. Client B highlighted that he felt sometimes he was the 'expert' in the room and sometimes the therapist was the 'expert'. Client B recommended that this felxibility in the relationship and the movement between 'student' and 'teacher' type roles was valuable for him in order to trust the space and feel involved in the therapeutic experience. Client B suggested that it was not just about what he was bringing into the room as a client, but also what the therapist was bringing into the room that was important to him.

Therefore when working pluralistically with HIV positive clients who have a relational goal of wanting the therapist to truly understand their experience of living with HIV, it may be helpful for the therapist to be in the role of 'student' and allow the client to 'teach' them about their experience. Taking client B's feedback into account it seems it would also be helpful for these roles to be flexible

With all three clients their goals either changed completely, changed angle slightly or completely new goals emerged during the course of therapy. Addtionally, with all three clients new goals were emgerging even in the final session. This could be a specific element of working with HIV positive clients or indeed clients with a chronic or terminal illness. New goals develop all the time as the person and the illness evolves. HIV has been described as a process of constant adjustment and re-adjustment and therefore perhaps the therapeutic goals of HIV positive clients could be seen as constantly adjusting and evolving and some of these goals don't seem to have an end point. Goals such as 'creating a quality of life' could be viewed as an ongoing process that may require the use of different tasks and methods at different times in the persons lifespan. It seems new goals could constantly emerge in the process of using pluralistic therapy with HIV positive clients. If there are new goals then the work will need to return to 'creating shared understanding' in order to explore what the goals are and what they mean to the client.

Therefore their should be a commintment on the part of the therapist to be flexible in relation to the emergent goals of HIV posiitve clients.

Contradictory goals were also a part of the therpaeutic experience with this client group. One of the specific contradictory goals was that the clients wanted to accept they were HIV positive and yet also wanted to 'fight' against this acceptance. When working pluralistically with HIV positive clients it is important to recognise and explore both of these goals in order to address abivilance and to also create an environment of respect. It seems that an outcome of exploroing contradictory goals with this client group is that the therapist is actively communicating to the client that they understand why both goals are important. Mathew stated in the feedback session that by working with two of his contradictory goals he felt that both goals were accepted and therefore he felt accepted as a client; not just certain parts of him that were accepted. Mathew also commented that an outcome of this was that he was more able to challenge and explore his goals in a critical way because he felt 'all of him' was acceptable in the room.

In the feedback session Peter felt that the exploration of contradictory goals gave him a space each week to explore these goals fully rather than constantly trying to decide which one was 'better' or a more appropriate path to choose. The goal of trying to 'fight' the fact he had HIV was prevelant in most of the sessions however, towards the end of the work Peter decided he wanted to change this goal to acceptance. By allowing Peter to explore and 'test' both of these goals the client was in a position where he felt he had enough information to truly choose which one he wanted most and also which one was going to be of most benefit to him. Working with contradictory goals within the pluralistic framework seems inportant for HIV positive clients in respect to coming to terms with the fact that they are HIV positive or perhaps acknowledge that they are not ready to accept. It seems to acknowledge and respect both goals, allows the client to explore them in a systematic way and gives enough space to the client to make the choices they truly want to make.

For Mathew, exploring contradictory goals meant that he was able to explore his identity more fully. He commented in the feedback sessions that, similar to Peter's experience, he felt that he was accepted in the room; not just certain parts of him. In this sense it could be suggested that working with contradictory goals is 'truly client centered' as it allows the therapist to communicate in an active way that the client is able to bring all of themself into the therapeutic experience including those parts that do make sense and those parts that do not. This is of particular importance to HIV positive clients as it has been highlighted in the literature that themes of shame, confusion and uncertaintly are prevelant. Therefore it is recommended that when working pluralistically with HIV positive clients that the therapist explore possible contradictory goals in order to facilitate an environment of acceptance and allow the client to explore possible ambivilance about their diagnosis.

Tasks

During the process of creating tasks a common element with all three clients was that the client became truly involved in the therapeutic work. More specifically, the client and the therapist colloborated at a high level in order to 'brainstorm' about the specific pathways that could lead to meeting the client's goals. In a way that client was encouraged to become a therapist with the therapist or a 'curious scientist' about their own issues. There were some tasks that were quite specific to each individual client; however there were some reoccuring tasks. One of the common tasks for these HIV positive clients was trying to make sense of a traumatic experience, with two of the clients the theme of this traumatic experience was death and mortality. For client B it was his own experience of death and mortality and for Peter it was making sense of the death of his family. For Mathew the theme of death and mortality was centered around his suicide attempt and his fear of it occuring again. Mathew also mentioned in the feedback session that the theme of death had been in his life for quite some time as he had watched friends die of AIDS. The research suggests that this may be a task specific to HIV positive clients or indeed clients living with a life threatening chronic illness. More

specifically the task of making sense of the clients experience of death and mortality or 'creating meaning' about their experience. This may include 'making sense' of the client's concept or feelings about death and mortality.

Another task common to all three clients was making sense of their relationship with HIV. For client B, this task was about his experience of having HIV and how this effected his personal and professional life. For Peter the task centered on making sense of his physcial symptoms and how these were or were not connected to his emotions. For Mathew the task was to make sense of how having HIV effected his quality of life. During each of these 'creating meaning' or 'making sense' tasks the clients idenitfied that there were 'invisible needs' due to their HIV status. These 'invisible needs' included feeling unwell even though they may appear fine, severe physcial pain that can't be seen visually, emotional pain, fear and feeling very low in mood. All three clients highlighted that HIV is often an illness that can not be seen. People with HIV do not necessarily look unwell. All three clients highlighted a therapeutic need for the 'invisible' parts of their experience of HIV to be understood. Therefore one of the possible helpful tasks when working pluralistically with HIV positive clients may be centered around making sense of or 'creating meaning' about their relationship with HIV; part of this relationship may include making sense of those 'invisible' parts of the illness and how they effect the client.

Enhancing and developing strategies for self care was a common task with all three clients. Mathew wanted to create space in his life for active self care in order to prevent feeling overwhelemed and becoming physcially unwell. Peter wanted to create a balance in his life between being able to work and taking care of his physcial and emotional needs. Client B also wanted to create more balance in his relationship and more time for his own needs in order to take care of himself physcially and emotionally. The research indicates that this task could be specific to the needs of HIV positive clients. In the case of Mathew, one of the ways to assist this task was to create specfic 'client activites'. These included activities such as taking time to cook, taking time to go to the park and read and putting up the tiles in his bathroom. In the

feedback session Mathew stated the value and importance of these client activities in order to assist with the task of enhancing self care, and in meeting his goal of developing ways to prevent feeling overwhelemed, feeling suicidal and becoming unwell. Mathew also suggested in the feedback session and in therapy sessions that he began creating tasks and 'activities' outside the sessions and continued when the sessions were over. It seems a possible outcome of identifying and creating tasks with HIV positive clients is that it teaches them how to create possiblities for developing self care. It seems this 'new learning' may continue once the therapeutic work has ended. It is something that the client can 'take away' with them.

Collecting data, making links within the data and developing strategies from this data was also a reoccuring task. This task could also be defined as 'problem solving and creating new strategies'. All three clients had existing strategies for coping; some of these strategies were effective for them, some of them were not and some of them used to work and were no longer effective due to life changes. For Peter this task involved collecting data about his physical symptoms and emotional reactions, understanding these links, analysing any links and then developing strategies about how to manage them. For Mathew this task involved collecting data about past experiences of anxiety, understanding and analysing this data and then creating new strategies for coping. For client B this task was about collecting data about his relationship with his partner, understanding and analysing this data and creating solutions to problems or new stratagies for interacting with his partner. Specific to HIV positive clients seems to be the need to assess, analyse and readjust coping stratgies as their external life changes, their illness changes or their 'internal life' changes. An important part of this task is also identifying those strategies that the client has developed that are working for them. Client B has been living with HIV for over ten years and had some very effective coping strategies for dealing with extreme pain. When working pluralistically with HIV positive clients it seems that this expertise about living with HIV is valuable and important to the work. Because of the emphasis on collaboration this valuable material can be incorporated into the therapy in a

systematic way thus creating a bespoke therapy for the client. This 'pooling' of information also makes the therapy relevant to the client's everyday life.

Methods

In the case of all three clients the therapeutic relationship was used as one of the methods to meet the client's goals. An important part of this method is establishing the type of therapeutic relationship the client feels would be most helpful to the work. As highlighted by client B in the feedback sessions, it is also helpful to make sure this relationship is flexible and can change and develop as the therapeutic work develops or new goals are identified. The specific method was to create a relationship where the client could 'teach' the therapist. This relationship was also flexible in that it also allowed for the therapist to 'teach' the client. Therefore when working pluralistically with HIV positive clients, if they have 'relational goals', it may be helpful to explore what sort of therapeutic relationship might be most effective for the work. In addition to this, when working pluralistically with HIV positive clients, it may also be helpful for the therapist to allow the client to be the expert in the room; to allow the client to 'teach' the therapist. This method can feasibly meet goals such as wanting to be understood and heard, the client wanting their expertise to be respected or for someone to understand the complexities of living with HIV in the context of an individual client's life.

A central part of this method is that both the therapist and the client are invloved equally in using it to meet the client's goals. In a sense the client becomes part of the 'solution' not just the problems. This method creates a high level of collaboration in a humanistic way. An outcome of this method is that the client plays a more active role in the therapeutic experience and an active role in meeting their goals. The client becomes central to the process of change.

Identifying and challenging thoughts and beliefs was also a common method used. All three clients seemed to have some core beliefs in relation to

themselves, the world and others as a result of their life narrative; this life narrative includes the fact they are HIV positive.

Peter seemed to have some core beliefs that centered around what he believed it meant to be a man and a provider and how having a chronic illness affects these beliefs. Some of client B's core beliefs centered around the world being an unfair place and that since his diagnosis he felt others saw him as less valuable in the world, particularly in relation to the work force. Mathew's core beliefs centered around the theme of not being able to cope and the fact that he felt he had no control over when he might become unwell. As explored previously, stigma about a HIV diagnosis still exisists. In addition to this, a diagnosis of HIV can feasibly affect every section of an individual's internal and external world. Therefore it may be important when working pluralistically with HIV positive clients to identify and challenge any maladaptive beliefs or thought processes that have developed about themsleves, the world, others or their illness over their lifespan.

Humanistic methods such as working in the 'here and now', working within the clients frame of reference, congruence and transparency also featured. These methods allowed the client and the therapist to create an authentic therapeutic relationship and maintain this relationship. These methods also allowed the therapist to communicate emapthy and a sense of openess to the client. With all three clients, congruence was sometimes used to challenge the client in the sessions. Through the therapist being congruent with client B about her feelings about his relationship with his partner, the client was able to more fully explore this relationship. Peter had some very strong beliefs about gender roles. Through the therapist being congruent with the client and open about her feelings about these beliefs the client began challenging these beliefs also. By being congruent with Mathew about how he was presenting in the sessions, the client felt 'seen and heard' and was able to more fully explore his identity. All three clients reported interpersonal conflicts and issues because of their HIV positive status: Mathew with his family, Peter with his wife and client B with the system of professionals he saw (e.g. doctors and pain specialists) and his partner. Therefore using methods such as being

transparent and congruent with the client may be important when working pluralistically with HIV positive clients in order to provide them with a different relational experience to what they might be experiencing in their everyday life.

Transparency as a method refers to the therapist being open and genuine with the client, but it also refers to being tranparent about the therapeutic process. When working pluralsitically there is a high level of collaboration with the client and, therefore, in order for true collaboration to take place, the client needs to know the 'therapeutic choices' available to him. More specifically, the therapist actively discusses possible methods and tasks with the client.

Due to the fact that these clients had been living with HIV for some time, they had many creative ideas about possible methods and tasks in order to meet their goals. Therefore, in accordance with the pluralistic framework, transparency is used as a method to actively use this expertise and creativity and incorporate it into the therapeutic work.

Another common method in this research was 'encourgaing the client to also be a therpist'; or encourgaing the client to be a scientist or a 'curious inventigator'. This method encourages the client to collaborate with the therapist in order to create a bespoke therapeutic experience that is both effective and relevant for the client. A possible consequence of this method is that the client learns new skills that can also be used outside the therapy room. In the feedback sessions, Mathew suggested that after the therapy ended he continued to use some of the ways we worked in the sessions. Mathew felt he was sometimes more able to 'stand back' from his issues and consider them from a more objective point of view in order to create strategies for effective coping. He described the experience as 'taking the boxing gloves off' that were not allowing him to 'handle' his life. Once these 'boxing gloves' were removed they revealed very capable hands that did have the skills to handle things and cope. This method of encouraging the client to become a scientist may be of importance to HIV positive clients as they can feasibly live with HIV for a 'normal lifespan'. This means their needs may change over

time, their physical and psychological issues may change and therefore the ways in which they cope may have to change as well. Using this method in the sessions utilises the clients creativity and expertise, however it can also teach clients how to use this creativity and expertise outside the sessions and in the future.

Monitoring mind and body connections was an important part of the work with Peter particularly, however this method was also used (to a lesser extent) with the other two clients. This may be an important method when working pluralistically with HIV positive clients as their psychological state can affect their illness and their illness can effect their psychological state. As the research suggests anxiety and depression can affect HIV, adherence to medication and general quality of life. Mathew suggested that when he was low in mood for a long period of time, his body would start reacting and produce specific physcial symptoms which told him he was 'run down'. Client B suggested that sometimes when he was experiencing pain for long periods of time he would become very low in mood and feel hopeless. It seemed Peter had specific symptoms that were sometimes linked with his emotions such as overwhelming feelings of anger or sadness. The method of monitoring mind and body connections allows the therapist and the client to identify any connections and then collaborate on possible hypotheses about these connections. It then allows the therapist and the client to 'brainstorm' about possible strategies for prevention and coping effectively. A possible outcome of this method is that the client may start to feel more in control of how their HIV status effects them. It means the client has the appropriate data in order to see where they can intervene and how. Peter commented in the feedback sessions that although the mind and body monitoring did not necessarily meet his goal of getting rid of his symptoms, it did help him understand them more and this made them less scary and the situation felt less hopless.

Creating Shared Understanding

In the feedback sessions with all three clients, they highlighted the importance of creating shared understanding within the sessions. Client B said that without creating shared understanding he felt the work would have been entirely different and he felt he would have been less open to me challenging him. He said that it would have been a similar experience to the experience he has had with 'other professionals' (e.g. doctors and pain specialists) where they try and work with him and he becomes frustrated, angry, defensive and stubborn because he has the sense that they have not tried to understand his specific needs first. Peter suggested in the feedback session that the experience of having someone try and truly understand him with the understanding he had of himself was a completely new and different interpersonal experience. Mathew suggested in the feedback session that if we didn't create a shared understanding about his identity, he would have continued hiding behind the 'masks' he had created and the therapy would not have been as effective. Therefore this research suggests that creating a shared understanding between the client and the therapist is a key element when working within the pluralistic framework. This is certainly the case with these three clients, but feasibly could be an important part of the pluralistic framework for all client work.

The process of creating shared understanding between the client and the therapist can be likened to the process of collecting data and using grounded theory strategies. It is similar in the sense that it is a 'bottom up' rather than a 'top down' process. Information is gathered with an 'open mind' rather than in accordance with pre existing theory. In this sense the therapist approaches the client as someone they have not worked with before, with issues they do not yet understand, as opposed to allowing their symptoms or diagnoses to lead the therapeutic encounter. Psychological theory can be used once the client is understood within the context of their life. Indeed, with these three clients, exploring and creating a shared understanding about the contextual factors of their lives, including cultural aspects, relationships (friends, family and other professionals), employment (or lack of), where they live, medication

and what its like to live their everyday life, were of utmost importance to the work. It seemed that without a detailed and comprehensive shared understanding of the client within the context of 'their world', it would be problematic to truly understand the client's goals; it would also be problematic to attempt to create appropriate tasks and methods in collaboration with the client.

One of the specific elements of creating shared understanding with HIV positive clients seems to be allowing the client to lead the sessions. When creating shared understanding with HIV positive clients that have lived with the illness for an extended period of time, it seems it may also be helpful for the therapist to see the client as the expert in the room; they may have very specific coping strategies and could have a very specific relationship with their illness. I suggest that a possible outcome of the process of creating shared understanding where the client is in the role of expert, is that the client and the therapist are able to tap into some of the extra-therapeutic factors that are specific to the client. In the feedback sessions client B suggested the process of creating shared understanding made him feel respected and very involved in the therapeutic process.

Conclusion

In conclusion, this research suggests that, in order to fully utilise the goals, tasks and methods framework effectively, a deep and comprehensive shared understanding between the client and the therapist should be created and maintained throughout therapy. Feasibly, as new goals emerge during the sessions, it may be helpful to return to the process of creating shared understanding in order to create the tasks and methods most relevant to the client.

The research suggests that, with these three clients, the therapeutic relationship was used as a method to meet some of the client's 'relational goals' for therapy. It is recommended that, when using pluralistic therapy with HIV positive clients, a relationship where the client is allowed to 'teach' the

therapist may be of some benefit to the work. This relationship should also be flexible so it allows for the therapist to also 'teach' the client. This may be particularly relevant for clients that have lived with HIV for a long period of time and have an established relationship with their illness, have existing coping strategies and with those clients that feel other professionals are not understanding them from their point of view.

It seems that the use of tasks in the pluralistic framework encouraged the clients to be actively involved in creating a bespoke therapeutic experience with the therapist. The task of exploring and making sense of the concept or the experience of death and mortality seemed important to these HIV positive clients. It seems that how these clients made sense of these concepts had an effect on other areas of their life, such as interpersonal relationships, and times in their life where they became unwell.

These three clients also used the tasks of collecting data, making links and developing strategies. Due to the fact that people can live with HIV for a normal lifespan it is possible that their needs and coping strategies may need to change as their 'internal or external world' changes. Therefore this task allows the therapist and the client to gather the relevant information, analyse this data and then create new pathways of coping.

These conclusions have been collated into a practitioner's guide for working pluralistically with HIV positive clients. Please refer to Appendix 5 for the full version of this guide.

In summary, using the pluralistic framework with these three HIV positive clients allowed and invited them to use their expert knowledge and creativity, and collaborate with the therapist's expertise and creativity in order to create a bespoke therapeutic experience. The client's goals provided the focus for the therapy. The foundation on which this therapeutic experience is built is the shared understanding between the therapist and the client about the context in which the client lives and what it's like to live in the client's world.

Links to the literature

As previously explored, Lambert (2003) suggests that the relationship accounts for 30% of the variance within a positive therapeutic outcome. Much of the research about the therapeutic relationship seems to concur with Lambert's (2003) finding suggesting that a strong therapeutic alliance is one of the most important predictors of a positive therapeutic outcome. However, Cooper (2008) reminds us that just because the therapeutic alliance is correlated with a positive therapeutic outcome does not imply it causes it. Bordin (1979) suggests that it may not be relational factors alone that create a positive therapeutic bond. Bordin (1979) advocates that collaboration and goal and tasks consensus may be just as important to create a meaningful alliance. It seems that this research reflects Bordin's (1979) theory in that consensus about tasks and goals and collaboration are key to creating an effective therapeutic relationship. However, this research suggests that when using the pluralistic framework with these HIV positive clients, consensus was an important part of each process, including consensus about the client's relational goals for therapy. More simply, this research suggests that consensus was an important aspect in the creation of goals, tasks, methods and the specific therapeutic relationship that the client wanted.

In the common factors research the domain that was said to account for the largest percentage of variance of a positive therapeutic outcome was the extra-therapeutic factors (40%) (Lambert, 2003). Extra-therapeutic factors include various aspects of the client that are specific to that client such as their life experience, personality traits or ethnicity. I suggest that a possible outcome of the process of creating shared understanding where the client is in the role of expert is that the client and the therapist are able to 'tap into' some of the extra-therapeutic factors that are specific to the client. By allowing the client to take this leading 'expert role' the therapist and the client were able to explore elements of the client's life experience, his personality traits and his culture. I feel these specific extra-therapeutic factors of each client became a part of the goals, tasks and methods framework and helped us to work towards a true and meaningful consensus about what it is we were doing.

In the case of these HIV positive clients each had a very different relationship with their illness, all three of them had lived through life experiences that impacted the way they currently lived their lives and each clients culture and identity seemed to effect their beliefs and strategies for coping. Without shared understanding being created about B's experience with death, or Mathew's relationship with HIV or Peter's experience of contracting HIV I don't think relevant tasks and methods could be effectively created. I also think that without 'tapping into' and using these extra-therapeutic factors a truly effective therapeutic relationship would be problematic to create. Therefore this research concurs with the common factors research concerning the extra-therapeutic factors of the client. It could be suggested that this was of particular importance in the case of these HIV positive clients when using the pluralistic framework.

Limitations of the research

Due to the fact that there were only three participants involved in this research, the level of generalizability is limited. The research is systematic and thorough and does provide a rich account of pluralistic therapy with these three participants however; it is problematic to draw definitive conclusions given the small sample size.

Another limitation of this research is a lack of quantitative measures. The data used was transcriptions from the therapy sessions and the feedback sessions thereby only providing qualitative data about the therapeutic process and experience. In order to reach more definitive conclusions about the helpfulness and efficacy of this framework for these three clients quantitative measures would need to be taken at different stages through the therapeutic experience.

An abbreviated version of grounded theory was chosen to analyse the data collected due to the time constraints of the research. Therefore only one set of data was collected and analysed. In order to conduct a full grounded

theory analysis and gain a deeper understanding about the efficacy of this framework, a second period of data collection would need to take place.

The main limitation of this research is that the therapy, the data collection and data analysis were all conducted by one researcher. More specifically, the researcher was also the therapist. This means that the researcher engaged in a therapeutic relationship with all three participants. Even though measures were taken to keep the role of researcher and the role of therapist separate it is feasible that one role would have an affect on the other. Therefore the results of this research can be viewed as one possible interpretation of the data collected, rather than an analysis that provides a definitive truth.

Directions of future research

As far as I am aware these are the first case studies that have explored the use of pluralistic therapy and therefore this is really the very beginnings of research about this model. Due to the clear and specific structure of the goals, tasks and methods framework Cooper and McLeod (2007) have created a model of therapy that is conducive to research. Therefore future research concerning specific goals, tasks and methods that are effective for specific client groups would be possible and would significantly build on literature about what is efficacious for clients. If I had the opportunity to do this research again it would be interesting to use quantitative measures, specifically about the therapeutic alliance and level of consensus between the client and the therapist.

In the feedback sessions some of the participants suggested that they continued using aspects of the framework after the therapeutic work had finished. Therefore perhaps a more longitudinal view of pluralistic work may also be helpful in order to see the effectiveness of this model over time. This could be done by conducting interviews with clients that have experienced pluralistic therapy at different time intervals after their therapy has been completed.

It would also be interesting at this early stage of research about the pluralistic framework to investigate what the experience of this framework is like for clients. After completing the feedback sessions with the three participants it became clear that this provided a wealth of information about the experience from the client's point of view in respect to what was most and least helpful. In the spirit of collaboration and pluralistic work it may be helpful to work with clients experiences and feedback in order to further develop this framework.

PART II

A CHALLENGE FROM GILLIAN TO BE AUTHENTIC: A PERSON CENTRED CASE STUDY

Introduction

This case study describes the development of a relationship between therapist and client that persisted in aiming for authenticity. The client's courage and strength to be vulnerable and engage at relational depth challenged me as a therapist to be vulnerable also. I chose to write a case study on this client because I was probably more vulnerable than I have allowed myself to be before in my work with clients. I feel the therapeutic alliance and how effective I was as a therapist was greatly improved by this new level of vulnerability. I felt fortunate to experience this relationship.

I feel this case study also illustrates a therapist and a client working together collaboratively. The client actually challenged me to work in a collaborative way. She had lots of ideas about how we would work together and what was effective for her in the sessions. The client was quite clear that being congruent with her was a helpful experience and that 'feeling sorry' for her was not. We incorporated her feedback and her ideas into our sessions. I feel this level of collaboration meant that the therapy was truly 'client-centred' and allowed the client to be involved in what her therapeutic experience would be. In a sense, what was created was a bespoke, person centred therapy that was specifically tailored for the client.

For the purpose of this case study all names and identifying features of the case have been changed in accordance with the BPS ethical guidelines.

The context of the referral

Gillian was referred by her GP to the voluntary organisation I work for. The assessment suggested that Gillian's presenting problem was that she was concerned about her anger and how it was manifesting itself in her relationships. The voluntary organisations policy is to offer a maximum of twelve, fifty-five minute sessions that are held at the organisations centre.

I have supervision once a fortnight for two and a half hours. Sometimes supervision is with one other trainee counsellor and at times on my own. The

supervisor is trained as an integrative therapist and is provided to me by the voluntary organisation.

The client and her background

Gillian is forty years old and was born and grew up in the United Kingdom. She was born into an Irish Catholic family with five children in total; Gillian had a twin brother, one older brother and two younger sisters. Gillian describes the household as '*loud and unpredictable'.* She describes her mother as very kind and strong and her father as someone she considered to be a friend. However, Gillian describes both parents as having a very much '*pull your self together'* kind of attitude towards emotions. According to Gillian, emotions were considered self-indulgent.

When Gillian was thirteen her older brother began to sexually abuse her. The sexual abuse took place in one form or another just about everyday and continued until Gillian left home when she was seventeen. From the first time it happened until Gillian left home she told both of her parents that it was happening and that she wanted it to stop. Her parent's response was that this was something they were not able to help Gillian with and it was not appropriate to discuss things of that nature.

Gillian continued to tell her parents what was happening about once a month from the time she was thirteen until she left at seventeen and continued to get the same response from both parents.

Since Gillian turned seventeen and left home she has been in a pattern of difficult relationships. She started going out with men that were verbally and physically abusive and found it difficult to be on her own for any extended period of time. Gillian's describes her current partner as a *lovely man* but she is frightened she is going to drive him away with her behaviour and inability to control her anger.

Gillian's anger manifests itself as being verbally abusive, throwing things, being physically abusive to her partner and feeling like she is losing control. She was concerned that over the last couple of months she had become angry at work and almost '*lost it'* with her boss. Gillian also reported that she would become verbally abusive with waiters in restaurants and retail assistants and then feel extremely guilty and ashamed of her behaviour when she got home. Her goals for therapy were to explore the sexual abuse she experienced when she was growing up, to understand why she was angry and to be able to control her anger. Gillian said she had tried counselling before and it hadn't worked but that she was giving it another try as a last resort.

Theoretical approach: Person Centred Counselling

Rogers (1957) suggests that an environment conducive to assisting the client to become a 'fully functioning person' is what is needed for therapeutic change (Rogers, 1963). This environment is largely created by the therapist's belief that each of us has the personal resources to create the change that we need (Bozarth, Zimring, and Tausch, 2002).

The client is the expert of their inner world and the therapist simply creates the climate for this expertise to come forth. Rogers recommended that there are six core conditions within this relationship that cultivate the client's ability to *self-actualise* and empower their use of an *internalised locus of evaluation* (Rogers, 1957). The necessary and sufficient conditions for therapeutic change in person-centred therapy according to Carl Rogers (1957: 96) are

1. That two persons are in *contact*.
2. That the first person, whom we shall term the client, is in a state of *incongruence*, being *vulnerable*, or *anxious*.
3. That the second person, whom we shall term the therapist, is *congruent in the relationship*.
4. That the therapist is *experiencing unconditional positive regard* toward the client.

5. That the therapist is *experiencing* an *empathic* understanding of the client's *internal frame of reference*.
6. That the client *perceives*, at least to a minimal degree, Conditions 4 and 5. The client should perceive the *unconditional positive regard* of the therapist for him, and the *empathic* understanding of the therapist.

Rogers stated that these conditions were all that was needed to create a climate for real and significant therapeutic change (Rogers, 1957).

It has been suggested that the therapist should try and work beyond what has been called the 'presentational aspects self' to meet the client inside their 'existential process' *(Mearns and Cooper, 2005)*. This is in order to meet the true, 'existential self' and show this person, congruence, unconditional positive regard and empathy. This 'existential self' can be defined as the true 'self', or the self that is underneath what the person thinks they should be or the self that others think they should be (Mearns and Cooper, 2005).

The literature suggests that due to negative *conditions of worth* that have featured in the clients past relationships the client can loose trust in their *organismic valuing processes* and their *existential self* (Mearns and Thorne, 2007). Attempting to engage a client in this sort of *profound contact* is an offer from the counsellor to engage at *relational depth (Mearns and Cooper, 2005)*. This profound contact can help the client to 'meet' themselves, accept themselves and experience a relational experience that does not contain judgement or conditions *(Mearns and Thorne, 2007)*. This can help to empower and locate their *internal locus of control* and empower their ability to *self-actualise* (Rogers, 1957).

Sanderson (1990) has suggested that some of the effects of being sexually abused include low-self esteem, guilt, shame and anger as well as general problems with interpersonal relationships. It has been suggested that through the sort of negative conditions of worth that come with sexual abuse a clients

self-concept might be summarised by statements such as ‘I am unlovable’ or ‘no one hears my needs, I am invisible’ (Bryant-Jefferies, 2003).

Assessment and formulation

I chose to work within the person centred framework with Gillian because I felt that this client’s relationships had taught her that relationships are unpredictable, often run by someone else’s agenda and frequently leave you alone to deal with your painful emotions. She frequently described herself as ‘*being out of control’*. I felt strongly that creating a space for Gillian that contained Rogers (1957) six conditions would help her to trust again in her *internal locus of evaluation*. I felt the person centred framework would help me to create a relationship with Gillian that could help her re-connect with her *actualising tendency* and her *existential self* (Mearns and Cooper, 2005).

In our first session Gillian was defensive and cautious. I have to admit that it was difficult to warm to her. She came into the session dressed in a suit, her hair pulled back tight. Gillian looked me straight in the eye all session, which at the time felt quite aggressive. I guess I felt a little cold towards Gillian in this initial session and I feel that the way I was in the room was far more ‘business-like’ than I usually am in a first session with a client. By the end of the session Gillian made it quite clear that she wanted to find out why she is so angry and then fix it.

Rennie (1998) has suggested that meta-communication or communication about communication can be particularly helpful with defensive or aggressive clients as it helps them not to feel trapped in the situation. Meta-communication gives them freedom in the room to create the counselling they want in collaboration with the counsellor; it has also been suggested that it is a key element to building a strong relationship (McLeod, 2007). For the last half of the session Gillian seemed to be less rigid in the way she was sitting and seemed less intent on staring directly into my eyes. It seemed she was starting to trust the space a little more. Yalom (2002) has highlighted the vast

amount of information that can be in the first session and the information Gillian seemed to be giving me was that she was going to require me to be authentic and trust worthy in order for her to work with me. Rogers (1977) has spoken of the importance of the therapist to be authentic and congruent and I believe in Rogers argument that authenticity can not be turned on for the counselling room and off in your own life. This was going to be tricky. I hoped I could meet Rogers and Gillian's challenge.

My initial thoughts about Gillian in the first of session were that she seemed to exhibit ego-syntonic processes (Mearns and Thorne, 2007). This can be defined as a process where the client attempts to '*protect themselves from intimacy through detachment and attempts to control others'* (Cooper, 2007:35). Ego-syntonic process can be developed when a person experiences an upbringing that is confusing and unpredictable and this can also include abuse (Mearns and Thorne, 2007). This ego-syntonic process can lead the person to be controlling and angry in their adult relationships because they are fearful of being close to people; they are not sure what they are going to get.

Towards the end of the first session we discussed our contract of twelve sessions, meeting once a week for fifty-five minuets and this discussion of 'containment' and the contract seemed to calm Gillian down. When I commented on this she replied, '*It feels good to have a set time each week that's mine'.*

The development of therapy

Our initial four sessions followed a quite distinctive pattern. Gillian would be defensive and detached for the first half of the session and then warm, calm and emotionally available for the second half. It was two quite distinctive and opposite parts of Gillian and she was bringing them both into the room. I asked Gillian how she felt about 'our situation', the space and the way we communicated. Gillian replied that she sometimes felt scared at the beginning of our sessions because she is afraid she might 'loose it' and cry

when she is discussing difficult subjects but that after a while she feels ok; 'I realise after a while I don't have to fight in here'. It was important to me that I accept, prize and reflect back all aspects of Gillian that she brought into the room even though at times this was challenging. Yalom (2002) has suggested that sometimes it is better to strike while the iron is cold and I felt this was not the time to reflect back to Gillian my experience of her in the sessions.

Mearns and Cooper (2005) suggest that in order to work with a client at relational depth it is important to engage with and offer the core conditions to the different 'configurations of self' the client might present. In contrast, Stiles and Glick (2002) have suggested that reflecting back aspects of the client that may be directly opposed can be confusing for the client. However, I decided to work with Gillian as Mearns and Cooper (2005) suggested because I felt it was the best path towards working with Gillian at relational depth. Research has suggested, and I felt, that our relationship was going to be the most reparative element of our work together (Lambert, 2003; Kahn, 1997; Hovarth and Bedlet al, 2002). Gillian's self-concept had been created by the conditions of worth of her past relationships and I wanted to offer her a different sort of relationship (Mearns and Thorne, 2007). Therefore, for these initial sessions with Gillian I attempted to accept, prize and reflect back both 'angry Gillian' and 'gentle Gillian'. I attempted to convey acceptance and unconditional positive regard mostly through non-verbal communication. I wanted to create a relationship that Gillian could trust.

The effect of this choice seemed to be that Gillian felt more and more comfortable with discussing difficult subjects and emotions. The effect on me as a therapist was that I sometimes felt a bit 'beaten up'. I felt because of this that perhaps in the initial sessions that my energy was low and this may have affected the length of time it took for Gillian to feel she completely trusted in our work.

In the next four sessions our relationship changed. I feel my acceptance of Gillian's 'configurations of self' in the beginning of therapy helped her to trust

the space and trust me (Mearns and Cooper, 2005). Gillian started to bring in many more emotions than just anger. I no longer seemed to be sharing the space with a powerful, angry woman; I seemed to be sharing the space with a hurt little girl. Gillian's eye contact was still held throughout the session but it was softer and she seemed to take more time to pause and allow silence in the room. I decided to trust in my client's process and follow Gillian's lead (Rogers, 1957).

During these four sessions Gillian started to give me feedback about our work together and how she wanted our work to progress. She told me that it was effective when I told her what I was really thinking, when I was honest about my impressions of her and when I challenged her. She said she wanted more of this in the sessions and that she wanted less of the 'therapist crap' that just made her feel like I felt sorry for her. I explained that although I felt a deep sense of empathy for Gillian I had never felt sorry for her and that I wondered what it was that I was doing to make her feel this was the case.

We started to explore what it was like for Gillian to ask for help and come in and see me each week. She explained that it felt like she was weak and that I must feel sorry for her. I invited Gillian to explore her experience of asking for help with her parents in relation to the sexual abuse she experienced. She suggested that every time she asked they just told her that it was her problem and this made her feel useless and disempowered. I made a choice to really allow Gillian to lead the sessions at this point. I reflected back to Gillian that I hear her request for help and I also hear that she would like some say in how that help is given to her. She agreed that this was an accurate reflection. Gillian seemed to almost 'breathe out' in this session. I think it was the first time I had seen her sit back in her chair and relax. I invited Gillian to give me feedback in each session as and when something occurred to her and that we would explore it and then incorporate her ideas into our work.

Our sixth session felt different from the beginning. Gillian began discussing a case of child abuse she had read about that morning in the newspaper. The baby had been called 'Baby P' by the papers. I had been reading about the

case in the newspaper that morning also. Gillian looked furious. Her voice was raised and she started asking questions like, 'how could they do that to a child?' I stayed silent and kept soft eye contact with her. 'Why didn't someone hear this child?' I reflected back that no one heard this baby's cries for help. As I reflected this back I felt tears welling in my eyes. I had been upset by the 'Baby P' story in the papers that morning also. I feel I carried some of this upset into our session without realising it and then also began to feel emotional as Gillian began making connections between this case and her own.

Gillian asked me to be authentic and congruent from the beginning of our relationship and I required this of myself also. I reflected back to Gillian that like 'Baby P' her cries for help were not heard either. I let a couple of tears fall and then we began to discuss the 'here and now' emotions in the room (Yalom, 2002). I reflected back to Gillian that the 'Baby P' case made me sad, as did the connection between this case and her story. Gillian commented that she felt comforted that I was saddened by this connection. She said that she thought she was just angry about the abuse she experienced; but then she realised that the main emotion she felt was not anger (although she did feel this), she was really sad and hurt. Gillian began to cry as she was saying this. She told me that seeing me cry made her feel like she could cry too. She said that she felt it was a 'cry' she has wanted to have for a very long time. Mearns and Cooper (2005) have suggested that we should allow ourselves to be affected by our client's stories. I felt truly vulnerable and affected by Gillian's story at this time and I feel it facilitated Gillian's exploration of her feelings about the abuse she experienced. I feel we were both truly working at relational depth at this time and in one way or another for most of the sessions after this moment (Mearns and Cooper, 2005).

An alternative to crying with Gillian would have been to use reflection. I could have reflected back to Gillian that even though she sounded angry she looked sad and possibly explored why this was. Mearns and Thorne (2007) have suggested that part of being congruent is reflecting back observations such as

this as they happen in the room in order to explore emotions or subjects that perhaps the client finds difficult. I guess I chose to be congruent about my feelings in the sessions though my behaviour and my words because I felt this would convey a high level of empathy, authenticity and congruence and would strengthen our relationship. I believe this helped greatly to create the kind of relationship necessary to work with a client at relational depth (Mearns and Cooper, 2005).

In our final four sessions Gillian explored the sadness, anger and fear she felt about being abused by her brother and her parents ignoring her request for help. These sessions were much more interactive and I became more directive in relation to Gillian's process in order to facilitate Gillian's processing of these difficult memories. Rennie (1998) has suggested that one of the impacts of process direction on clients is that it can encourage the clients to begin to accept themselves where they are. This was certainly the case for Gillian. In these last sessions Gillian said she was changing in the way she interacted with her partner. She explained that she found it easier to recognise and express her emotions and therefore was not as angry and frustrated anymore.

Gillian told me in the last session that the thing that had been most helpful was the deep connection she felt with me. She said it was strange to be in a relationship where she knew for sure that I had her best interests at heart and that I didn't want anything from her in return. I told Gillian that I felt a deep connection with her also and that I felt honoured to spend each session with her.

Difficulties in the work and supervision

Mearns and Thorne (2007) discuss the counsellors use of self in respect to being able to listen to ones self and also acceptance of ones self. These were the two major difficulties that I had to work on throughout my relationship with Gillian. In order for me to accept certain 'configurations of self' that Gillian presented I had to become more accepting of myself as a therapist

(Mearns and Cooper, 2005). At times in the initial sessions I felt intimidated, useless and drained.

On a practical level, my supervisor and I agreed that I would not book any clients in after Gillian and this made me feel more able to deal with feeling drained. However, each time I discussed Gillian in supervision I came away feeling that the best path to take was to continue to accept her as she was. The more I trusted in the client's process and the person centred model the easier it was for me to show Gillian unconditional positive regard and acceptance (Rogers, 1957).

The other 'difficulty' and blessing that followed this acceptance of the client and an acceptance of myself was that I became more present in the room as did my own emotions. I allowed myself to not only be affected by the client but I allowed the client to see this and use it as part of the work (Tudor and Worrall, 2006). There were a couple of sessions where I felt completely naked and I was unsure whether I had stretched boundaries too far by crying with her. I explored these feelings with my supervisor and the message I got back was that I needed to trust that I am a practitioner who is very aware of boundaries (my supervisor is aware of my work with other clients) and that it's ok to show my humanity. I feel these discussions with my supervisor were fundamental to my work with Gillian. The word 'humanity' stayed with me throughout our work and I feel that it was my sense of my own humanity and taking a risk to be vulnerable with Gillian that helped me to get through the difficulties in the work.

I feel a consequence of working in a way where I allowed myself to be affected by the client's material was that my 'professional mask' started to slip down. In our initial sessions my reaction to feeling that Gillian was being aggressive was to go into 'therapist mode' and in a way I was hiding behind my interventions and my role as a therapist. I feel the work was still effective and helpful but it certainly slowed down the solidification of our therapeutic relationship. I feel that when the mask started to slip Gillian was able to start really trusting our work; and fair enough too. I realised from working with

Gillian that a level of academic knowledge is imperative in order to be an effective counselling psychologist but this knowledge should not be used as a shield so I don't have to get too 'close' to the client's material. Gillian didn't want to be with a bunch of textbooks and journal articles for an hour each week; she wanted to be with a human being that was going to respect her and her material enough to at the very least 'be' present in the room with her.

Evaluation of therapy

Critiques of some trainee counsellors are that they miss the opportunity to be truly congruent and to use themselves as instruments in therapy (Corey, 2005). I feel that without the supervision that I had this certainly would have been me. However, I felt it took me quite a long time for me to adjust to Gillian when she was being defensive in the sessions. I found it challenging to operate within the person-centred model when I didn't feel immediately warm towards Gillian. Through supervision and allowing myself to be affected by Gillian it became easier to accept all her 'configurations of self' (Mearns and Cooper, 2005). I feel I could have handled the development of the relationship better in the beginning. In retrospect I think my initial reaction to Gillian's anger was to go into 'expert' mode. My reaction was to act in a 'professional' way in the room. As soon as I trusted more in myself and felt confident enough to be 'human' in the room the relationship began to change.

I feel the person centred model was effective for Gillian. I was able to see Gillian's concept of herself and the world around her change as our relationship grew. I also had the privilege to experience a deep therapeutic relationship with Gillian. I feel the choice to be more open, congruent, vulnerable and 'human' as a counsellor facilitated the development of the relationship and meant that we were both able to work together at 'relational depth' (Mearns and Cooper, 2005).

Overall I am pleased of the way Gillian and I worked together and I know that Gillian was pleased with our work also. Gillian seemed to develop and change over the course of the therapy both inside and outside the therapeutic

space. I feel I worked well with the core conditions and was privy to watching how powerful the core conditions can be.

What I learnt as a therapist

1. The strengths of the person centred model in particular the relationship that can be created through the core conditions.

2. Empathy can be shown clearly without using words. Sometimes it is more empathic to be silent, attentive and without an agenda.

3. Congruence can sometimes sneak up on you. Part of congruence is being your authentic self with the client. When you are being your authentic self you should strive to be accepting of this authentic self for this is what you are aiming to help your client to do.

4. Twelve sessions is enough for powerful change to take place

PART III

HIV POSITIVE CLIENTS: COULD THIS AREA BE DEVELOPED FURTHER BY COUNSELLING PSYCHOLOGISTS?

’HIV needs psychology," said Coates. "Research is essential in the areas of prevention, adherence, stigma, and removing policy barriers to prevention and care--as well as in areas such as gender inequality and homophobia, as these are the driving causes of the epidemic‘ (Coates, 2002:37).

Introduction

Human Immunodeficiency Virus (HIV) is a virus that diminishes the efficacy of immune system functioning, disabling the body from fighting off infections and disease (Penedo et al, 2003). HIV is found primarily in blood, genital discharge and breast milk (semen, vaginal fluids and menstrual blood) and therefore any activity where there is a point of entry that allows these fluids to transmit from one person to another is potentially a high risk activity for possible transmission (McKeganey and Barnard, 1992). HIV infection can affect almost every facet of an infected person’s life including work, family, sex life, friendships, travel and more obviously the person’s physical and mental health (Miller, Weber and Green, 1986). This does not mean that a satisfying quality of life can’t be achieved, it does however; mean some quite drastic and sometimes complex lifestyle adjustments (McKeganey and Barnard, 1992).

In 2006 the total number of people living with the virus rose to an estimated 39.4 million; the highest ever level (UNAIDS, 2005). Adult (defined as aged 15-49 years) prevalence rates of those living with HIV/AIDS vary region by region, from an estimated 0.1% prevalence in East Asia to an estimated 7.3% prevalence in sub-Saharan Africa (UNAIDS, 2005). Worldwide it is estimated that 1 in every 100 adults are infected with the disease. The pandemic is threatening to overwhelm healthcare financing and healthcare delivery systems (Passer and Smith, 2001). HIV/AIDS still remains an incurable disease today.

As little as ten years ago it used to be that the majority of people with HIV would go on to eventually develop Acquired Immune Deficiency Syndrome (AIDS). Today, although this illness is still incurable, medical science has progressed as such that HIV is now a chronic illness rather than a terminal

one. HIV is often viewed in four biological or medical stages and with each stage comes different psychological needs. The virus can now be managed using a cocktail of drugs called 'Combination Therapy' (Terrence Higgins Trust, 2007). These medical advances mean that people are potentially living a normal human lifespan with an illness that can be debilitating not only in a physical sense but also in a psychological and social sense (Terrence Higgins Trust, 2007).

These medical advances mean two things; firstly that HIV is no longer a terminal illness and secondly, people have to cope with the psychological, psychosocial and physical effects of this illness for the rest of their lives (Terrence Higgins Trust, 2007). This paper is a review of the literature pertaining to the way in which counselling psychology has approached this client group when HIV was a terminal illness, and how counselling psychology approaches this client group where HIV is the chronic illness it is today. Following a review of the current literature, this paper will critically discuss the areas where counselling psychology could be more effective in having a positive impact on this client group. More specifically, this review will focus on the social construction of HIV and how counselling psychology can more positively impact this construction through the way it approaches research in this area. Additionally, research pertaining to the specific needs of women with HIV will be explored.

The history of HIV and the psychosocial effects

To comprehend the vast impact that living with HIV can have on an individual's life and therefore how counselling psychology can have a positive influence; it is useful to understand HIV in the context of its history. In the early 1980s, the first years of the epidemic in the United States, science could tender very little in the way of treatment or even social support (Gallo, 2002). The disease did not have a name, its agent and the mode of transmission were unknown, and it was customarily fatal. Groups of people that were not always appreciated as equals in society such as gay and bisexual men, drug users and sex workers fell seriously ill, were diagnosed, and died, often within

a year after seeking medical assistance (Gallo, 2002). Many in these so-called 'high risk' groups felt a sense of inescapability, culpability, fear and further rejection of what and who they were by society (Gallo, 2005). Hopelessness, aggravated by a lack of information, typifies this perplexing and anxious time (Gallo, 2005). It is significant to remember that this was only just over 20 years ago.

Research that explored the attitudes and social acceptance of people with different impairments and disabilities used the Friedman Test in order to rank the order of social acceptance (Deal, 2006). HIV was consistently ranked in the top three least acceptable impairments or disabilities to have (Deal, 2006). The psychosocial impact that these attitudes can have can make coping with the impairment or disability extremely challenging (Deal, 2006). Using a sample of participants who were living with HIV (n = 271) researchers explored what it was that contributed to the participant's levels of depression (Ingram and Hutchinson, 1999). A significant amount of the variance of depression in this group was found to be a function of negative or 'unsupportive' social interaction (Deal, 2006). Therefore it has been suggested that negative social interactions, social rejection and social stigma could be one of the causes of depression within stigmatized groups in society (Deal, 2006). Deal (2006) also suggests that therefore social oppression may be correlation with depression. For the purpose of this essay, it could be suggested that the historical social oppression, leading to the current stigma surrounding HIV positive people has had, and could continue to have, a direct impact on this client groups psychosocial functioning.

HIV/AIDS as a terminal illness

Historically, along with the stigma of HIV/AIDS there was also the terminal nature of the illness as well. Using the framework of bereavement counselling as well as models such as 'The stages of dying' was the most common format for counselling clients with HIV/AIDS (Kubler-Ross, 1969). Due to the terminal nature of HIV/AIDS at that stage, it was inevitable that death was what the client was preparing for. 'The stages of dying' are suggested to be

denial, anger, bargaining, depression and finally acceptance (Kubler-Ross, 1969). This model has been criticized by some psychologists as being to rigid in its 'stage theory' format (Bowlby, 1986). However, this model is still widely accepted and used in bereavement counselling and counselling clients that are terminally ill (Kubler-Ross, 1997). Bowlby's revised four-stage theory (previously three stages) of loss can be seen as more fluid and also includes a general time frame for each stage (Bowlby, 1986). Bowlby (1986) suggests that firstly there is a period of feeling numb interjected with outbursts of anger. This is said to last anything from a few hours to a week. Secondly there is a yearning and a searching for answers that can continue for months or years. Following this stage are feelings of disorganization and despair. Finally, to a greater or lesser degree, Bowlby suggests we come to a stage where our feelings are organized, clear and easier to understand (Bowlby, 1986).

Elizabeth Kubler-Ross has written specifically about counselling clients with AIDS and discusses not just the stages of dying in an emotional sense but also a practical sense (Kubler-Ross, 1997). Kubler-Ross also discusses the review of life and the examination and change of priorities that can also come with terminally ill clients. Kubler-Ross discusses the psychologist's role in counselling terminally ill clients as varied and complex (Kubler-Ross, 1997).

In the context of someone dying from AIDS, pain management and the doctor- patient relationship would be explored to ensure the client's comfort and to make sure they have a voice that is heard during their time in care (Kubler-Ross, 1997). Assistance with helping the client to create the dialogue they wish to have with their family members, partner and friends can be a very important part of the client dying with dignity and peace (Kubler-Ross, 1997). Additionally, Kubler-Ross suggests that many clients may want to review their life and discuss the past, make sure their present life is settled and to heal old wounds. Ultimately Kubler-Ross discusses the clients need to style a 'vision' of how they wish to die and that the role of the psychologist is to empower and support the client to achieve this (Kubler-Ross, 1997).

People are of course still dying from AIDS and this form of counselling is therefore still valid in the world of mental health and HIV/AIDS (Terrence Higgins Trust, 2007). However, now that HIV is a chronic illness there are increasing numbers of people that have the ability and to 'live well' with this illness rather than die from it (Terrence Higgins Trust, 2007). This means that potentially someone in the western world with HIV today may never contract AIDS, could live a normal lifespan and could have a quality of life that they enjoy (Terrence Higgins Trust, 2007)

HIV as a chronic illness

In remembering this problematic history it firstly must be recognized that depression, anxiety and stress are actually all understandable responses to a diagnosis of HIV and/or the difficulties that come with living with this diagnosis (Miller, Weber and Green, 1986). Depression is one of the most frequent psychosomatic responses in newly diagnosed people with HIV (Kalichman and Sikkema, 1994). Some of the most commonly reported reasons for the onset of depression are; the sudden realization of the notion of mortality, the perceived loss of power and control over the wellness of your own body, the necessary but sometimes intrusive changes that take place in a HIV positive persons lifestyle and the expectation that they will be rejected sexually and socially (Miller, 1987).

Some studies have found that depression among people with HIV has physiological effects that not only compromise the improvement of the CD4 cell count; but that depression actually attacks and depletes it, leading to the further decline of the immune system (Ickovics et al, 2001). In women with HIV, depression has been allied with disease development and death however; research that has investigated women with HIV is inadequate and requires an augmented measure of attention due to the increasing numbers of newly infected females in recent years (Ickovics et al, 2001).

Studies have found that among 30% to 60% of HIV positive women tend to experience depression and for HIV positive men the figure is approximately

20% (Ickovics et al, 2001). A longitudinal report that studied over 700 HIV positive women for seven years established that those women who had long-drawn-out incidences of depression were twice as likely to pass away as women who had minor or no symptoms of depression (Ickovics et al, 2001). Conversely, depression has been associated with an increased incidence of unsafe sex and poor adherence to antiretroviral drug regimens due to increased feeling of hopelessness and a sense of worthlessness (Desquilbet 2003; Chin-Hong 2004; Kleeberger 2004; Vincent 2004).

This research shows that not only is depression very much associated with HIV, but it can also progressively make the effects of the virus worse due to its attack on the immune system (Ickovics et al, 2001). The effects of depression are far reaching as they can affect the person's level of hope to become well, and level of self worth. As mentioned in the literature these two elements can affect the person's level of adherence to the highly active anti-retroviral treatments (HAART) that could dramatically improve the person's quality of life (Desquilbet 2003; Chin-Hong 2004; Kleeberger 2004; Vincent 2004). Therefore, counselling psychologists can have a great impact on a client's physical and mental health, and their quality of life through being aware of the psychological needs of HIV positive clients and helping them to manage these needs.

Stress and anxiety, like depression, are also linked with having the HIV virus (Miller, 1987). Some of the issues said to contribute to anxiety in the context of HIV are; the risk of passing the virus on to others, social and sexual rejection, being alone and in pain, the possibility of opportunistic infections, side effects from the drug treatments, issues of disclosure or people finding out and loss of the ability to physically and/or mentally cope with the infection (Miller, 1987).

A meta-analysis of nearly 300 studies suggested that long-term stress overpowers the capability of the immune system to battle viral, bacterial and parasitic infections (Segerstrom and Miller, 2004). It was also suggested that chronic and persistent stress results in overall reduction of all immune

functioning (Sergerstrom and Miller, 2004). The biological process is that stress hormones like cortisol increase when the hypothalamic-pituitary axis is activated. The increase in stress hormones creates a decrease of natural killer cells (NK) and lymphocytes. This in turn increases the viral load (Antoni, 2003 and 2003). Consequently, there is a possibility that a reduction in stress could improve immunity. Improvement in immunity for this client group could ultimately mean a longer lifespan. Therefore, through research and knowledge of the particular stressors that can accompany HIV infection, counselling psychologists can possibly affect the client's quality and quantity of life.

Research into how counselling psychologists can help their HIV positive clients manage these psychological effects has suggested several different interventions and strategies. Ones such study suggested the use of health-promoting behaviours such as stress management particularly for women who are HIV positive (Riley and Fava, 2003). Another study asked their HIV positive participants to write about their traumas and then coded the transcripts for levels of emotional expression and levels of personal disclosure (O'Cleirigh et al, 2003). The study was looking at the effects of emotional disclosure on physical and psychological health and the processing of these stressors in the context of HIV (O'Cleirigh et al, 2003). The study found that emotional disclosure, expression and deeper processing were correlated to long-term survival and reduction in stress, anxiety and depression (O'Cleirigh et al, 2003). It was also noted that some of the participants had physiological reactions to emotional disclosure where their CD4 cell count actually increased during the study (O'Cleirigh et al, 2003).

In additional research into HIV clients it was recommended that maladaptive cognitions characterize the psychopathology in the HIV population (Thomason Bachanas, and Campos, 1996). This research also proposes that feelings of worthlessness, obsessive thinking over the individual's historical behaviour and guilt are regularly reported (Thomason et al, 1996). Treisman, Fishman and Lyketsos (1994) suggested that the principal maladaptive thought

patterns described by HIV positive clients were that there was no hope in finding a cure and that they felt they would not be able to cope with the illness in the future (Treisman et al, 1994).

Cognitive behavioural therapy (CBT) is based on the theory that maladaptive thoughts (cognitions) and behaviours can impact emotions (Beck, 1997). This can have an effect on, or cause, mental health issues as well as physical issues (Lazarus, 1986). Due to the nature of some of the possible maladaptive thought processes suggested above, *CBT* has been used with HIV clients (Emmelkamp and Oppen, 1993). Cognitive interventions have been used extensively in behavioural medicine for the treatment of cardiovascular disorders, obesity, bulimia, chronic pain, benign headaches, asthma and cancer (Emmelkamp and Oppen, 1993). Research observing the efficacy of cognitive-behavioural therapy for treating chronic and ongoing pain has been positive (Emmelkamp and Oppen, 1993; Cottraux 1993).

Cognitive-behavioural therapy with HIV clients has the ability to focus on challenging the individual understanding and experience of pain. It also attempts to increases a patient's aptitude to use these cognitive and behavioural coping techniques while actually experiencing pain. Emmelkamp and Oppen (1993) and Cottraux (1993) have stressed the need for further studies that investigate the affect of cognitive-behavioural treatment on immunosuppression (Emmelkamp and Oppen, 1993; Cottraux 1993).

CBT and certain behaviour change strategies such as increasing daily exercise, training in meditation, assertiveness skills training, self-hypnosis, and practicing muscle relaxation exercises have been incorporated into a variety of treatment plans for HIV clients (Antoni et al., 1990, 1991; Mulder et al., 1995; Kelly et al., 1993; Taylor, 1995). A study conducted with asymptomatic HIV-positive men (n=5) provided the participants with progressive muscle relaxation training, electromyography biofeedback, meditation and hypnotic training biweekly for ten weeks. This group was compared to a control group that did not receive the intervention. It was reported that the intervention group experienced significant clinical

improvement on measures of anxiety, overall mood, self-esteem, and even T-cell count (Taylor, 1995).

Although Taylor's (1995) study had a small sample size other studies with larger samples have had similar findings. Mulder et al. (1994,1995) measured the immunologic patterns in a group of homosexual, male, HIV positive, asymptomatic participants (n=39) over a two-year period. The participants were presented with seventeen 2.5-hour sessions of cognitive-behavioural and experiential group therapy that lasted for 15 weeks. The outcome from these studies was a significant decline in overall psychological stress (Mulder et al, 1994; 1995). Significant changes were also reported in the participants coping skills, ability to process difficult emotions and emotional expression when compared to the control group. These two pieces of research suggest that Cognitive behavioural therapy is potentially an effectual and relatively economical treatment for enhancing long-term outcome for people with.

Another therapeutic intervention that has been suggested for HIV clients is a systemic approach (Bor et al, 1993). This form of therapy suggests that the themes of potential loss and loss are central to working with HIV clients. Bor and colleagues (1993) suggest that both the HIV positive individual, as well as the social systems around this individual, need to create their own construction of the illness. The idea is that the social system and the individual's personal construction of the illness will help create a sense of hope and power as well as a way to construct what support may be needed. Bor and colleagues (1993) place focus on the use of 'Circular Questioning' in order to form a basis of what this construction may look like (Bor et al, 1993). The questioning aims to:

1. Gather information about beliefs without assuming anything
2. Establish how the social system and the individual relate to each other.
3. Make clear what the ideas and beliefs are
4. Assist the counsellor in remaining outside any problematic patterns of behaviour.

5. For the counsellor to use these questions to continue to modify his/her hypotheses (Bor et al, 1993).

A therapeutic intervention that includes many of the above mentioned strategies is the 'Unified Theory of HIV/AIDS counselling' (Balmer, 1991). To date the most accepted forms of HIV/AIDS counselling have been based upon cognitive behavioural therapy. This theory has been adopted by the World Health Organisation and its main aims have been the prevention of HIV and psychosocial support for those already infected. It is argued that future counselling interventions should be redirected from the 'disease-centred' approach to a more person centred approach. It has been suggested that by using self-concept as the 'central measure for evaluating change' this redirection can successfully take place (Balmer, 1991). It is argued that various strengths from CBT, psychodynamic and humanistic theories of counselling should be used. These ideas should be merged into a *unified theory* which could provide an integrated theoretical foundation from which interventions could take place (Balmer, 1991).

The 'Unified Theory' encourages a person centred, rather than disease centred approach. The Unified Theory relies on these themes:

1. Self concept
2. The Rogerian Core Conditions (Rogers, 1957).
3. Education
4. Sexuality is a powerful motivation drive.
5. It is client led.
6. Thoughts and behaviours are learnt.
7. The clients history is important
8. Counsellors should accept the client is unique
9. Should be independent of medical settings (Balmer, 1991).

Research within this approach has centred on group counselling. A group of HIV positive (n=10) participants were video recoded during group therapy sessions (Balmer, 1991). The self reported results suggested that

participants felt they had more hope, insight and acceptance of self and felt they were no longer alone (Balmer, 1991).

It is recognised by this paper that there is a vast amount of research that concentrates on the prevention of HIV through counselling as well as research surrounding HIV testing procedures (Catania, Coates, Stall, Turner, Petterson, Hearst, Dolcini, Hudes, Gagnon, Wiley and Grovesl, 1992; Catania, Kegeles, and Coates, 1990; Roberts and Miller, 2004; Becker, 1974; Jemmett et al, 1992; Chippindale and French, 2001). Although it is recognised that this research is valuable, it has been suggested this approach means that the aims for counselling are about the disease and not the person. The concentration on stopping HIV positive individuals from infecting others also places the pressure of the HIV negative population's sexual health on their shoulders. It is advocated by the Terrence Higgins Trust that sexual health is every individual's right and responsibility (Terrence Higgins Trust, 2007). Therefore, the focus of prevention should not be directed *only* to the HIV positive population (Terrence Higgins Trust, 2007). Being given the responsibility of the sexual health of those who are HIV negative could possibly have a further negative impact on how the HIV positive population sees themselves and how they construct their beliefs about their illness.

Areas of research that require further development

The previously mentioned psychological issues such as depression, stress and anxiety that do frequently occur with HIV are more observable areas where counselling psychologists can and do assist within the psychosocial management of the virus. However, counselling psychologists and researchers also have the ability to assist in the management of HIV on a social level through the discursive construction of the infection (Lawless, Kippax and Crawford, 1996).

In the past HIV has been constructed as a white, gay, male disease or an illness that seemed to attack people such as drug addicts, sex workers and people who were sexually promiscuous (Lawless, et al, 1996). Even today

HIV continues to be constructed as an illness heavy with judgment that is acquired through irresponsible, morally questionable acts (National AIDS Manual, 2007)

Some of the research that has explored HIV and women suggest considerably lower levels of quality of life compared to men with HIV (Watchel, Piette, Mor, Stein, Fleishman, and Carpenter, 1992). It has been maintained by numerous researchers that women with HIV present unique needs which require research specifically dedicated to this group (Watchel et al, 1992). Quality of life was also assessed in one study that explored black African women (n=57) who were HIV positive and living in London (Onwumere, Holttum and Hirst, 2002). The results specified low levels of physical and psychological health and quality of life, with levels falling significantly below UK norms of quality of life for women with a chronic illness (Onwumere, et al, 2002).

It has also been reported in the literature that women with HIV are particularly susceptible to the negative effects of stress and to add to this are commonly diagnosed later in the advancement of their HIV status (Riley and Fava, 2001). High levels of stress mixed with late diagnosis and the possibility of chronic stress further compromising the immune system means that HIV women are a faction that deserve increased research attention and perhaps unique psychological assistance (Riley and Fava, 2001). Therefore counselling psychology could assist this client group further through research into what it means to be female and HIV positive.

A review of the literature demonstrates frequent contradictions in the severity of emotional disturbances in participants at different stages of HIV illness. Many studies examining psychological disturbances in the HIV population have failed to use appropriate controls, classify symptomatic patients by severity of illness, and provide asymptomatic comparison groups (Kalichman and Sikkema, 1994). A failure to control for pre-existing psychopathology, cohort effects, as well as sampling bias also makes the validity of some of the earlier studies questionable (Kalichman and Sikkema, 1994). Kalichman and Sikkema (1994) suggest that the difficulty in estimating levels of psychological

distress and maladjustment prior to HIV infection is a methodological flaw in prior research that still has not been overcome.

A further critique of the literature pertaining to counselling HIV clients suggests that much of the research is only applicable in the western world (Kaaya and Smith Fawzi, 1999). Therefore there appears to be a lack of specialized training for counsellors as well as a specific model or set of therapeutic interventions to work from in the places that possibly need it the most such as sub-Saharan Africa (Kaaya and Smith Fawzi, 1999). For example, much of the literature specifically for African communities' centres on the disease centred approach mentioned previously. Much of the counselling seems to be educational and directive in the hope of preventing the illness from spreading. Therefore the counselling that is available is usually pre and post HIV testing procedures and not actually to assist individuals and communities to live and cope with the illness (Kaaya and Smith Fawzi, 1999).

It has been further suggested that this education approach does not necessarily accomplish its aims. The aims of the disease-centred model are to prevent spread of the illness, increase knowledge of HIV and to reduce risk behaviours within the HIV positive population. Many studies suggest that knowledge and the directive approach do not necessarily lead to prevention or decrease of risk behaviours (Kelly et al, 1993; Zimmerman and Olson, 1994). Further research has again focused on the need to understand the individual's personal construction of identity and of their illness in order to better inform counsellors. It was suggested that a unique knowledge of the individuals personal understanding of sex, their needs in sexual practice and what sex means to them must first be explored in order to better understand sexual behaviour (Crawford and Fishman, 1996).

Research has looked at the efficacy of psychodynamic, person centred and CBT in comparison with one another It was suggested that there was no significant difference in the efficacy of each of the models when it came to counselling people who were HIV positive (Olatunji et al, 2006). Additionally,

there is limited research about the 'Unified Theory' of counselling HIV/AIDS. Although the model appears to be comprehensive in covering the complex needs of HIV clients its complexity poses problems for training and therefore accessibility. The complex mixture of several different models means that specific training would be necessary for counsellors. Specific training for HIV counsellors particularly in sub-Saharan Africa is minimal and resources and funding make this problematic (Kaaya and Smith Fawzi, 1999).

Conclusions

Although counselling psychologists have contributed much to HIV positive clients it is clear that more can be done. The literature outlines that research into the needs of this client group has revealed many of the areas where attention should be focused. The correlation of HIV with stress, depression and anxiety has allowed counselling psychologists to work with this client group predominantly using CBT techniques that have been shown to be efficacious with these issues (Mulder et al, 1994, 1995; Miller, 1987). However, it is clear through a review of the methodology of these studies that certain groups such as women require substantially more attention (Onwumere, et al, 2002). Studies that have explored the needs of women with HIV reveal unique pathology and ironically, a group that could benefit enormously from the attention of counselling psychologists (Riley and Fava, 2001. Statistics reveal that this group (16-24 year old women) has the highest rate of newly diagnosed cases in the last year (Terrence Higgins Trust, 2007).

The literature has revealed several other methodological issues within HIV research (Kalichman and Sikkema, 1994). These pertain to sample size, pre and post-test measures and the sample itself. This is not a gay, white, male disease yet this is the group most commonly sampled within the research. This is a fundamental flaw and one perpetuated by the social construction of the illness. As mentioned previously, much of the research fails to control for stressors that are not HIV and also fails to look at the participant's pathology prior to HIV (Kalichman and Sikkema, 1994). This means that the results may be reliant on confounding variables for which the researcher has not

controlled. Additionally, much of the research is comparably small in sample size making generalizing to the wider population problematic (Kalichman and Sikkema, 1994).

These methodological flaws reveal areas for improvement but they also show case the power of social construction. Therefore, the outcome of research is important, but it could be argued in the field of counselling psychology, that how we research and which words we choose to report this research is just as important for our wider client populations. By using our skills as counsellors to approach research such as not making assumptions, being empathic and not judging, there is a greater possibility of being more therapeutically helpful to this client group.

This review of the literature also suggested that a more person centred approach to HIV counselling may be efficacious (Balmer, 1991). This review suggests that the *disease centred* model could create further complications for how HIV positive people feel about themselves while also negatively effecting the social construction of the illness. This is due to the aims of the model being prevention of risk taking behaviours in order to prevent the HIV positive population spreading the illness to the HIV negative population (Catania et al, 1992; Catania et al, 1990; Roberts, Miller, 2004; Becker, 1974; Jemmett et al, 1992). As explored previously, this places the responsibility of the 'well' on the 'unwell' when it is every individual's right and responsibility to take care of their own sexual health (Terrence Higgins Trust, 2007).

Issues were also raised with the ability of research to be generalized to non-western world communities where HIV is most prevalent (Kaaya and Smith Fawzi, 1999). The author suggests it is necessary to know both the individuals social construction of themselves and the illness as well as the community they live with in order to know what the needs of the client are. The literature also suggested that sexuality and meanings of sex for the client and the client's community need to be explored in order to meet both educational and psychosocial needs more effectively (Kaaya and Smith Fawzi, 1999).

In summary, counselling psychology has had a positive impact on the HIV positive community. This has been achieved through research revealing the general areas where counselling psychologists can help HIV clients have a more positive quality of life through stress, depression and anxiety management. However, much more could be achieved through counselling psychologists and researchers putting forward a more realistic social construction of the illness and being more focused on those communities that have not been as present in the research to date.

Future research ideas

As shown in this review further research with HIV positive women is necessary. The author feels this would be particularly applicable for young women (16-24 year old) as statistics show this to be the community with the highest rates of new diagnosis. Longitudinal studies that show the needs of HIV positive women over long periods of time would be beneficial to show links between stages of the chronic illness and psychological needs. Further research into the specific needs of women surrounding issues of childbirth, fertility, sexuality and motherhood could also be explored.

The perspective of social constructionist theory is that reality is constructed and created and does not live independently to the individual or community (Fransella, 1995). The implication of this mode of thinking is that everyone has a unique way of constructing HIV and therefore assumptions about experiences of HIV cannot be made. According to this theory this construction further means that needs, beliefs and experience need to be clarified before counselling could take place (Fransella, 1995). It is the suggestion of the author that due to the fact that HIV is steeped in social views and stigma as well as being an illness that can permeate every part of a persons unique life that the social constructive perspective would be an apt place from which to conduct further research. It has been suggested that if HIV was viewed from a social constructivist perspective there would be less focus on the physical outcomes and more on what it means personally to the individual and the community (Hamilton, 1995).

The author further suggests research from the point of view of the theories proposed by George Kelly in 1955 (Fransella, 1995). These theories were originally created as a way of explaining how people make sense of their world as individuals. The philosophy underlying these theories is 'constructive alternativism' which describes the way in which we make sense of the world as a group of 'alternatives' from which we choose (Fransella and Dalton, 2000). This philosophical theory became the psychology of personal constructs from which personal construct counselling developed. This model of therapy suggests that the process of counselling is a process of understanding the client's personal construction of their world (Fransella and Dalton, 2000).

Once this construction is understood the therapist can work with the client to 'reconstruct' their world to create a more satisfying life experience. This theory also works from the basis that the mind and the body are one. Kelly (1955) also proposed that the medical model stops counselling psychologists from seeing their client (Fransella and Dalton, 2000). Basically, it is a form of therapy that approaches each client as unique and therefore, the counsellor must be open to step into the unique world of each client and 'learn' their world's beliefs and needs in order to help them deal with what their unique world presents them.

Therefore the author suggests that research that is produced from a social constructivist or personal construct perspective would eliminate further bias towards certain groups as well as give voice to the individual experience of HIV. It is also suggested that research could explore using individual social construction of HIV almost like an assessment tool to better inform choice of therapeutic model or intervention.

In conclusion, counselling psychologists could do more to further the area of counselling for HIV positive clients now that HIV is a chronic illness. Although the management of stress, depression and anxiety have been somewhat explored more methodologically robust research needs to be conducted.

Particular areas of focus highlighted by this review are further research into women's experience of HIV as well as exploration of more culturally adaptable therapeutic interventions. Social construction plays a large part in the way clients experience this illness and therefore it could be suggested that counselling psychologists keep this in mind when researching and working with clients. Due to the particular influence that social construction plays in client's experience of HIV it is recommended by the author that it has increased influence in the field of counselling psychology and HIV clients.

PART IV

THE APPENDICES

APPENDIX [1]

CONSENT AND INFORMATION FORMS

1. ETHICAL APPROVAL FROM THE NHS

2. LETTER TO PARTICIPANTS

3. CONSENT FORM

4. CLIENT INFORMATION SHEET

1. NHS ethical approval

NHS
National Research Ethics Service

Camden & Islington Community Local Research Ethics Committee
Room 3/14
Third Floor, West Wing
St Pancras Hospital
4 St Pancras Way
London
NW1 0PE

Telephone: 020 7530 3799
Facsimile: 020 7530 3931

24 September 2008

Mrs Erin E. Miller
510 Royle House
Wenlock Road
London
N1 7SH

Dear Mrs Miller

Full title of study: **A pluralistic framework for counselling HIV positive clients: an evaluation of this process using pragmatic case studies**

REC reference number: **08/H0722/62**

Thank you for your letter of 02 September 2008, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information was considered at the meeting of the Sub-Committee of the REC held on 22 September 2008. A list of the members who were present at the meeting is attached.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

Ethical review of research sites

The Committee has designated this study as exempt from site-specific assessment (SSA). The favourable opinion for the study applies to all sites involved in the research. There is no requirement for other Local Research Ethics Committees to be informed or SSA to be carried out at each site.

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

Management permission at NHS sites ("R&D approval") should be obtained from the relevant care organisation(s) in accordance with NHS research governance arrangements. Guidance on applying for NHS permission is available in the Integrated Research Application System or at http://www.rdforum.nhs.uk.

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	*Version*	*Date*
Application		23 June 2008
Investigator CV	Supervisor's CV - Carla Willig	
Investigator CV	Version 1	24 June 2008
Protocol	Version 1	27 March 2008
Letter of invitation to participant	Version 1	24 June 2008
Participant Information Sheet	Version 1	24 June 2008
Participant Information Sheet	Version 2	04 September 2008
Participant Consent Form	Version 2	04 September 2008
Participant Consent Form	Version 1	24 June 2008
Response to Request for Further Information	Cover Letter	02 September 2008
Revised answer to Question A19	Version 2	04 September 2008
Letter of local support	Dr Bruce Fernie, CASCAID, SLAM	13 June 2008

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Now that you have completed the application process please visit the National Research Ethics Website > After Review

You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website.

The attached document "After ethical review – guidance for researchers" gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Progress and safety reports
- Notifying the end of the study

The NRES website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

We would also like to inform you that we consult regularly with stakeholders to improve our service. If you would like to join our Reference Group please email referencegroup@nres.npsa.nhs.uk.

08/H0722/62	**Please quote this number on all correspondence**

With the Committee's best wishes for the success of this project.

Yours sincerely

pp

Ms Stephanie Ellis
Chair

Email: katherine.ouseley@camdenpct.nhs.uk

Enclosures: *List of names and professions of members who were present at the meeting and those who submitted written comments*

"After ethical review – guidance for researchers"

Copy to: *Dr Paul Holland*
Director – Doctorate Counselling Psychology
City University
Northampton Square
London, EC1V 0HB

R&D office for NHS care organisation at lead site – Gill Lambert, South London and Maudsley NHS Foundation Trust

Camden & Islington Community Local Research Ethics Committee

Attendance at Sub-Committee of the REC meeting on 22 September 2008

Committee Members:

Name	*Profession*
Ms Stephanie Ellis (CHAIR)	Former Civil Servant
Ms Irenie Morley	Assistant Registrar

2. Letter to participants

DEPARTMENT OF PSYCHOLOGY
City University
North Hampton Square
EC1V 0HB
Telephone: +44 (0)20 7040 5060

Dear ……..,

My name is Erin Miller and I am a doctorate student at City University. I would like to invite you to participate in some research I am conducting as part of a requirement for my doctorate course.

The research involves participants allowing me to provide them with twelve weeks (one hour per week) of a therapy called pluralism. If you would like to read more about pluralism please refer to the client information sheet enclosed with this letter.

I would be your therapist for the twelve weeks. I have practiced as a counseling psychologist for over three years and I have received training in pluralistic therapy. I have worked with a broad range of clients.

Each therapy session would be recorded using a digital audio recording device and you will also be asked to keep a journal during this time.

The aim of this research is to look more closely at how people who are HIV positive experience pluralistic therapy. Hopefully this research will add to our knowledge about counseling and clients that live with HIV.

If you would like to consider this invitation to participate please read the enclosed client information sheet so you are able to make an informed decision.

If you then feel you might like to participate please call my number below and we can organize some time before your first session to come in and ask any questions. If you then decide you would like to participate you will be required to sign a consent form before our first session.

Thanks for your time.

Kind regards,
Erin Miller

My Contact details
Mobile: 0788 1708 874
Email: erinem13@yahoo.com

Version one: 24th June 2008

3. Consent form

DEPARTMENT OF PSYCHOLOGY
City University
North Hampton Square
EC1V 0HB

CONSENT FORM

Title of Project: A pluralistic framework for counselling HIV positive clients: an evaluation of this process using pragmatic case studies.

Name of Researcher: Erin Miller

Please initial box

1. I confirm that I have read and understand the information sheet dated the 4th of September 2008, version two, for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my right to receive counselling from CASCAID or legal rights being affected. ☐

3. I understand that eight people will be participating in the research and from these eight people three cases will be chosen randomly to be written into the researcher's doctorate thesis. A summary of the data from the other five participants will also be written in the thesis. ☐

4. I understand that relevant sections of the data collected during the study, may be looked at by individuals from City University and CASCAID, from regulatory authorities or from the NHS Trust, where it is relevant to my taking part in this research. I give permission for these individuals to have access to my records.

☐

5. I understand and give my consent to the audio recording of the twelve sessions of counselling I will receive.

☐

6. I agree to take part in the above study.

☐

_____	_____	_____
Name of Participant	Date	Signature

_____	_____	_____
Name of Person taking consent	Date	Signature

Version two: 4th September 2008

4. Client information sheet

DEPARTMENT OF PSYCHOLOGY
City University
North Hampton Square
EC1V 0HB

Title of Project: A pluralistic framework for counselling HIV positive clients: an evaluation of this process using pragmatic case studies.

Name of Researcher: Erin Miller

INFORMATION ABOUT THE RESEARCH
PART ONE

We would like to invite you to take part in a research study. Before you decide you need to understand why the research is being done and what it would involve for you. Please take time to read the following information carefully. Talk to others about the study if you wish.

It is up to you to decide whether you wish to take part. We will describe the study and go through this information sheet, which we will then give to you. We will then ask you to sign a consent form to show you have agreed to take part. You are free to withdraw at any time, without giving a reason. This would not affect the standard of care you receive.

ABOUT THE RESEARCHER

My name is Erin Miller and I am currently doing a professional doctorate in counselling psychology at City University. My studies require me to engage in research and the writing of a doctorate thesis. I currently have a Bachelor of Science in psychology and a masters of science in counselling psychology.

ABOUT THE RESEARCH

The research that you have been invited to participate in concerns the use of a newly developed theory of counselling and how this counselling works with HIV positive clients. The aim of the study is to look at how this newly developed theory of counselling interacts with HIV positive clients, basically how the two work together. The research also aims to show the journey between HIV positive clients, the therapist and the therapy over twelve weeks of therapy sessions. The theory of counselling is called *pluralism.* The research will be conducted by offering eight participants twelve, fifty-five minute sessions of pluralistic therapy free of charge. I will be the therapist. During my time as your therapist I will not be engaging in any part of the research apart from taping our sessions. This is so I am able to give each client my full attention and stay in the role of the therapist, not a researcher. I will invite each participant to sign a consent form however; this form does not bind the participant to the research. Each participant is free to stop participation in the research at any time and no reason needs to be given. Withdrawing from the research will not exclude the participant from receiving counselling from CASCAID.

I will be working with eight clients for the purpose of this research however; three out of these eight people will be <u>randomly</u> chosen to be written up as case studies as part of my

doctorate thesis. There will be a section in the thesis that briefly summarises my work with the other five clients.

WHY HAVE I BEEN ASKED TO PARTICIPATE?

You have been invited to participate in this study because you are HIV positive and have requested counselling from the organisation CASCAID and are on their waiting list.

WHAT YOU CAN EXPECT

The twelve sessions of pluralistic therapy will be taped using an audio recording device. After our sessions are finished the researcher will be transcribing the sessions in order to analyze them to inform the writing of case studies. I will ask you to keep a journal during the twelve sessions. I will provide the journal for you. If there are certain parts of this journal you would prefer were not used for research or would prefer not to show me this is up to you. The choice is yours. I will also be recording notes after each session that may be used in the research. I will also be keeping a journal of my experience throughout the twelve weeks.

ABOUT THE THERAPY: PLURALISM

I am able to provide much more comprehensive information about pluralism to those that request it however I shall briefly introduce it here. When I was first introduced to pluralism I thought it might be really helpful for HIV positive clients. This is a form of counselling that prides itself on being inclusive, believing in the individual, respect for the individual and it celebrates diversity and difference. This is a very collaborative therapy. We will work together towards the goals that you set. I am not an expert about your experience; I believe you are. Pluralism suggests that it is my role to create an environment for the client that allows them to explore what they need and then help 'brainstorm' how the client might achieve this. Pluralism suggests we are all individuals,

we live in individual cultures, with different families, different friends and different beliefs and all of this can be brought to therapy because all of it is you. If movies, art or writing is important to you then there will be space to incorporate this into the therapy.

Basically it is up to you how you use our time because the agenda for the session is your agenda. As a therapist I may introduce techniques from a range of different models of therapy such as cognitive behavioural therapy, person-centred therapy and gestalt therapy. We may use relaxation techniques or breathing exercises. However, the techniques we can use are not exclusive to models of therapy. If you have found something that works for you we can discuss it and possibly incorporate it. Finally, it is my job to be open and understanding and most of all listen to you.

ADVANTAGES AND DISADVANTAGES TO TAKING PART

The main disadvantage to taking part in this research is that pluralistic therapy has not been tested or trialled extensively. Mick Cooper and John McLeod from Strathclyde University in Scotland created this form of therapy and to my knowledge, pluralistic therapy has not yet been used with HIV positive clients.

A possible advantage to taking part in the research also comes from the fact that this therapy has not been tested extensively. The researcher's main aim of the study is to see how HIV positive clients and pluralistic therapy work together. The research wishes to look at the process of a HIV positive client experiencing pluralistic therapy. There is a possibility that this may help to create a better understanding of HIV positive client's specific needs for counselling.

COMPLAINTS ABOUT THE RESEARCH

Any complaint about the way you have been dealt with during the study or any possible harm you might suffer will be addressed. The detailed information on this is given in Part 2.

If the information in Part 1 has interested you and you are considering participation, please read the additional information in Part 2 before making any decision.

PART TWO

CONFIDENTIALITY

Each participant's identity will remain confidential within the service. The only other person that I would be discussing details of the sessions with would be my research supervisor, Carla Willig. However, I will change all identifying details where possible when I am discussing the participants with Carla. All recorded sessions will be stored on my computer and will be password protected. The notes that I will take after each session will remain in my care and will be secured in accordance with BPS (British Psychological Society) standards. Participants can request to see these at any stage of the research. Participant's names and any identifying details about the participant will be changed for the purpose of reporting the research. Participants can ask to read the research before it is handed to my research supervisor. The only time that I have to break confidentiality is if I feel you are at risk of hurting yourself or others. This is a standard rule in counselling psychology and not exclusive to this research.

WHAT WILL HAPPEN IF I NO LONGER WISH TO PARTICIPATE AFTER I AGREE TO THE RESEARCH?

If at any stage during the research you do not wish to participate any more you will be able to withdraw from the research no questions asked. Withdrawing from the research will not affect your ability to have access to the counselling service at CASCAID. Another qualified counselor will be allocated to you as soon as possible and your sessions will resume.

CASCAID. Another qualified counselor will be allocated to you as soon as possible and your sessions will resume.

COMPLAINTS

If you have a concern about any aspect of this study, you should ask to speak to the researchers who will do their best to answer your questions (contact details below). If you remain unhappy and wish to complain formally, you can do this through the NHS Complaints Procedure. Details can be obtained from the hospital.

In the event that something does go wrong and you are harmed during the research and this is due to someone's negligence then you may have grounds for a legal action for compensation against City University, CASCAID or South London and Maudsley NHS Foundation Trust but you may have to pay your legal costs.

WHO HAS REVIEWED THE STUDY?

All research in the NHS is looked at by independent group of people, called a Research Ethics Committee to protect your safety, rights, wellbeing and dignity. This study has been reviewed and given favorable opinion by The Camden & Islington Community Local Research Ethics Committee.

If you have any further questions or concerns don't hesitate to contact me or my supervisors:

Student Researcher: Erin Miller erinem13@yahoo.com.au
Supervisor at City University: Carla Willig C.Willig@city.ac.uk

Research Supervisor at CASCAID: Bruce Fernie bruce.fernie@slam.nhs.uk
Bruce Fernie's contact number: 020 3228 5121 or 5123

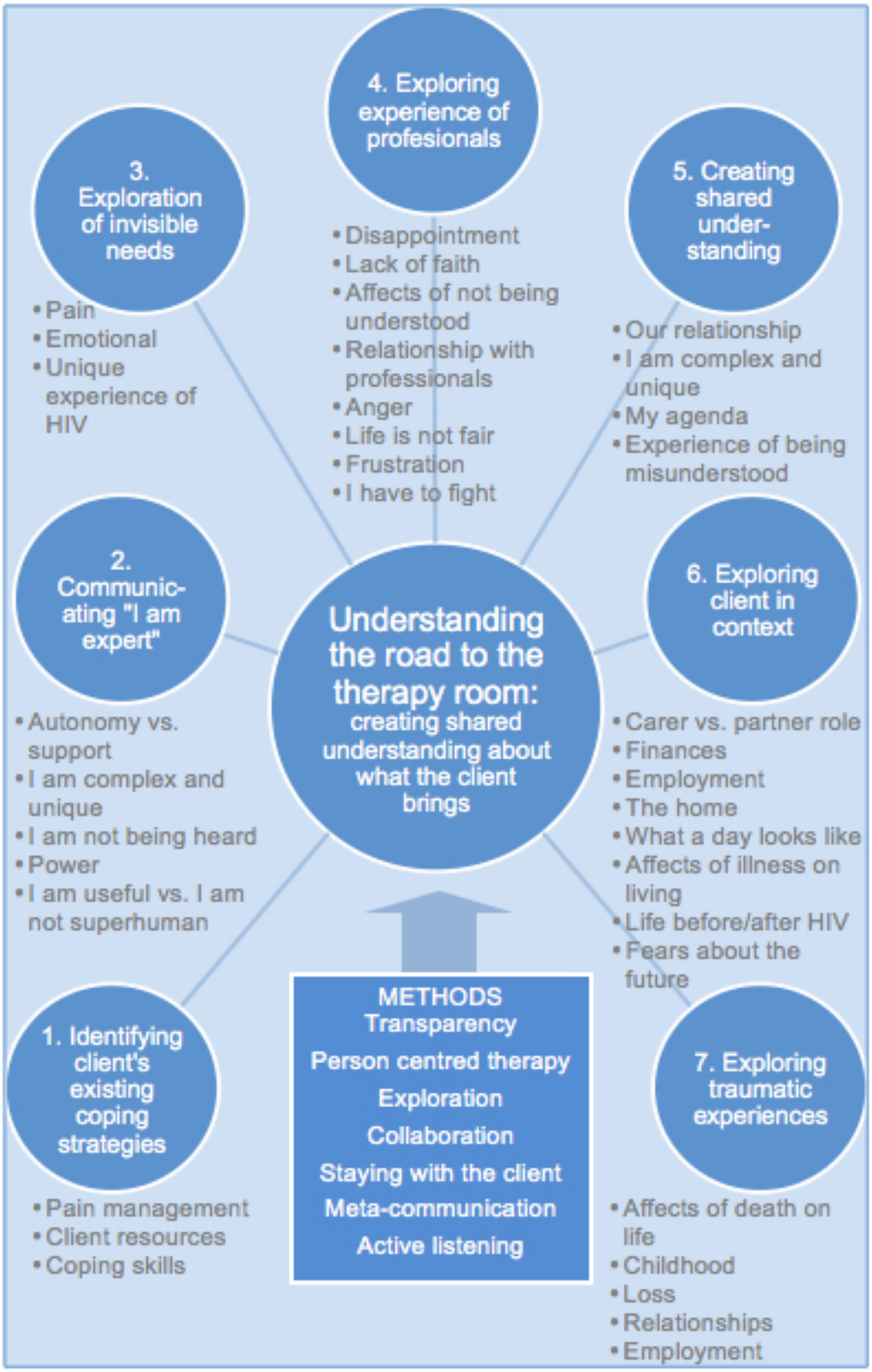
Version two: 4th September 2008

APPENDIX [2]

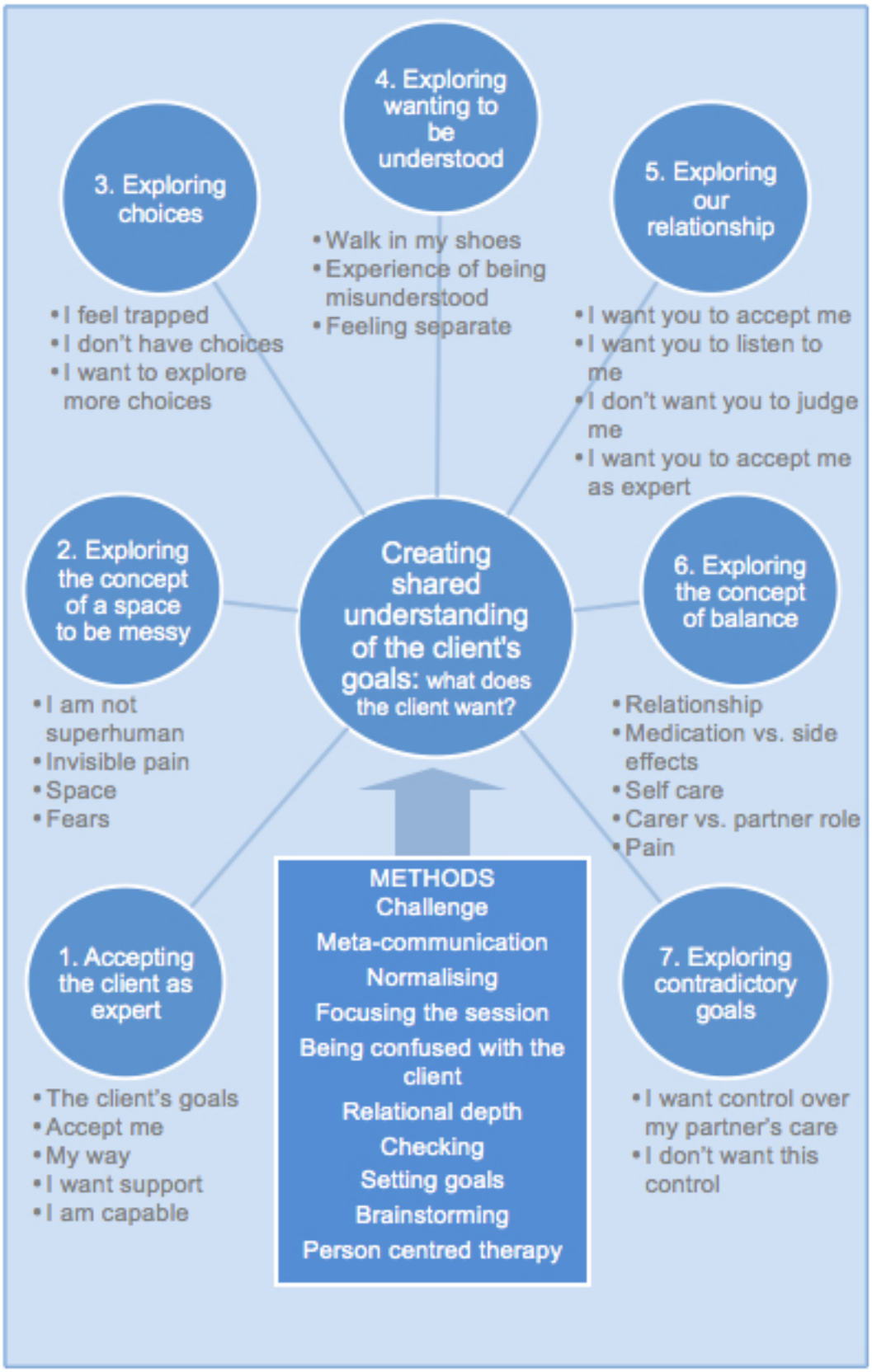
GROUNDED THEORY CLUSTER ANALYSIS

The following are diagrammatic representations of the ‘clustering technique’ used in accordance with my grounded theory analysis (Chamaz, 2006).

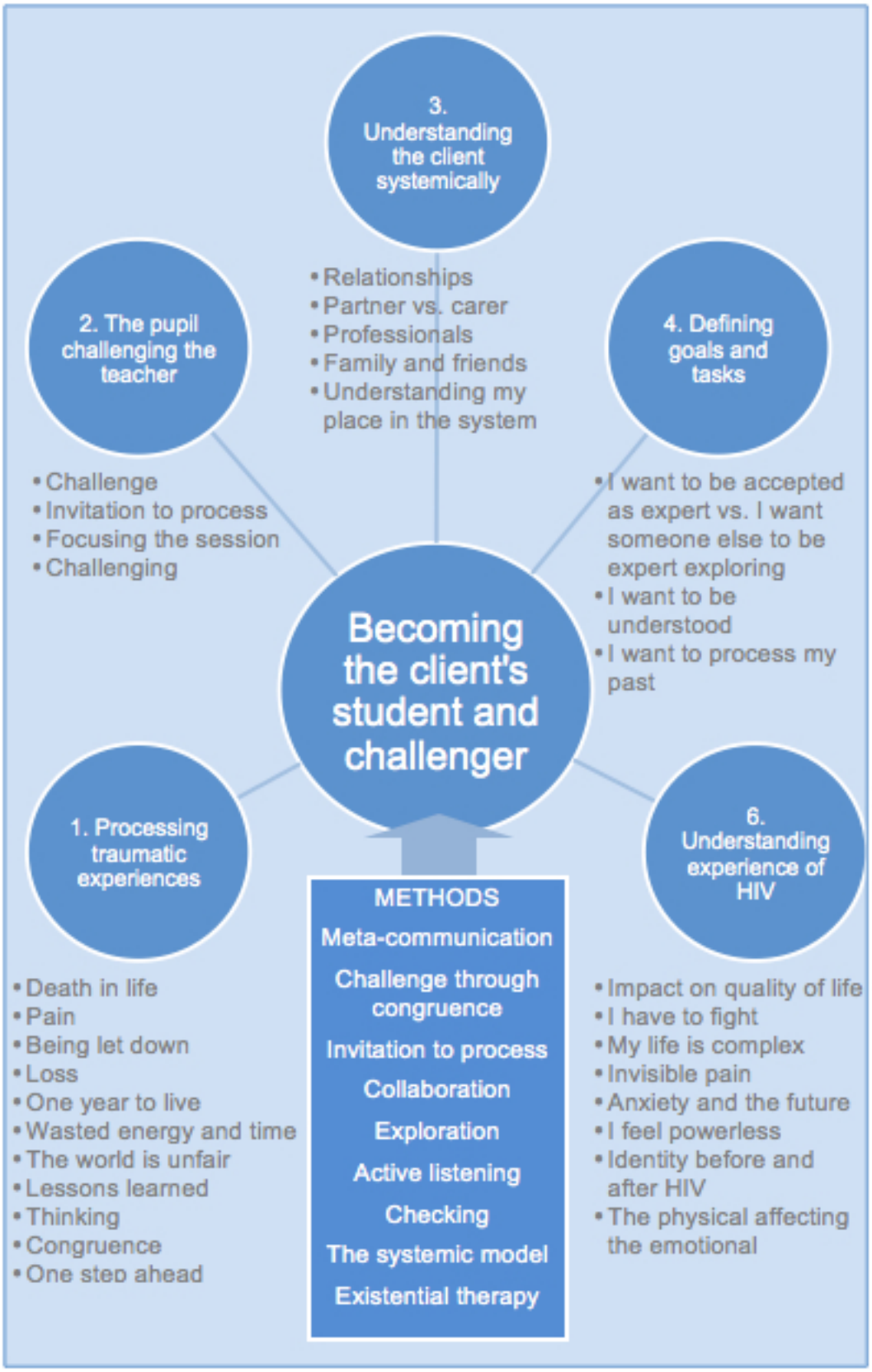
Client 'B' Process One



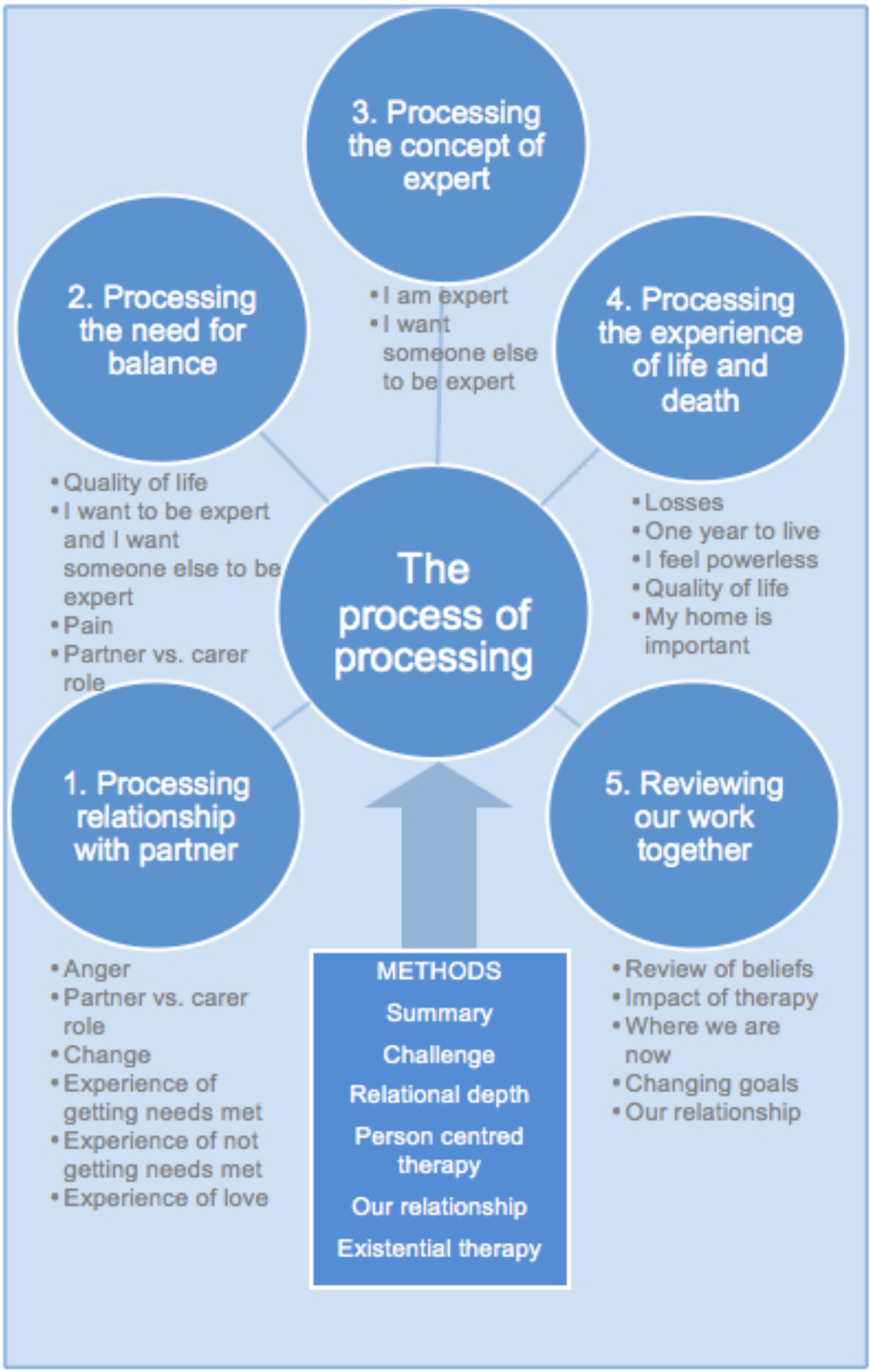
Client 'B' Process Two



Client 'B' Process Three

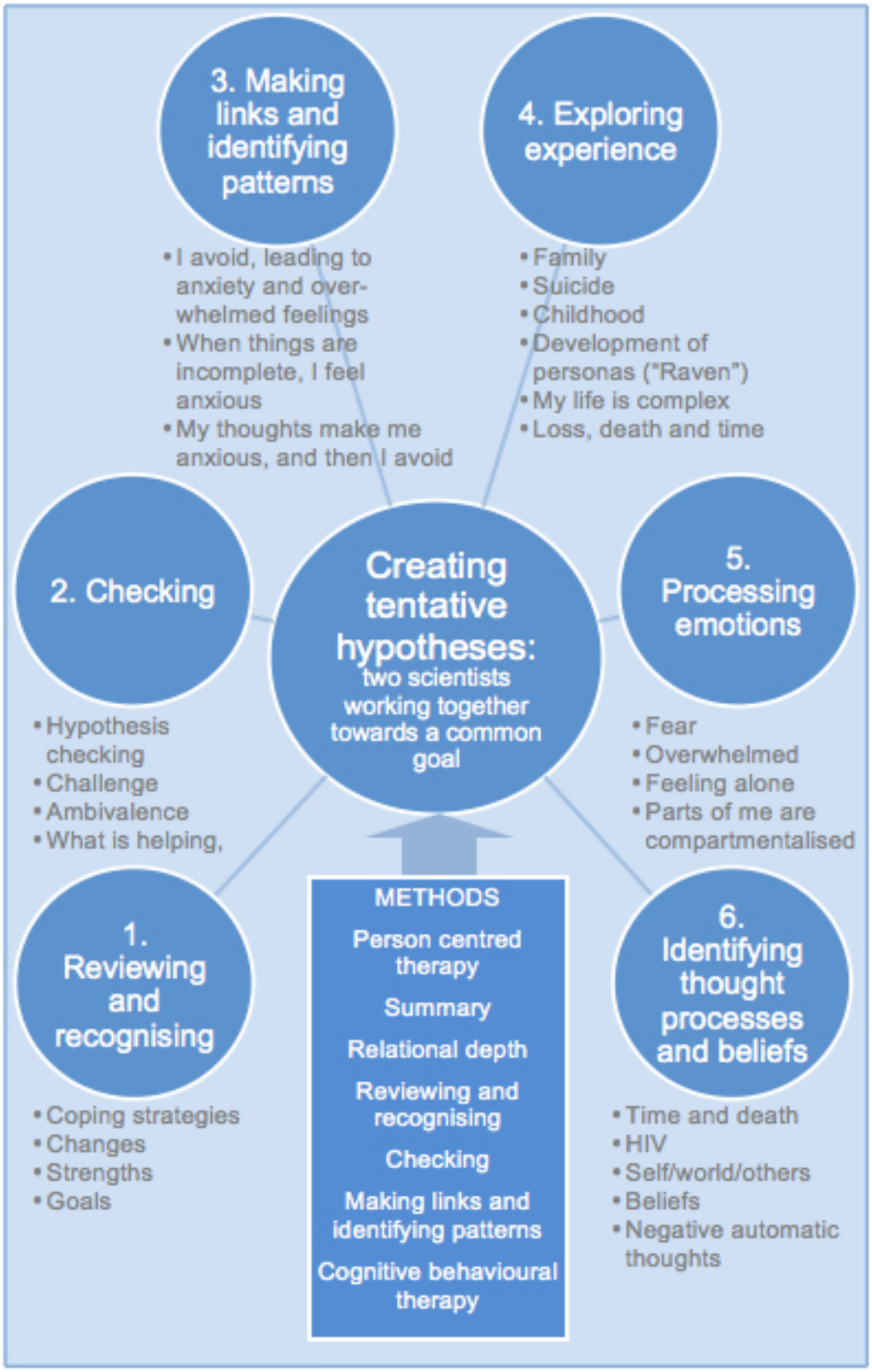


Client 'B' Process Four

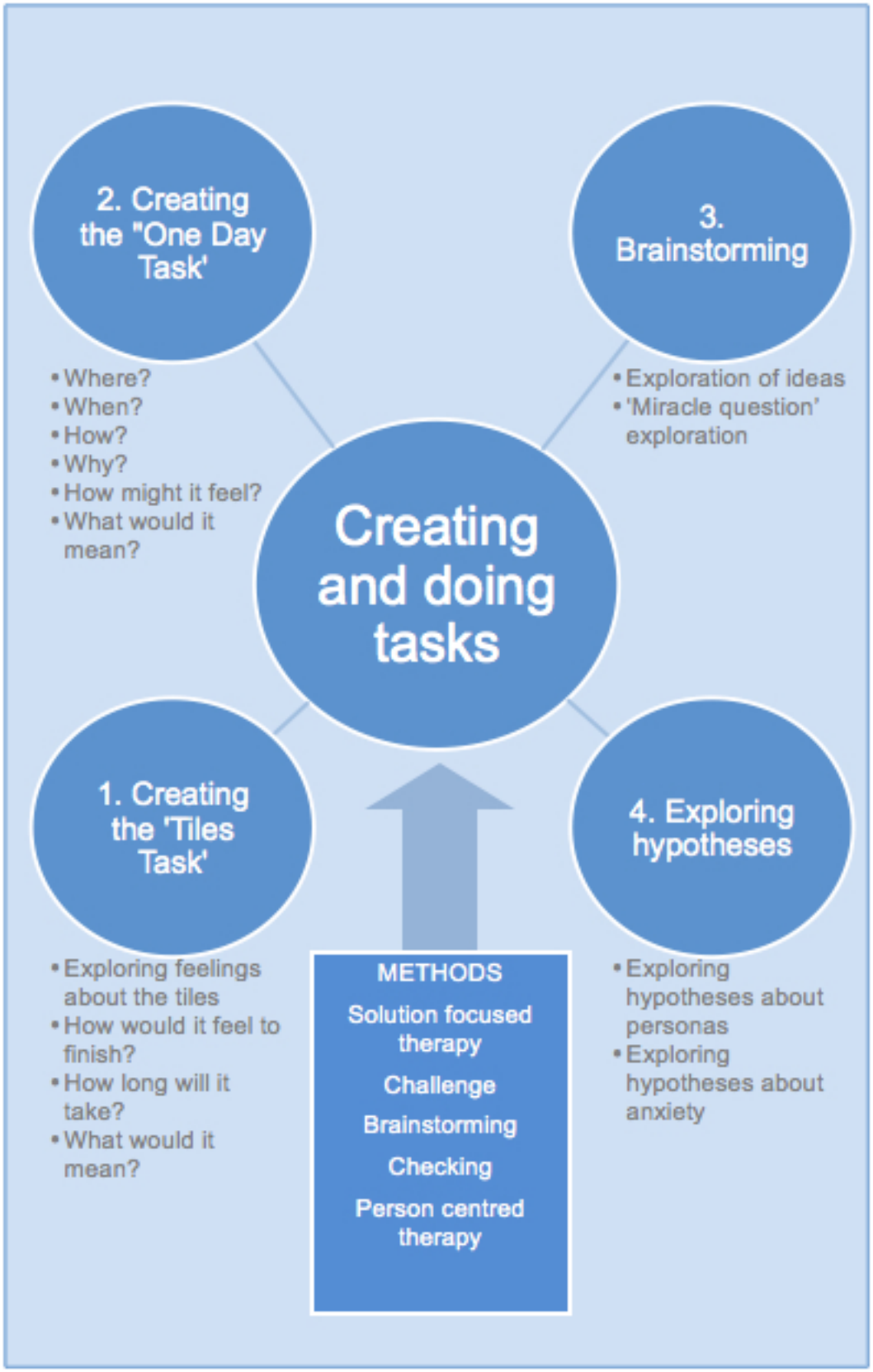


Client Matthew Process One

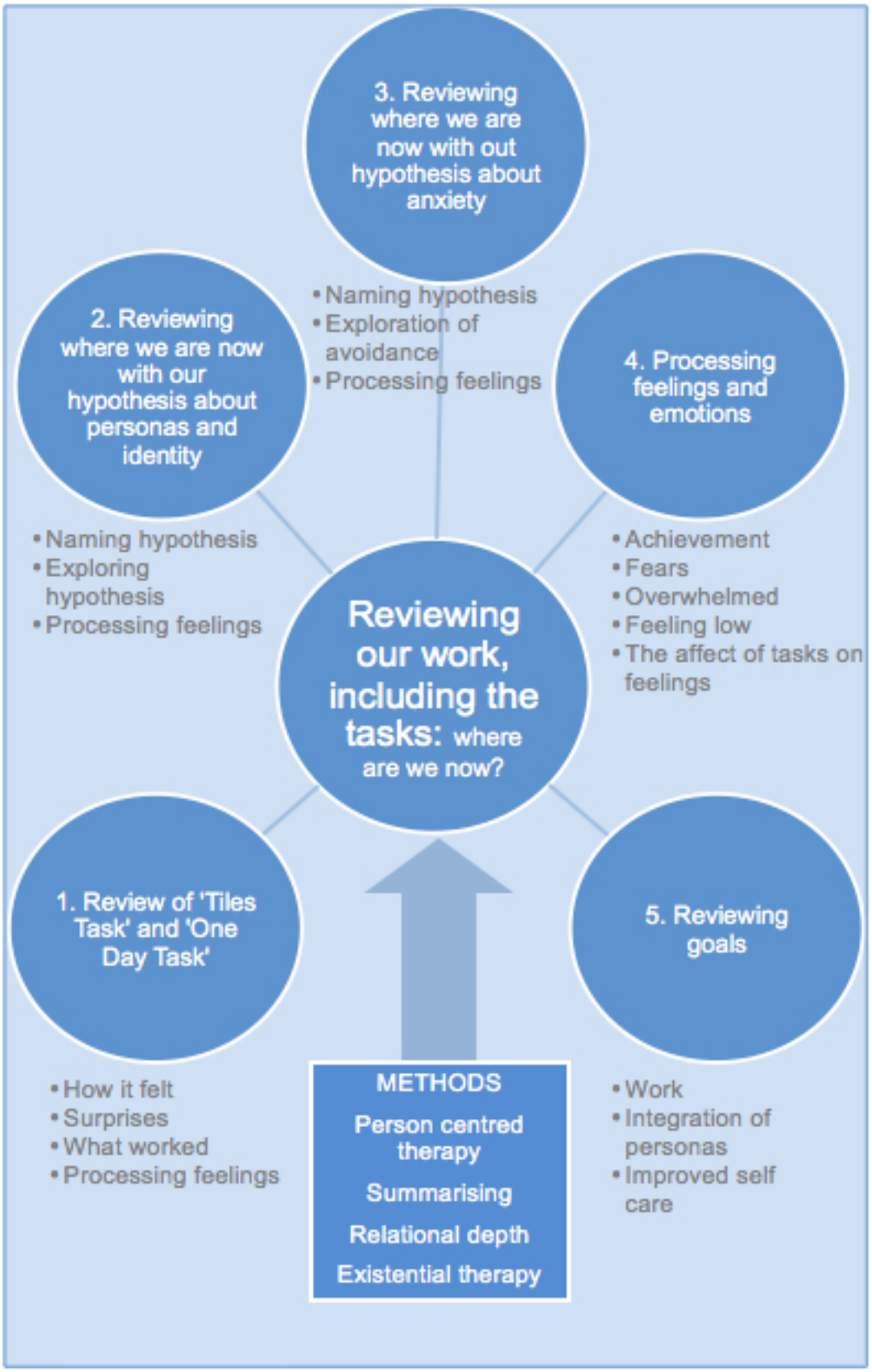
Client Matthew Process Two



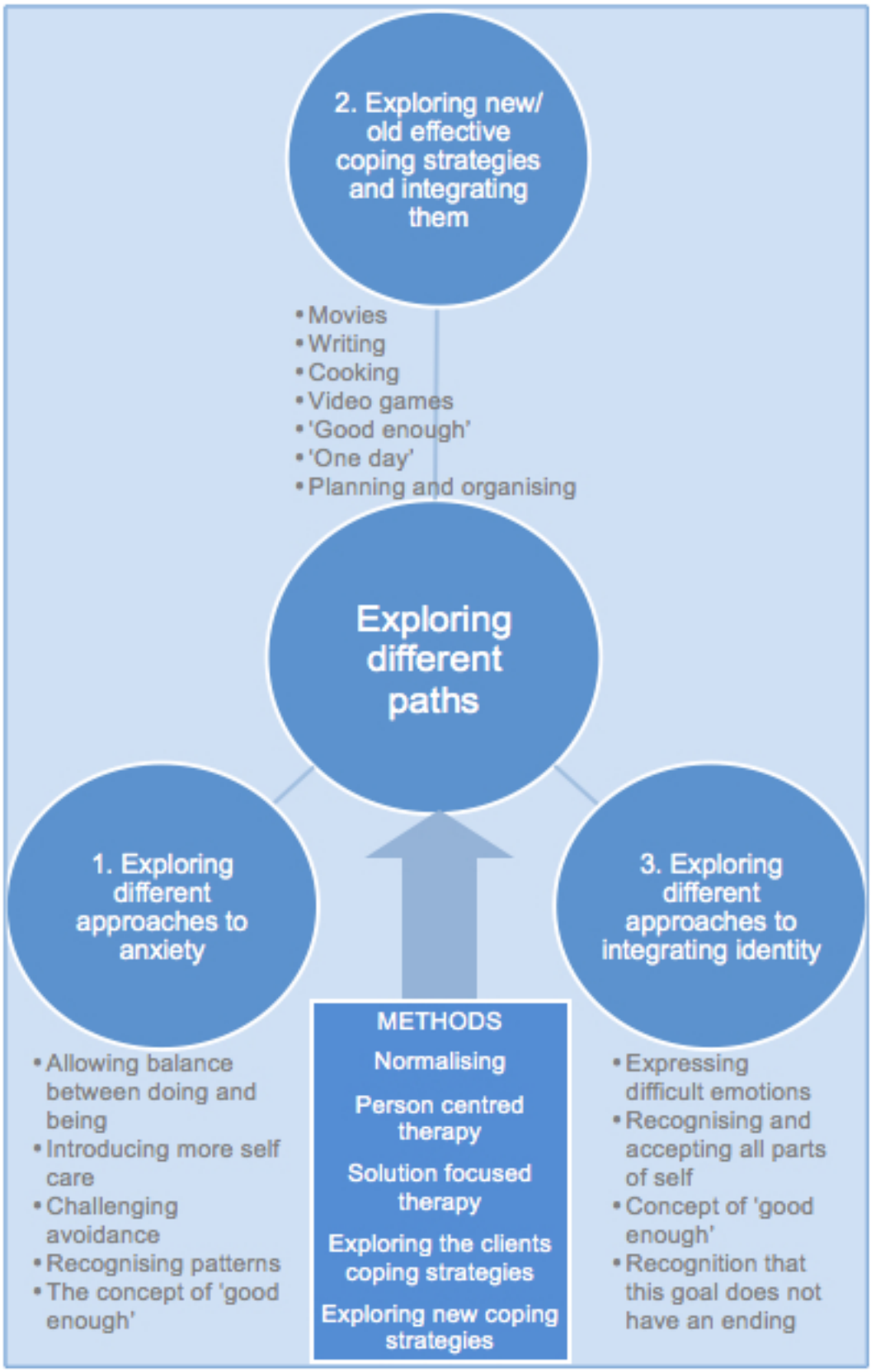
Client Matthew Process Three



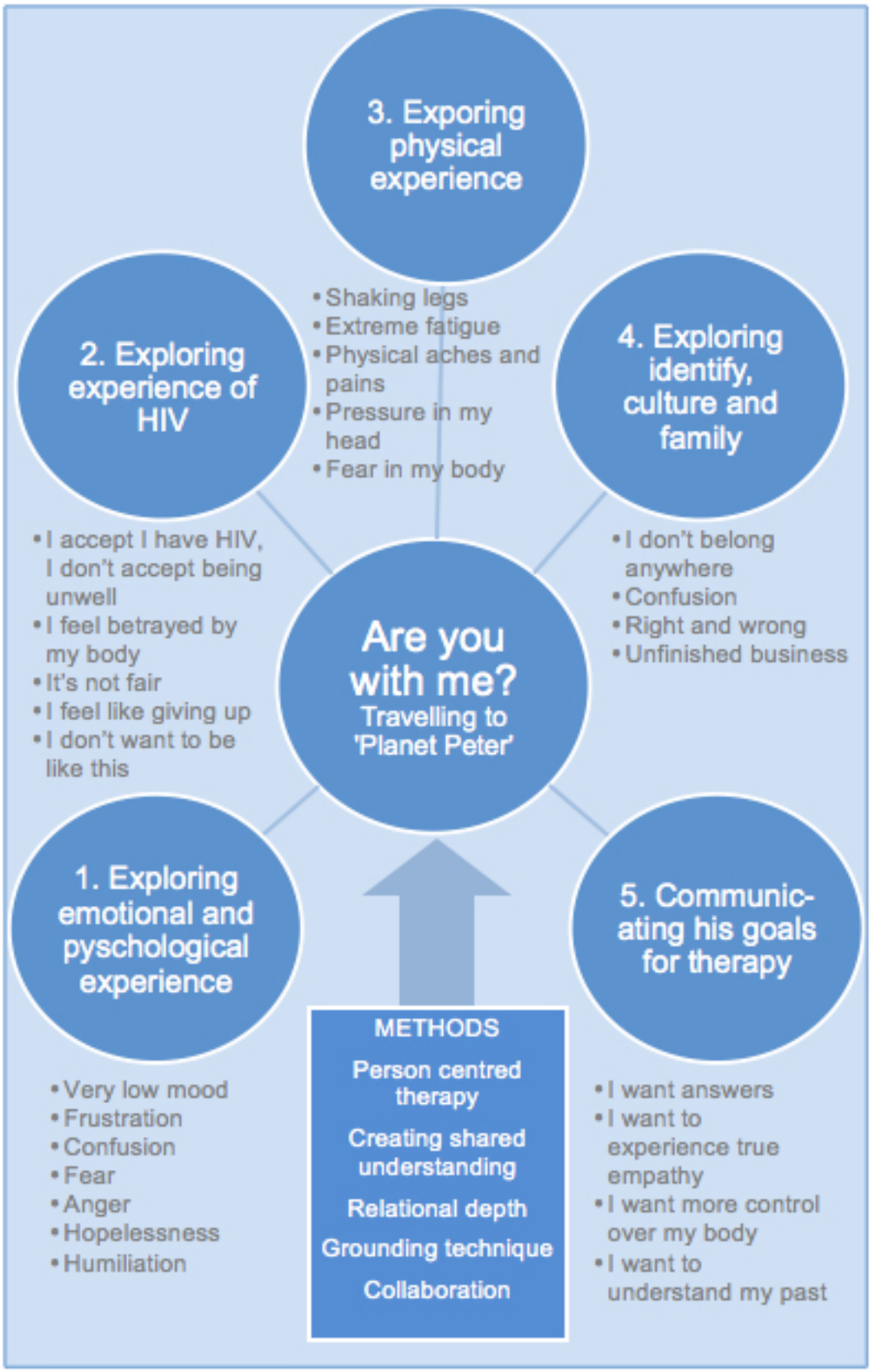
Client Matthew Process Four



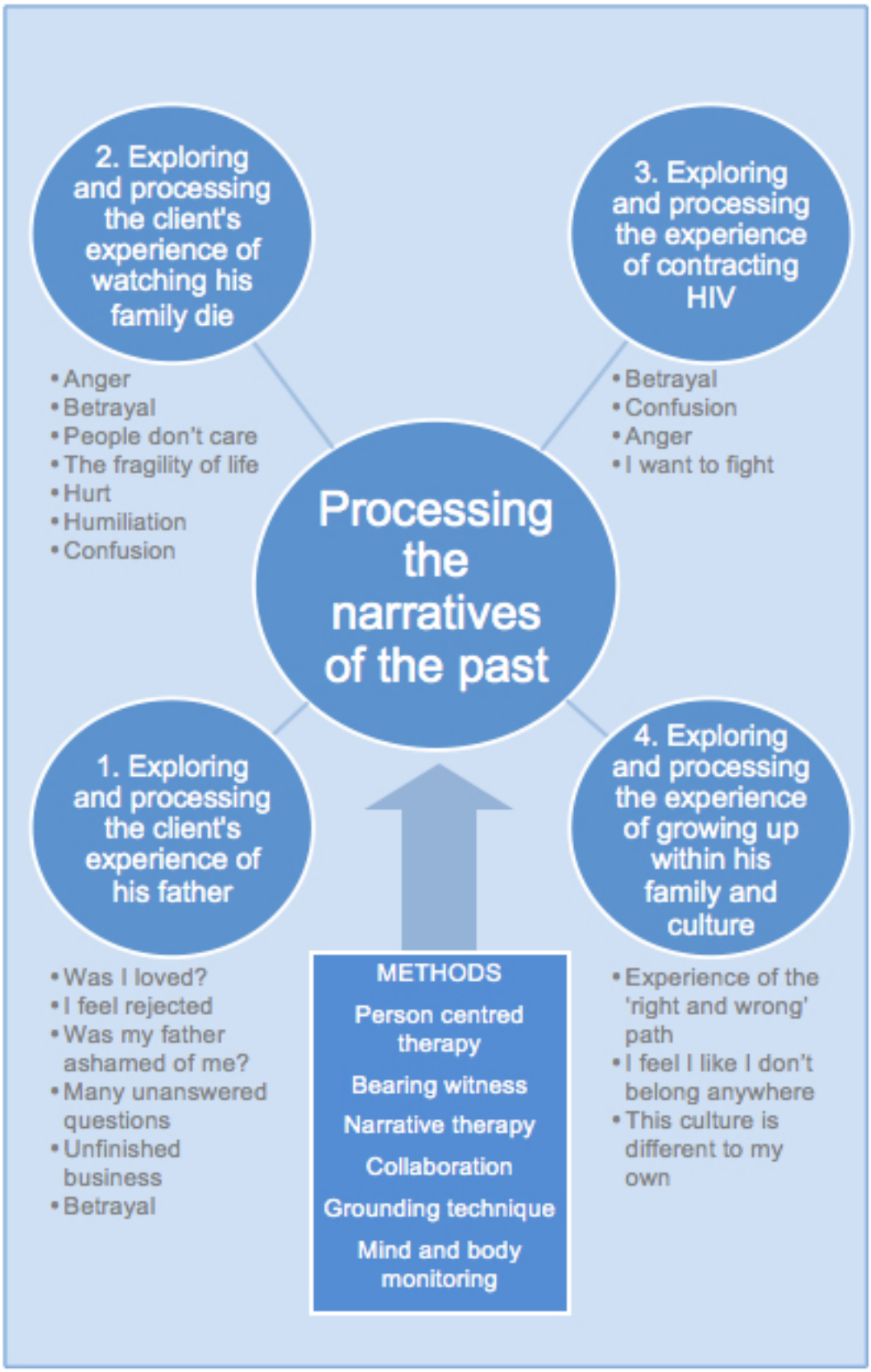
Client Matthew Process Five



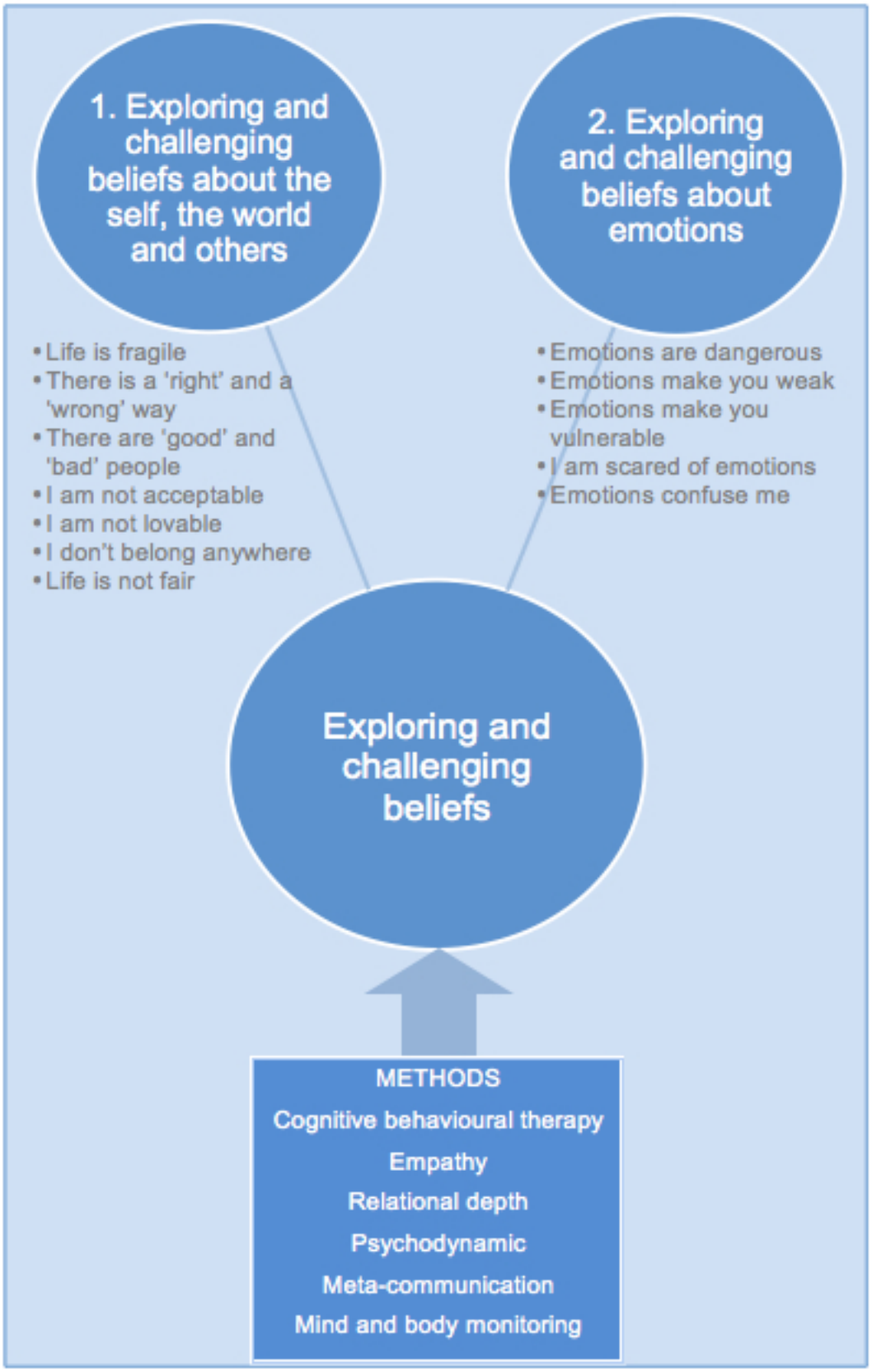
Client Peter Process One



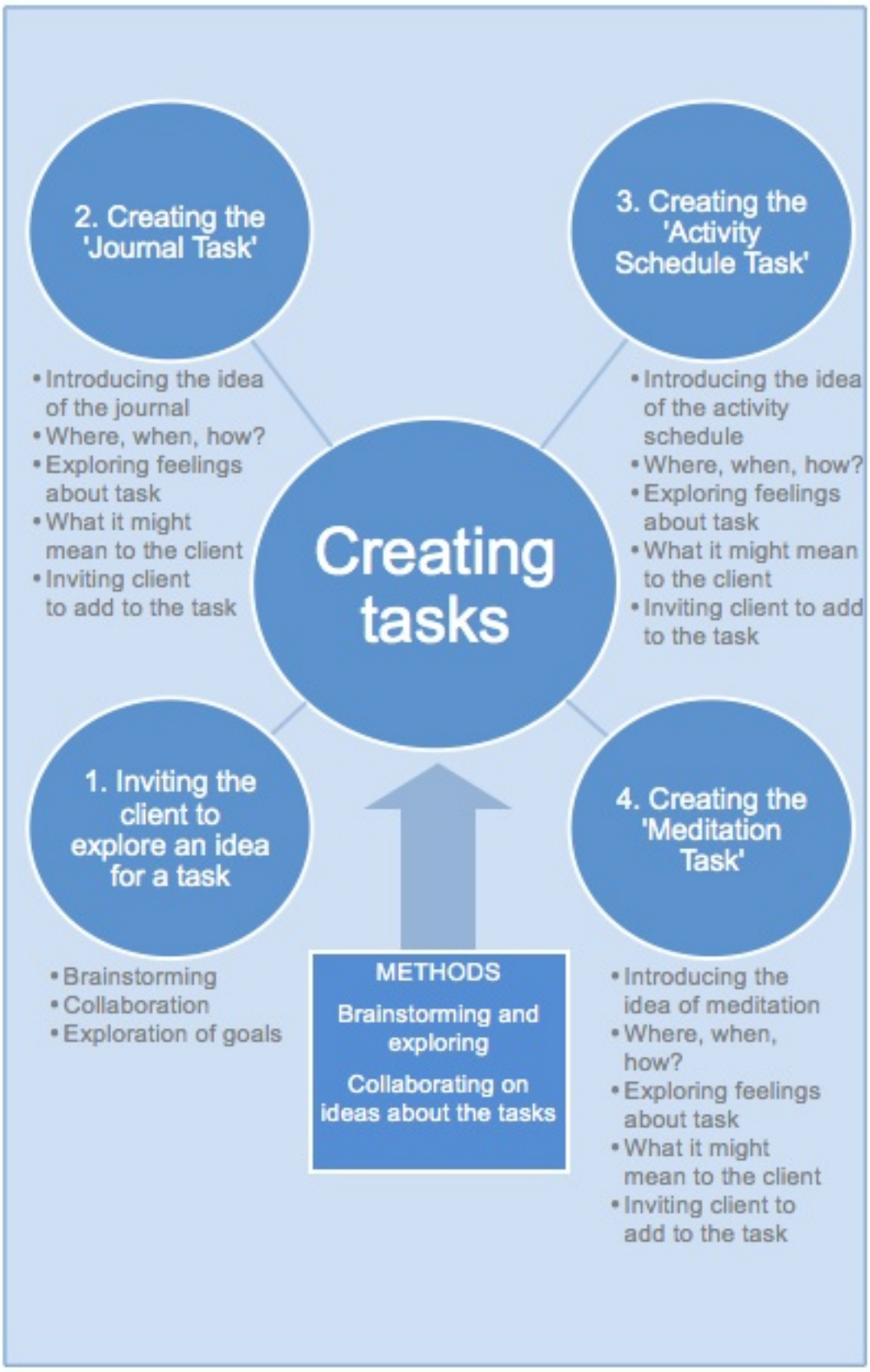
Client Peter Process Two



Client Peter Process Three



Client Peter Process Four



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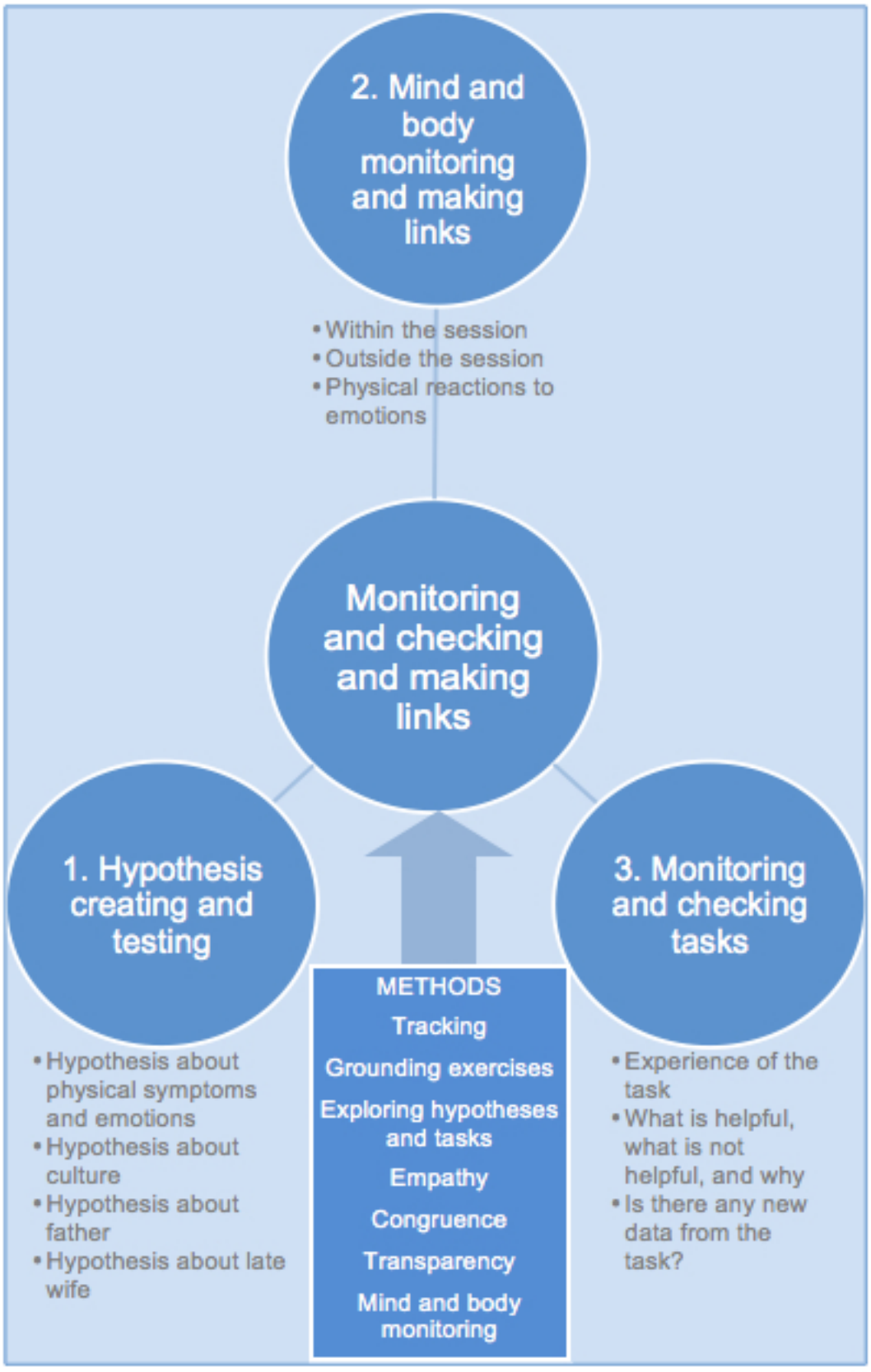


APPENDIX [3]

DETAILED DESCRIPTION OF THE PROCESSES

The following are more detailed descriptions of the grounded theory analysis of the processes for each case study. I have added in parts of the transcription verbatim to give examples of the processes. I made the choice to include certain parts of the transcription where the section was succinct and keeping inline with the confidentiality agreement I have with the clients.

CASE STUDY ONE: CLIENT B

PROCESS ONE

UNDERSTANDING THE ROAD TO THE THERAPY ROOM: WHAT THE CLIENT BRINGS.

The themes that emerged from the transcripts were:

1. Identifying the client's existing coping strategies

B had many effective coping strategies that he had developed over the years. One of his most effective coping strategies concerned coping with uncertainty and new opportunistic infections. B had been through many periods in his life where he was unwell. Therefore he had repeatedly been through the process of discovering something different, not knowing what it was, going through a barrage of tests to find out what it was, finding the right dosage of medication to treat it and then dealing with the side effects of this medication. This process involves uncertainty, fear and time. If B found something different about himself physically, his pain changed or he felt unwell he was adept at accepting that he may be about to go through a stressful period. He would locate the type of help he needed and he would engage one hundred percent with this help. He frequently experienced debilitating 'ice pick' headaches where his whole face and jaw would be in excruciating pain. Sometimes the medication would work, sometimes not. When B was experiencing one of these headaches he would take a moment to rest and he would actively tell himself that he needed to relax and that it would eventually pass. It seemed

to me in the sessions that B's level of patience was of a very high level however, I feel it was not necessarily naturally high (although this may be the case) I feel he had almost trained himself to be patient with pain.

Co. Counsellor
Cl. Client

Cl. I'm very aware that I'm, I opened a magazine the other day, of positive new, can't remember the name. It was a world aids day, special edition thing. On the back page, there was all these obituaries of people who had worked in their HIV sector who had died recently, and I knew every single one of them.

Co. How many of them?

Cl. There were 3 on the back page, and all 3 of them I knew. They had all been long-term survivors, and that really kind of brings it home a bit. It's like you know….I've been scared of dying, and you know I know I'm not immortal but I'm just not ready.

Co. You not ready to go yet.

Cl. Not ready to go yet, but I'm very conscious that that could happen at any point, I mean it absolutely happens at any time. So that kind of scares me.

Co. When you have extra things that come up in your body are you sort of reminded of your mortality?

Cl. Yeah well some things I manage alright, this is probably some things that I struggle with, with my GP. I really know my own body, and so when I've got somebody who can't even be bothered to read my notes to actually have seen the reason why I'm on a certain medication.

Co. Because you've worked really hard to understand your own body and this is the person who is supposed to be assisting you with that and you feel they're not working as hard as you feel they should be working.

-Cl. Yeah…..and so I um, there are times when there are certain things, I'm like ok this isn't anything to worry about, I need to go and do this and there are other times like this for example.

Co. So you know when this something is really worrying and when something is not.

Cl. Yeah but sometimes when it's a new symptom that I don't understand it's difficult.

Co. So when it's new and it's unknown it makes it more challenging to cope.

Cl. Exactly. When it's unknown, and it's not happened before. Now the thing is that I've smoked for a long, long time and I've stopped smoking about 4 years ago and it could just be that my body is adjusting to that, you can actually…it may not be anything serious, I'm always positive, I'm an ex-smoker, the risks of smoking blah blah. I'm at greater risk, so those things I can't ignore.

Co. It sounds like that with new symptoms they concern you and you find it difficult but you don't try and go through all the things it could be, it sounds like you have a little think about what it might be and then it sounds like you try to let it go.

Cl. Yeah that's right. Well, when I had my blood clots in my legs and my lungs, which was a very sudden attack and life changing literally event. I went through a process in the hospital of a quite massive contemplation and I, it's something that I know people have said…I just have to let go of the things I cannot control, and concentrate on the things that I can. And I kind of just,

that's what I try and do, I apply that to everything really. I just feel that there's no point, whatever this is, in my throat right now, I don't know but I've asked someone else who might come up with an idea.

Co. And that's something you feel you can control.

Cl. Yes exactly. And now, but there's no point of wasting my energy in, I can't lie of course there is a little anxiety there but I won't let it overwhelm me because I don't see the point in doing that. It'll probably exacerbate it, probably. And so it's just a coping mechanism.

Co. That feels like it takes quite, I'm guessing, quite a lot of energy to do…. but it's a conscious process, you have to choose to do it each time.

Cl. Yeah, yeah. It does, I have to say, because I've had to do it so many times, it's become a strategy that's not so hard the next time I have to do it.

Co. So you are well practiced?

Cl. I mean when I had my first ever, ice pick headache, it, I felt like I had a stroke and I, it was so scary and I thought this is it, I'm going to die on the 319 (which is a bus). I thought is this, and I thought no I'm not going to die on the 319 (laughs).

Co. You refused to die.

Cl. I refused, I just thought this is going to be really humiliating, I can just imagine people 'Where did he die?' 'He died on the 319'. I just was like, no I don't want that to happen (laughs) thankfully, it passed, I didn't know what it was but all I needed was someone to explain to me what it was.

Co. Yes I get that feeling, that your anxiety is soothed by people understanding and helping you to understand. So once there is a shared

understanding, your anxiety seems to…obviously your well practiced…it's when something is unknown, it feels like that's when you, you have difficulty, it sounds like that's when thoughts of death and thought of mortality comes up, when it's unknown…. But when you understand what is going on or someone explains it your anxiety is soothed.

Cl. When someone explains, when the neurologist explains what it was, it just made sense. But the intensity and the pain still exists, but I understood, so sort of on a psychological side of it, in terms of managing pain, the pain was still there, but I understood it so it, I didn't have the anxiety that went with it.

Co. So you found a way to have the pain, and manage the pain but not keep the anxiety going up, on an upwards slope.

Cl. Am I going to die? Am I going to die? – I'm not going to die, it's another ice pick headache, it hurts, ouch but you're not going to die, this moment in time.

Co. Again, it's a feeling of you being really understood, your pain, I remember us talking in the last couple of sessions about this invisible pains that you have, and invisible scars that you have from other emotional things you've gone through, but the fact that you look well, and you have to explain to people 'I am actually…this is what's wrong'. These people understood and acted accordingly, and it sounds like even that act was soothing to you.

Cl. Yeah absolutely. I would have to make a comparison with you, in a sense of, you just kind of get it, and that's very, very re-assuring and comforting, and even those words are not enough to actually um put the value that I put to that, it's just such um, I kind of, It's very important for me to be understood actually.

2. Communicating 'I am expert'

For all extents and purposes B was an expert concerning HIV and his life. In these early stages I reflected on this by looking at the fact that I had studied psychology for seven years in order to be in the position where I am writing this doctorate thesis. B had studied and experienced HIV for ten years. Although our subject matter was different B was further ahead in his 'studies' than me. However, just like I need support to study for seven years and produce a thesis, so does B. In saying this, if the sort of support I received was someone telling me what areas of counselling I should be studying or that I had to use a certain theoretical model with my clients I would find this unhelpful and disempowering. B wanted support, but he wanted his expertise to be respected and taken seriously.

3. Exploring invisible needs

B frequently discussed his experience of pain. He explained that unlike other illnesses where the person 'looked unwell' frequently he could be in debilitating pain and remain looking well. Additionally, my experience of B in the sessions was that he was adept at looking like he was emotionally very together and an extremely capable man. Although he was extremely capable he was also someone who needed support and yet often both his emotional and physical pain could not be easily seen. B felt that this meant sometimes people didn't take his pain seriously and that sometimes he would have to find a way to explain the depth of his pain so others would understand. We coined this term 'invisible pain' in the sessions. A consequence of understanding this theme was that I began to pick up on subtle differences in B's demeanour in order to invite him to explore any possible 'invisible pain' that may exist. I was also able to challenge B there appeared to be incongruence present, such as if he was saying that he was fine when his expressions and body language were telling me that perhaps he wasn't. B had remained emotionally and even physically strong for the benefit of his partner for some time and therefore sometimes the 'invisible pain' was something that he was actively making invisible.

Co. The interesting thing I just thought of is when you were describing the pain that you can't see. It's interesting that you have a lot of pain that you can't see, physically as well as….

Cl. Yeah and I think I've got an awful lot of emotional pain as well.

Co. That maybe isn't easily seen?

Cl. Yeah.

Co. And that you feel like nobody maybe…not many people have seen what you sort of introduced today when you first came in that people have heard you but not necessarily understood.

Cl. Yeah. And I think that people look at me and I look very well.

Co. You do yeah, sounds like you feel most people don't understand or maybe even know about your invisible pain.

Cl. And but you see…then I end up in a dilemma because it's like I want you to see me as someone well but I want you to also recognize my disability you know, but treat me equally. It's kind of a real very difficult struggle.

4. Exploring experience of professionals

Before the client had arrived in the therapy room he had a vast and complex experience with 'professionals' such as doctors, GP's and other HIV specialists. B wanted me to understand this experience as it was an important part of his 'life experiences'. During our first session this was the first issue that B raised as he was not satisfied with the care he was receiving from particular health care organisations he was involved with. This theme was an important part of our first session and me truly understanding what the client was 'bringing' to therapy.

Cl. I respect their opinion but if it conflicts with my own knowledge base and experience than again I do find it a struggle to have to keep fighting but again and again to date so far I have been right so it's not like I've gone down a route of challenging everyone for the shake of challenging it.

Co. I can hear frustration, maybe anger in your voice….. this is really a guess but does it make you angry that you have to rely on medical staff sometimes?

Cl. I am absolutely! But I don't think I can do this on my own. I know I make it very difficult for people to understand or even see because I present in such a way, sometimes where people don't actually know that there's a problem

Co. I guess maybe when you present as expert, you look like you've got it all sorted.

Cl. Yeah, yeah….

Co. And therefore I guess it's difficult maybe to know where you need the help, and I know that you're saying and I know you're being very clear but I guess for some people it's difficult to see what you need. I know I've said this to you before, but I found it difficult to know how to be there for you because you did come across as someone who didn't need or want anyone else.

Cl. Well I think we got there eventually, I knew we would and I trusted you because I knew that you would understand. I knew that was, beyond your being a professional, that was down to I think who you are as well and I think that without that than these sessions wouldn't have worked at all

Co. So it was important that I was a therapist but it was also important that I was a human being that was trying to understand.

Cl. Exactly.

5. Creating Shared Understanding

B arrived in the therapy room in crisis. He was unhappy about the care his partner was receiving, he was very stressed about the aggressive elements of his relationship and he was a cross roads with several choices in his life. His issues were not just in the past they were present in the room in the 'here and now' and therefore we created a shared understanding about what these immediate needs were. B's immediate needs were to find the right sort of support for his partner, support for himself and someone to listen to his needs and take them seriously. Therefore I involved the service I was working for so we could start the process of finding the right support for his partner as well as trying to create enough space in each session where I could best support and listen to B.

6. Exploring the client in context

This theme was very important for 'bringing me up to speed' about what the client was bringing to the therapy room. This theme ending up being more complex than I originally thought and eventually challenged our relationship. B's relationship was complex and at times difficult for me to understand. Therefore this theme was the beginning of me trying to understand this relationship. As reported in the literature, HIV can affect almost every section of someone's life and this certainly seemed to be the case for B. His financial, housing and working situation were all greatly affected. For example, B desperately wanted to work but could only physically manage a part time job. However, a part time job would not pay enough to cover all of his expenses and therefore he was constantly looking for ways to overcome this restriction. B is a highly intelligent and capable person and he felt hugely frustrated and angry that his talents and strengths were not being used. This made him felt like society was 'finished with him' and that he was deemed no longer useful in the eyes of the workforce.

Cl. Yeah, you see my…my…my life has not been something where I have been happy, I know there are some people who perhaps enjoy a life of not working and receiving benefits, unfortunately they exist, but it's never been

my enjoyment. I've just been constantly frustrated, every time I've tried to moved forward and try to get back into employment or whatever, I've actually had a physical knock back, generally quite a serious knock back…of either a brain infection or something that is very serious. Which is then prevented me from moving forward, and so I never wanted to be in a relationship where both of us are living on benefits…

Co. Hmmm…

Cl. That has never been my ideal from when I was a child…it was never something that I wanted.

Co. It was not something you dreamed about…

Cl. It wasn't what I went in and studied for, and worked hard for. This isn't my…I hate it, I hate every…not just the um the thing that lives inside of me, the infection but also just the…all the consequences…the loss of my partner, my previous partner, the loss of my job, the way I was treated by my employer, um the loss of my pension, I've been denied it.

7. Exploring traumatic experiences

B had experience some significant and traumatic life events that we both felt had shaped his belief system and how he felt about the world. He had experienced the sexual abuse, the death of his partner, living with a variety of painful conditions through being HIV positive, he had faced his own mortality, he had experienced the loss of a career he loved and he felt he had experienced injustice and discrimination. These experiences that the client brought with him to the therapy room were important parts of his narrative and therefore important for me to understand in relation to what B was 'bringing with him' into our therapeutic relationship.

Cl. So there was a big part….you see it is very difficult again to try and, at one point I was told that my prognosis was probably six months to a year at the max.

Co. So you were given a diagnosis that you were going to die in that time.

Cl. Yeah, yeah. And that had a massive impact on me, and my goal, this was in '98, '99, so my goal was just to see the year 2000 in.

Co. really?

Cl. As long as I could see the year 2000, so emotionally I went through this whole process of preparing myself to die. And saying goodbye and giving things up, letting things go, giving away things and then I lived.

Co. It sounds like there's positives and negatives that comes with that. When you've prepared to die.

Cl. Well it just becomes quite, and I'm so glad I'm still alive um but it was a real huge adjustment.

Co. It sounds like it's daunting to live after death.

Cl. Yeah……and then unfortunately then, my health didn't go into a rise of improvement (client uses his finger to draw a graph on the wall), it was just this erratic cause of ill health and I was never…and have never been sure whether this is the time that I'm going to…that's a graph by the way. (laughs).

Co. (laughs) So there's this huge uncertainty within your own body as well, within your own mental health…

Cl. Sure, sure. Again you see this impacts on my relationship with (Anthony), because his perception of me…I want him to be with someone who is well,

and is you know…but his worry is…is he going to die? Is he going to you know be healthy? Which impacts on the way he looks at me sexually, all of those kinds of things, and I want to portray to him that I am well. But then it was only last year I was in hospital with encephalitis.

Co. So again you're having to keep certain things invisible as well because you want to appear well…… but these invisible things affect so much in your relationship, including how you feel he looks at you sexually.

Cl. Exactly.

The themes in relation to the methods being used that emerged from the transcripts were:

1. Transparency

Through creating a shared understanding about B's experience of professionals it became apparent that he had felt judged or misjudged. Therefore I felt creating a relationship that was based on transparency was important for our work. I also felt that transparency gave B the opportunity to correct me if my assumptions or hypotheses were incorrect. I did not believe I was beyond misunderstanding B as it was apparent from our first session that what he was bringing into the therapy room was complex. However, if I remained transparent about my assumptions then I could trust that this transparency would eventually lead to a place where true shared understanding was achieved. In accordance with the pluralistic model I was also transparent about the way we were working together. This meant explaining the models I was using and the way I was working so I could collaborate with the client and they could be included in the decisions concerning what methods we were going to use to meet the clients goals.

2. Person centred

Throughout this process there were reoccurring themes within the transcripts such as reflection, unconditional positive regard, congruence, paraphrasing,

and empathy. All of these themes indicate that person centred therapy was the main method used at this time. Person centred therapy allowed me to explore the client's material concerning what he was bringing to therapy with the spirit of acceptance and positive regard. This also allowed the client to lead the 'content' of the session and allowed me to make sure I was understanding this content through the use of reflection and paraphrasing. The client was also in crisis at the point of entering the therapy room and I feel that the person centred model allowed me to create a space that was able to somewhat contain this crisis.

3. Exploration

Exploration was something that we were both engaged in during this process as we were both trying to understand the path that led the client to the therapy room. This mainly involved the exploration of the content of the client's material that he was bringing in rather than exploring how we might process this content.

4. Collaboration

Collaboration is an important aspect of pluralistic therapy and it was an important part of the therapeutic process from the first session. Collaboration in this process also involved collaborating with the service I was working for in order to meet the client's goal of getting what he felt was adequate support for his partner. In order to create collaboration, transparency and the person centred model were important. True collaboration cannot take place between two people unless both people are transparent about 'how' they are collaborating and what they bring to the collaboration. Therefore I was trying to understand what the client was bringing to the therapy room while also trying to be transparent about what I was bringing so collaboration could take place.

5. Staying with the client

This theme came up frequently in this process. Although it could be linked to the person centred model it occurred so frequently that I decided to make it a theme on its own. This staying with the client seemed to be a way to give the

client space and time in order to full explain his experiences and where he was in the 'here and now'. I recall in the first session that the client sat in the edge of his seat and spoke very quickly with a sense of urgency. The feeling I got from the client was that there was no time or that time was running out; there was a sense of rush and almost panic. I feel that by staying with the client it slowed down the pace of sessions and communicated to the client that there was time to explore his material. Staying with the client entailed allowing the client to explain his narratives in full, asking minimal questions so that the client continued to have control over the direction of the session and exploring what the client most wanted to explore at that point in time.

6. Meta-communication

Meta-communication can be defined as 'talking about talking'. It is basically communication about the way in which the therapist and the client are communicating and what affect this way of communicating is having on the therapeutic experience.

7. Active listening

Active listening was vital in order to create a shared understanding about who the client was. I feel active listening also helped to create an environment where the client could feel comfortable enough to explore all aspects of who he was in the knowledge that the therapist was actively listening and actively interested in what he had to say. In this sense active listening provided the client with the respect he was asking for.

PROCESS TWO

CREATING SHARED UNDERSTANDING OF THE CLIENT'S GOALS: WHAT DOES THE CLIENT WANT?

The themes that emerged from the transcripts were:

1. Accepting the client as expert.

The client wanted to be recognised as an 'expert' on his experience of HIV. However, what became apparent through this process and my analysis was

that he also wanted someone else to become 'expert' on his experience. He wanted to 'teach' someone how to be expert on him so he could get the support he truly needed and wanted.

2. Exploring the concept of a space to be 'messy'

The client felt that sometimes he didn't have a space to be unwell or be 'messy'. If he appeared to be unwell at home it would worry and upset his partner and friends and therefore he had learnt to 'act like he was well' or make his pain 'invisible'. The client explained to me that he would like a space where he could cry or be in pain and he wanted me to be understanding and empathic; but he also wanted me to be able to 'stand it'. This goal seemed to be about him wanting me to recognise and accept his pain while also being empathic.

3. Exploring choices

One of the client's most immediate 'wants' was to create more choice in his life or to be able to see the choices that were available to him more clearly. We identified this goal through exploration of the client's material and within the process of creating shared understanding.

4. Exploring wanting to be understood

Before we could create other goals that were relevant to the client his first goal was that he wanted to explore his experiences in order to work out what he truly wanted. He also wanted to know that I respected and understood him. B made it quite clear that he wasn't going to fully trust me until he felt I understood him and took the 'data' he was providing seriously. Therefore his first goal was to make sure that the therapeutic space and our relationship was suitable for what he wanted, and he wanted to explore his experiences to try and work out what he truly wanted.

5. Exploring our relationship

The client made it clear that he wanted me to listen and not tell him what to do. He explained that he had friends, family and professionals that were all giving him 'advice' and he didn't need me to do this also. He also wanted a

space where he could be vulnerable but before we could meet this goal he wanted me to show him that I understood, that I was being congruent and that I was genuine and authentic. It was really about building and creating the most relevant and authentic relationship with the client that was possible.

Co. You just mentioned our relationship there and perhaps we can explore that for a moment. In the beginning sessions you were discussing a lot about mental health, some of the medications you were on, the experiences of having HIV, it sounded like, it sort of, I had the term coined in my head, you were an expert actually. What you were trying to communicate to me actually it felt like 'I'm actually the expert of my own life, am good at being this, am good at having HIV, I know where I stand with certain things'. You were an expert at you

Cl. Yeah. That's it. I wanted you to know that I know certain things. Important things and that whatever idea you have of HIV may not be my experience of HIV. Plus because I have so many physical issues I really do know quite a lot about the medical side of being HIV positive.

Co. So this was something you were actively trying to communicate…actually still communicating to me and you weren't sure if actually, if another person……. I feel like you want someone else to come in and help with that and be expert with you. How does this sound?

Cl. Yeah. It feels strange to hear that. I think that's a thought that is inside me but has not been formed into words. Does that make any sense?

Co. It does make sense. It sounds like you are saying that perhaps this is a need and want that you haven't fully verbalized before but is there. Can I just check to see if we can add to my understanding of this need……. So you do want someone else to work with you to be an expert but if their not going to do it the way you need them to than it makes you angry.

Cl. Yeah. There's no point in me having all this information about how my body works, and how I manage my pain if someone isn't going to respect it and use it. I see no point in doctors or psychologists giving me their expertise without using mine.

Co. I can see in your face that the thought of these professionals not using your expertise makes you angry.

Cl. Yeah, no it's absolutely right I you know, I get frustrated with the challenges I've had from being on methadone, I mean in the process from going here I've now changed GP which is something I struggled with for so many years. But yes, I do want help, I just want the right help.

Co. Yes. I think I've got a good sense and understanding of what you're saying actually.

Cl. I feel like you do too. But my God now I've done it, it's like so lovely. There is not an issue, there's no issue with my new GP. And in here, in here I feel like you try and understand my experiences before challenging me or working with me. Does that make sense?

Co. Are you saying that you feel in our relationship that I try and understand you before I challenge you?

Cl. Yes. This probably wouldn't work otherwise. But you know it's going back thinking of my other experiences with doctors and stuff, look at me as an individual, look at me as my, all of my uniqueness and listen that I know what am talking about. I may not always get it right but when I've made the call, you know the call before I have tended to be right, so even when it's gone to examples of when I've gone into the hospital and they said 'why are you here?' I said 'I think I've got encephalitis and their like 'what?' and I said 'I think I have encephalitis I'd like to be treated please.' And their almost astounded that I, how could I have possible known, but because I, you know, I

just know my own body just so well and I was right, I did have encephalitis.

6. Exploring the concept of balance

The theme of balance reoccurred in the transcripts in relation to several different topics. Through our exploration we highlighted that B felt his life was "generally unbalanced". It took quite some time to explore this concept of balance and really understand what balance would look like for B. It became clear that my concepts of balance and B's were at times different however we continued to try and identify and clarify what his goals concerning balance were.

7. Exploring contradictory goals

Pluralism advocates that all the client's goals be accepted and worked through: even if these goals are contradictory. By exploring contradictory goals with this client I feel we were also actively working through some of his feelings of ambivalence and it also allowed me to understand the true complexities of the choices he was trying to make.

The themes in relation to the methods being used that emerged from the transcripts were:

1. Challenge

By challenging the client through being congruent with him in the sessions we were able to create a deeper understanding of the client's goals for therapy. Although this client had some clear goals he was struggling to understand what he truly wanted. Therefore some of our work together involved exploring and challenging in order to work towards a position of clarity.

2. Meta-communication

Please see detailed description in Process One.

3. Normalising

This client sometimes struggled with what he wanted and what other people felt he should want. Therefore normalising was a part of communicating to the client that it was alright to have contradictory goals or wants and needs that others were disagreeing with. This further facilitated our exploration of the client's goals and communicated to the client that all goals were 'allowed'.

4. Focusing the session

Focusing the session became an important part of our work as the client wanted support for his partner, but he also wanted support for himself. I found in the beginning stages of therapy that the client spent a large section of each session on discussing his partner's needs and very rarely his own. Therefore, in order to explore the support that he wanted, I decided to put a boundary around how much time we would spend each session on discussing his partner in order to create space and time to discuss the goals he had for him.

Co. My idea is to start, I said to you in the 2nd session or the 3rd session that I'm going to fight for you to be in the room, but I also agree that your partner is a part of your life and part of you want from counselling was support with that. My idea is for our next lot of sessions to actually put sort of a frame around your partner and you, allowing more time for you to actually come into the room. For instance, saying that in each session I can give you a 15 minute window if you need it or less, or a little bit more, we can adjust it and I'll actually keep a frame around that so you have that time to talk about you and your partner so the rest of it will start on you. How do you feel about that?

Cl. Yeah that's great.

Co. Do you feel alright about that?

Cl. Yeah I think that's a really good approach

Co. Yeah I sort of feel like, I was trying to think of ways to bring you in without

taking your partner out, Um but I don't want to take your partner out of the picture but I do want more of you in here…I've noticed you've actually brought a lot more of you in here today, I feel like it's organically happening but I feel I'm going to have to structure it as well so we can meet your goals.

Cl. Yes yeah.

Co. I feel like I need to create that space for you otherwise you might not do it.

Cl. Yes yes, I agree and….but I think that's a good…I think I'm um finding the sessions incredibly useful in terms of the impact that they're having and just about really thinking about me more…

Co. You want me to know that you're thinking about you more.

Cl. You know, just being able…the things you've said to me, even like…this is our 4th session we're still talking about your partner, that really impacted on me…it's like my god, I am! You know, and so I think that, that really…the things that you've reflected back to me has been very, very powerful and useful for me to think more about me.

Co. It did seem to me in the first couple of sessions you were almost all about, there was so much of your partner in your mind, you were almost all about your partner. Were you surprised in those first sessions about how little of you, you brought in? or did that not surprise you?

Cl. No I was surprised.

CO. You were surprised.

Cl. I knew that because of the situation we would talk about my partner but I didn't realize how much he was dominating every thought

Co. There was a sense of urgency in the first session. But there was a sense of urgency particularly with the research side of things, you didn't want that to get in the way and rightly so and you made sure of that. I remember you sitting on the edge of your seat almost in the first session, the image I had was sort of a pot boiling over, you had so much that you needed to get out. Um but a lot of it, was about your partner.

Cl. Yes. I think the need and the want of just um of um having someone understand what I was saying, and really grasping what the issues were was so important and I think I was…probably at the…before I even came was being sceptical just wondering if that was even going to be possible, but it has happened. Like it happened with someone understanding my pain, and it's happened here you see. So the relief is…

Co. The relief of being understood?

Cl. Yeah its meant a lot..

5. Being confused with the client

This client didn't want a professional to give him answers; he wanted a space to explore and discuss the complexities of his life. He wanted a space to be 'messy' and confused. Therefore part of our work involved me being confused with the client. I felt a consequence of this was that the client felt like someone was with him while he was exploring his issues; this meant that he didn't feel so alone.

6. Relational depth

Working towards a relational depth while identifying the client's goals was a necessary part of stepping into the client's frame of reference in a meaningful and relevant way. This client seemed to need to know that our relationship was a safe and genuine 'container' for our therapeutic work and he wasn't going to trust me or the space until a relational depth was achieved. It could

be said that relational depth was also one of his goals in that he had specific goals for our relationship.

7. Checking

Checking allowed us to stay on the 'same page' during the sessions and check what the client's goals were. A large number of the sessions were spent trying to identify the client's goals and therefore the specifics of the goals were fluid and changeable for some time. Therefore it was important to check with the client 'where we were' with the goals in each session, and sometimes several times during the session.

8. Setting goals

Setting and naming goals is an important part of the pluralistic framework as it is the basis from which the methods and the tasks can be created.

9. Brainstorming

In order to set the goals there were several periods of brainstorming where the client and myself would discussing and explore the experiences of the client, their true desires and how these might be put together into clear goals for therapy.

Cl. I think because of my history, I think that, some of it has been very traumatic, I think that I've experience a lot of traumatic stress, that has never been dealt with properly, because I've had to then…suddenly something else has landed in my lap and I've never had the time to process the things…and it's been this ball.

Co. So traumatic stress would be important for you to have a couple of sessions on, just looking at the trauma itself?

Cl. Yeah.

Co. And maybe what was gained and lost from that?

Cl. Should I …I was just thinking off the top of my head, of something that might be useful…of the time lines, so you get a sense of my life events.

Co. hmm that would be great. Would that be helpful for you to do as well?

Cl. Yeah, I just suddenly thought, maybe that would be something…

Co. Maybe do it in your diary, so you can bring it in, and we could work with it out of that, if that's alright. I think that's a great idea.

Cl. I think it would give you a better sense of who I am

Co. Yes I think you're right, I love that idea actually. I think it gives us some structure around you as well, and just what's happened to you, which is lovely, I think it's a great idea.

10. Person centred therapy.

Throughout this process there were reoccurring themes within the transcripts such as reflection, unconditional positive regard, congruence, paraphrasing, and empathy. All of these themes indicate that person centred therapy was the main method used at this time. Person centred therapy allowed me to explore the client's material concerning what he was bringing to therapy with the spirit of acceptance and positive regard. This also allowed the client to lead the 'content' of the session and allowed me to make sure I was understanding this content through the use of reflection and paraphrasing. The client was also in crisis at the point of entering the therapy room and I feel that the person centred model allowed me to create a space that was able to somewhat contain this crisis.

PROCESS THREE

BECOMING THE CLIENT'S STUDENT AND CHALLENGER: CREATING A BALANCED RELATIONSHIP WHERE THE CLIENT IS EXPERT.

The themes that emerged from the transcripts were:

1. Processing traumatic experiences.

Processing the traumatic experiences of the client was an important part of becoming his student. I attempted to be a pupil of his expertise in order to almost earn the right to facilitate processing the experiences.

2. The pupil challenging the teacher.

Once we had developed a depth of shared understanding I challenged the client, mainly through being congruent, in order to facilitate further processing of his experiences.

3. Understanding the client systemically.

Bor and Miller (1993) suggest that understanding a HIV positive client systemically can help to understand the client within the 'systems' that they operate. For example, this client faced challenges with the medical community that he had regular contact with, within his relationships and within the mental health community. It was important to understand these systems and how they affected the client in order to truly understand the context in which he lived. In order to truly understand I used the systemic model and engaged in the process of becoming the client's student.

4. Defining goals and tasks

Within the process of becoming the client's student and also challenging the client we were able to further define and refine the goals and tasks that would be most effective to meet the client's goals.

5. Understanding experience of HIV.

Understanding the client's experience of and relationship with HIV was an important part of our work and one of the client's goals. Therefore this was an imperative part of truly becoming the client's student as this was a part of his expertise that had a significant impact on his life.

Cl. Yeah. I suppose, it just feels like I, there are times when I forget that I, well I don't get forget it but I try and live my life without really being affected by living with HIV. But there are some days when I really feel like I've got it, and today is one of them.

Co. Is it sometimes a bit of a shock? Not a shock perhaps but….

Cl. It's sort of just like oh god, this is just, actually I just feel quite not very ill, I feel very tired and um like, it's not like a normal tiredness, it just feels like I have no energy at all.

Co. So, completely flat?

Cl. hmm but it's ok, I mean it's the sort of thing I live with and I'm used to, but it's a reminder of you know sometimes when the suns shine although its cold, it just makes you feel a bit um and then I'm trying to think also of my future and what I'm going to do and then on days like this I just think, oh god what am I going to do? You know, cos I just feel so rough today.

Co. So it reminds you, the fact that you've got to live your life while being un-well. All the things you wanted to do, all the things you've wanted to achieve you are suddenly reminded well actually, you've got to live with this as well. When you do feel like this, what do you do on days like this?

Cl. 5 Um, well generally I try and not do as much as possible but today is one of those days where I've actually got quite a lot to do, which is kind of a bit frustrating. But its just one of those tings, there's not option really.

The themes in relation to the methods being used that emerged from the transcripts were:

1. Meta-communication

Please see Process One for detailed description.

2. Challenge through congruence

Please see Process Two for detailed description.

3. Invitation to process

This invitation to process was a method used to meet the client's goal of processing experience of the past. It was done within the process of becoming the client's student and challenger as this invitation took place once I had learned enough from the client's expertise.

4. Collaboration.

Please see Process One for detailed description.

5. Exploration

Please see Process One for detailed description.

6. Active listening.

Please see Process One for detailed description.

7. Checking.

Please see Process Two for detailed description.

8. Systemic model.

Please see Process Two for detailed description.

9. Existential therapy.

Barnett (2009) suggests that each HIV positive client may have a specific construction of their illness. Barnett (2009) suggests the therapist take a

stance of 'unknowing' in order to accept and explore the client's personal construction of HIV. The suggestion is that this stance helps further collaboration between the client and the therapist to create a deep shared understanding of the client's inner world. This client had faced his own mortality and had a very specific construction of HIV and what it meant to him. Therefore existential therapy helped us to create a shared understanding about these constructions while I was in the role of student and the client was in the role of teacher.

10. Our relationship

Our relationship was part of the process of therapy but it was also one of the main methods used to meet the client's goals. The client wanted to be respected, listened to, understood and taken seriously. Therefore our relationship of student and teacher helped to meet these goals.

PROCESS FOUR

THE PROCESS OF PROCESSING

The themes that emerged from the transcripts were:

1. Processing relationship with partner

One of the client's goals was to process his relationship with his partner in order to understand the experiences he has had with him and what this meant to him.

Cl. Absolutely, my partner was fantastic, he was really, really good. Bless him, the thing is in some ways he doesn't…he was brilliant but he was incredibly nervous and so…but you would have never have known, they didn't pick up on that all. And afterwards, he was just like a huge bee. Afterwards he was sweating, anxiety thing…just afterwards, he was all sorts of things but he handled himself very well. and um he had, it was the right…you know, I was trying to step back and let him do…I didn't want to sit there and make it, and be the one…it needed to come from him. I have to say, both (the people in the

meeting) and I've forgotten her name, was fantastic. She was very, she was very I found her to be very mindful of my needs. She was very um, she was wanting to make sure. I think she picked up very quickly, or maybe not, maybe she had just had conversations. She picked up very quickly that my partner /carer role was quite difficult without being explicit in front of my partner, do you know what I mean?

Co. That sounds very sensitive, doesn't it?

Cl. Yes and so she was very keen to say to (person in the meeting) that she wanted to make sure that my needs were, on going, met as an on going thing rather than a short. Which I was really pleased about, cos I was you know…but ultimately I was so relieved that my partner has got what he wanted which was re-engage with the service, which was to have his medicine re-viewed by a proper psychiatrist.

Co. oh great!

Cl. The halleluiah chorus was going on!

Co. So your partner's needs were taken care of, but at the same time it feels like your needs were taken care of as well in the meeting.

Cl. Yes, I can't remember her name but she just was a very lovely lady, just said clearly 'by addressing your partner's needs, your needs will be met too'. And I was like wow you've got it, absolutely right.

Co. Wow. So your role as a carer that we've spoken about several times in here was really nurtured and taken care of which hasn't been for a long time.

Cl. Yes absolutely, I brought…quite rightly so and said how valuable I felt that these sessions had been. Oh what was I going to say… um I had it in my head then, I'm sorry.

Co. That's alright, take your time…

Cl. I can't remember her name but she recognized the importance of my needs being met, and ah I was saying in these sessions it had been brought up quite clearly that, I wanted to be a partner not his carer. I was able to say that and having the back up as using this, the therapy sessions, as a reference point. By saying it was quite clear in my sessions that I was loosing the role as a partner because I was taking on the carer. They were also happy to address the issue of supporting his claim for DLA in terms of the carer's element, which again, hopefully, financially will for the short term will certainly help.

Co. I'm really please for you both….. you did it.

Cl. I'm please for my partner, because it's been a long time for him not to have someone. I just now hope that he is able to, and people are able to address the real issue.

Co. Of course, because this is everything you've asked for, but I guess the additional things you've asked for is that it's the right kind of care. It sounds like it couldn't have gone better and it feels like you were both very well taken care of, and your needs were very well taken care of. How did it feel for you in the meeting?

Cl. Well we discussed what we wanted…

Co. How did that go? The discussion before hand?

Cl. I said to him 'what do you want from the meeting? What do you want me to do?' and um I said ' I can do as little or as much as you want me to do'. And um I said…and so we had kind of, he was incredibly nervous around doing it, and um you wouldn't have noticed it, I could naturally see it in his face and

stuff but you wouldn't have known it.

Co. I was about to say, I can hear pride in your voice.

Cl. I did say to him you did really, really well in there. Because it was really hard to sit in front of a room of 4 people anyway, let alone talk about your mental health problems.

Co. Very, very brave to do. Brave for both of you.

2. Processing the need for balance

The client wanted more balance in his life but he also wanted to understand what balance meant to him. Therefore we tried to process this concept. We explored what balance would look like in his relationship and balance between his medication and his pain.

3. Processing the concept of expert

We attempted to process and understand what being an expert meant to the client and why it was important to him.

4. Processing the experience of life and death

The client wanted to process his experience of life and death in order to see what he had learned from these experiences and what impact these 'learnings' had had on his life and the way he lived.

5. Reviewing our work together

We also processed and reviewed our work together in order to establish what we had done together and what meaning it had for the client. We also reviewed and processed whether this work had met the client's goals and what goals the client had at the end of therapy.

The themes in relation to the methods being used that emerged from the transcripts were:

1. Summary

Summary was a method we used to review our work together and to process what we had achieved in therapy. We also used summary to summarise the outcome of processing the client's experiences in order to track and 'name' what the outcome of this process was.

2. Challenge

Please see Process Two for a detailed description.

3. Relational Depth

Please see Process Two for a detailed description.

4. Person centred therapy.

Please see Process One for a detailed description.

5. Our relationship

Please see Process Three for a detailed description.

6. Existential therapy

Please see Process Three for a detailed description.

CASE STUDY TWO: MATTHEW

PROCESS ONE

CREATING SHARED UNDERSTANDING OF THE CLIENT AND THE CLIENT'S GOALS

The themes that emerged from the transcripts were:

1. Exploring anxiety and loss.

Anxiety was one of the first topics the client brought in as having a significant impact on his life. Therefore we explored the client's anxiety by exploring specific situations where it became debilitating, why the client felt he was experiencing anxiety and how it affected his quality of life. The client also wanted to explore the time in his life where his mother died and how this affected how he saw himself. The client had also experienced several other losses such as loss of his job, loss of his health and the experience of almost losing his life.

Co. So it used to work for you in the way it used to decrease anxiety am guessing?

Cl. Yeah

Co. And also it used to sort of allow you time to…

Cl. To just sort of say 'ok I'll take time…'

Co. Or the illusion of time

Cl. Yes, yeah cause things would still be going on around but I hadn't dealt with, it's then I suppose there's an aspect of me that always puts everything to the last moment. It's like doing, rehearse, not rehearse its like, or doing prep at school, it'll be like 'I've got weeks' and than its night before and than it would all flow and I suppose that's something that I used over the years as I sort of, the mind focuses or otherwise the mind wonders I think and as a result that's another thing that I've got to try and get, a bit of focus in my life

Co. So how do you feel when things go to the last moment? What's the feeling or lets say the night before?

Cl. Umm it's a case of everything just like distils and the mind just focuses on one thing and it will just work through that….

Co. So you use 'last moment' to focus yourself down and use the adrenaline I guess?

Cl. Yes that's it

2. Exploring current coping strategies.

Part of the reason the client decided to engage in therapy was that he felt his current coping strategies weren't working for him anymore. Therefore we explored his existing coping strategies, how he wanted to change them and what parts of them he might want to keep.

Cl. Yeah, it was, while I lived in my parent's home, I would also do bits and pieces like decorating my own bedroom, I added bits and pieces, I had to buy things for the house, like I wanted wardrobes, my mother said no, you've got to buy them, so I bought the wardrobes,

Co. You bought the wardrobes.

Cl. I bought my own wardrobes, put in them in, I used to do a lot of baking and things like well, bakery things like cutlery, all sorts, little bits and pieces,

Co. Do you still enjoy baking now?

Cl. Yes. I, I actually did something over the weekend, I baked a cake, from, it was uh, um, a four, four-ingredient recipe, it was in the metro last week, a frugal fruit cake,

Co. A frugal fruit cake?

Cl. Yeah and it was like, it was meant to be a kilo of fruit, that was meant to be soaked in either wine or …..

Co. Yes, yes.

Cl. ….and you'd just mix it with about two kilos, two cups of umm, self-raising, organic self-raising flour and put it in the oven for about two hours and you get a fruit cake.

Co. Right!

Cl. It's about four, total of about four ingredients and I did, and ohh that's silly, cos I love making fruit cakes, and this fruit that had been marinated and all . It's, it's in a way it's like, trying to get rid of the old stuff that being there and there for a good reason, but at the same time using it, utilizing things I've got, um, rather than, hanging onto it for no apparent reason.

Co. Hmm.

Co. I think that's, it's umm, it was a safety blanket, for me, having things around me are my safety blanket,

Co. So having sort of, having sort of, anything around you really,

Cl. Yeah, I think it's….

Co. Or is it a particular things?

Cl. Particular things, I mean when I was growing up it's cars, it's comics, things like, those were things I could get myself involved in and they became,

because I had that, I was able to escape, into my own little world, where my parents were doing various things, it was me and I was happy, on my own.

3. Exploring the client's 'wants'.

Pluralistic therapy advocates that the therapist works from what the client wants rather than what the therapist thinks the client needs. Therefore we explored what the client wanted out of the therapy, what he wanted out of life at this time in his life and what he wanted in the future.

Cl. I don't want to lose the work, I want to be able to grow from the work.

Co. Yes, I think in the beginning I had this idea that perhaps what you wanted was, um, to sort of, keep them almost compartmentalised, bring (client's name) forward and take (personas name) back, I'm sort of thinking more now, that actually what you want is something different.

Cl. I want to be able to use them….. them together.

Co. Oh I see. So more, seeing these two personas as one person with different attributes.

Cl. That's it, because I feel, it is a part of me, both of them, I don't know what bits yet, but I guess there might be parts of me in both characters, I want to work out why they are there, what bits are me and how I put them together.

4. Exploring thought processes and beliefs.

Mathew had several beliefs mainly about himself that were not helpful for him anymore. For example, he attributed most of the positive attributes of his identity to 'Raven', the female stage character he created. However, through exploration of his thought processes and beliefs we became aware that in fact these parts of Raven were actually parts of Mathew; they were the same person. We also explored Mathew's thought processes, particularly in relation

to his anxiety. For example we explored some of the thoughts that go through his mind when a stressful situation occurs and how this affects his behaviour and whether this is something that Mathew wanted.

5. Trying to understand the client within the context of their world.

In order to fully understand the client and his 'wants' I attempted to understand the contextual factors of the client's life. It became apparent from the first session that these contextual factors had a significant impact on the client's overall quality of life. For example we explored the client's finances, how his flat looked and how he felt being in his flat, we explored what a day looks like for him and how he spends his time and who he spends it with. This exploration gave me a more three dimensional understanding of the client and his 'wants' within the context of his world.

Through my analysis I identified the main themes in relation to the therapeutic 'tools or methods' that were used to create and maintain this process:

1. Collaboration.

This was mainly a collaboration of our ideas about anxiety. Mathew explored and explained his experience of anxiety, how he usually coped with it and how he felt about his experience of anxiety. I would then explore and explain my ideas about anxiety in relation to Mathew's experience in order to pool all of our ideas together to begin to create a picture of his experience and how we might work.

2. Relational Depth.

I feel that attempting to work at relational depth created a strong relational foundation on which the therapy could take place. It felt important that not only did I understand the client but that he had the experience of feeling understood in a way that meant something for him.

3. Existential Therapy.

Existential therapy was also included in this process and was used as a way of 'noticing the client' in the therapy sessions in order to work with the 'here

and now' material that the client was presenting. This was a way to create more in depth shared understanding about what the client was bringing to the therapy room.

4. Making links.

During this process we both began making links between the client's existing coping strategies, his thought process, his behaviour, his emotional experience and his quality of life. The data we collected during this time and the links we were beginning to make gave us the information needed to start making changes in a way that was relevant for the client.

5. Identifying Negative Automatic Thoughts and beliefs (CBT).

We used Thought Records to identify possible negative automatic thoughts that Mathew had during recent experiences of high anxiety. We also attempted to identify any beliefs that were underlying these negative automatic thoughts. At this stage we used the thought records to identify possible thoughts and beliefs rather than challenge them. This was so we could continue working towards creating a shared understanding of the client, his wants and what he was bringing to the therapy room.

Cl. And then went back to the bus stop and started waiting and waiting and waiting and at that point I'm thinking oh god you know maybe and it just

Co. What were the thoughts when you were waiting and waiting?

Cl. Umm, it was, it was weird. I sat there thinking I can't, I can't do this, Everybody is looking at me thinking I am made, I can't leave from here, I can't leave from here cos, I mean they'll know that I was going somewhere and I'm not going somewhere now and then also sort of like I wanted to get to the interview but at the same time I'm going oh the longer it takes, will I get there in time and I just, I just felt negative and I just completely

Co. It spiralled.

Cl. Spiralled in a snowball.

Co. So what was the first one? I can't leave from here? Or was it oh no?

Cl. Yeah and I was sort of like, 'I can't leave from here'. I was trapped.
Co. So you thought, 'I can't leave from here' and this made you feel trapped and, well it sounds like you felt you were no longer in control.

Cl. Yes, that's it. But at the time it was just no, I've been waiting now and I've got to wait until it arrives. And that just became, sort of, really, sort of, s'like negative in a way, that I just felt, one, I couldn't move, and the other way I couldn't go for the interview. And it just spiralled.

Co. So you were frozen. In the middle so to speak.

Cl. Frozen, totally.

Co. And is that, what how does it manifest itself physically?

Cl. My heart got faster and I just I just felt I had to get home. I just could not do anything else.

Co. You couldn't be out anymore and you felt like you had no choice in the matter.

6. Person centred therapy.

I used person centred therapy in an attempt to create an environment of acceptance. One of the client's goals was to integrate all the different parts of his identity that he had separated in order to be able to cope with the stressors in his life. He explored that he wanted to be more accepting of who he was, including his strengths and weaknesses. We also explored the concepts of an external and internal locus of control as the client felt that he frequently made choices about his life and judged himself in accordance to what others felt about him rather than what he felt about himself. I felt by using congruence, unconditional positive regard and empathy that an environment would be created where the client would feel accepted and might be better able to access his internal locus of control in order to start making choices that were truly for him.

PROCESS TWO

CREATING TENTATIVE HYPOTHESES: TWO SCIENTISTS WORKING TOGETHER TOWARDS A COMMON GOAL.

The themes that emerged from the transcripts were:

1. Reviewing and recognizing.

Both the client and I recognised and reviewed his coping strategies in order to work towards creating tentative hypotheses about his current situation. This was also working towards the client's goal of understanding his anxiety, how he currently coped with it and how he wanted this to change.

2. Making links and identifying patterns.

We also began to identify patterns and explore possible links within Mathew's behaviour. For example we explored the links between his thought processes, emotions and behaviours. We also made links between his past and his present such as exploring the first time he 'put on mask', why he did this, how it changed his experience of life and the possible link it has to his behaviour today.

3. Exploring experience.

Exploring Mathew's experiences was an important part of creating tentative hypothesis. Our tentative hypotheses were collaboration between psychological theory, the data that Mathew collected about his experiences and the data we collected during our therapy sessions together.

4. Processing emotions.

By taking this stance of two scientists working together towards a common goal, emotional processing of the experiences we were exploring was taking place. By recognising and reviewing, exploring and making links and identifying patterns, Mathew also began to process how he felt about his past experiences and how he felt about how they had effected his life in the

present. I feel this was also working towards Mathew's goal of understanding the function of why he created different personas or masks and the emotions he was feeling at the time they were created.

Co. How do you actually feel in yourself at the moment?

Cl. In myself at the moment, umm, happy and sad.

Co. Happy and sad.

Cl. Happy at the fact that some things are moving in the right direction, sad that some things that I thought were moving in the right direction aren't, and its just sort of putting more stress and sort of building up to sort of deplete my desire to do things, my motivation and that is, trying to constantly battle against that. That seems hard at the moment.

5. Checking.

Checking was an important aspect of this process as it allowed us both to check to see if we were collaborating our ideas effectively and if we were working towards Mathew's goals. It also allowed us to check where we were in our relationship and if the way we were interacting was effective. Checking also allowed us to check what the focus of the session was and whether this focus was relevant to the client.

Co. This sort of feels like maybe what we're going to concentrate on today, while your mother was ill?

Cl. Yeah

Co. And the interaction between you and your brother.

Cl. Yeah.

Co. Would that be most helpful for us to focus on today?

Cl. I think so, might be, yeah that sounds good.

The themes in relation to the methods being used that emerged from the transcripts were:

1. Person centred therapy.
Please see explanation of person centred therapy in Process One

2. Summary
By summarising the hypotheses we were able to establish what hypotheses we had created through our exploration. This allowed us to see if we both agreed on our summaries of what was going on for Mathew and therefore gave us a base to move on to create ways of working with these hypotheses.

3. Relational Depth.
In order for this highly collaborative process to take place we were also working towards a relational depth that allowed us to create a more in depth understanding of what was going on for Mathew. I feel this also helped to build a strong therapeutic alliance.

Cl. Whether you actually win the game is vaguely relevant (laughs) in a way, I mean it's nice to win and yes you get a bit of extra money but it's the fact they've looked after you, you've got through all of the competition with them and they're saying 'well done for getting this far, have some fun on us' … and than of course you'll feel relaxed when you do the show so therefore we're gonna get the best from you win or lose. You wont feel 'oh good I lost' or really that, you'll feel 'oh that's a wonderful experience, I enjoyed that…'

Co. So you really, you've actually really liked this experience and you're saying that….

Cl. Yeah

Co. Part of the experience that you like is that they take care of you.

Cl. Yeah

Co. And that you feel a little bit… how do you feel while you're doing it?

Cl. Special

Co. Special

Cl. A little bit special… and its sort of like saying 'oh thank you'

Co. So that's actually enough for you, not the winning.

Cl. Not the actual winning

Co. That's interesting isn't it?

Cl. Yeah cause I think sort of, I mean it's nice when we do win…

Co. Course

Cl. But I don't always win but these are cases where I like the fact that 'oh I can go somewhere new I may have not been to before'

Co. Ahh

Cl. Be to a different hotel and be like 'oh that's nice, oh fab'

Co. So something new

Cl. New yeah

Co. And something that's challenging and being taken care of and feeling special while you're being taken care of.

Cl. Yeah that's it.

4. Reviewing and recognising.
Please see explanation of reviewing and recognising above

5. **Checking**
Please see explanation of checking above

6. Making links and identifying patterns.
Please see explanation of making links and identifying patterns above

7. Identifying thought processes and beliefs.
Part of creating hypotheses that were meaningful to the client was identifying thought processes and beliefs that were a part of, or the result of, Mathew's experiences. Mathew identified early on in our therapy that his thought processes effective his emotions and his behaviour and therefore this became an important part of the way we worked together.

Co. I wonder where that came from, that you've got to be together?

Cl. Umm I suppose it's a family trait.

Co. You've got to be together.

Cl. Yeah.

Co. There is no room for feeling messy.
Cl. No there wasn't. Sort of umm always, because I think to a fair degree we were always on show.

Co. Yes.

Cl. And therefore you didn't show the grief, you kept it behind closed doors and that's why it's always been like 'no yes I've got to keep it together…' yeah present a sort of calm influence outside but inside feeling completely awash.

Co. So I guess the positives you get from keeping it together are you can avoid the intense emotion itself.

Cl. Yeah.

Co. But also that other people are mmm…

Cl. Stops them feeling uncomfortable.

Co. Stops them feeling uncomfortable, I see and what's it like for people feeling uncomfortable around you? What's your experience of that?

Cl. Umm I think that if they feel, I feel… I suppose it's the, it's the thing of always trying to make people feel comfortable, that's what….

Co. I wonder why that is important to you.

Cl. Why? Umm… because I, deep down I suppose it's, when I was younger umm my accent was very, very English and very upper class and when I spoke to first white English people they'd go, and they wouldn't hear a word I said.

Co. What they wouldn't listen?

Cl. The colour, they'd hear the voice but the colour just didn't correlate

Co. So black skin and a…..

Cl. And a very posh accent

Co. A posh accent

Cl. Didn't go together.

Co. I see.

Cl. So they didn't hear a word I said. So they in a way felt slightly uncomfortable sort of thinking 'he speaks better than I do and am English, am from England' and of course I felt that they were gonna go 'oh' and they felt to demeaned and I didn't want to make them feel demeaned so therefore I developed an American twang.

Co. You developed an American twang?

Cl. A north Atlantic twang, so its very sort of, so am accent, its still very English but every now and then it does get, more [says personas name] I say has the twang now

Co. I see

Cl. But before it was [says own name] had the, developed sort of, this Mid Atlantic sort of umm accent so therefore they thought 'oh his just American' and therefore they could correlated a black skin with an American accent but they couldn't correlated it with an English accent

Co. And therefore the outcome was they were gonna feel more comfortable and the other part of this belief is that you feel you can't show strong emotion.

PROCESS THREE

CREATING AND DOING TASKS

The themes that emerged from the transcripts were:

1. Creating the 'Tiles Task'.

The tiles task was created through an exploration of what an average day looked like for Mathew. After identifying how unfinished tasks around his house made him feel I suggested he did one of these tasks and then we would come back and discuss it in the sessions. Therefore the task was that Mathew was to complete some of the tiling in his bathroom. He had wanted to complete this task for the last two years. I asked him to note how it felt to do the task and how it felt after it was completed. I also asked him to time how long it took him to complete it. This was so we could review the task as a whole in the following session.

2. Creating the 'One Day Task'.

Through a solution-focused exploration of what a 'perfect day' might look like for Mathew we identified that he really wanted to create some time that was just for him to relax and enjoy. We also explored that he didn't feel like he could take this time due to his anxiety. Therefore we created the 'one day task'.

We did this through firstly organising his week to make sure that everything that needed to get done was done. We then blocked out an afternoon where he would pack up a picnic basket and go to the park to read. I asked Mathew to monitor how it felt to do this task, how difficult it was to do and how he felt

when it was completed. This was so we could review this task in the following session.

Cl. But at some point I would like just a moment to say 'ahh!' just for a moment and that's, so I can maybe savour some of the good parts. The fact is I don't get a chance to

Co. So what would that moment look like?

Cl. To me that moment would be a chance where I can sort of I suppose just wake up in the morning and just go 'ahh… what do I want to do today' and just enjoy the day, not sort of like worry about everything around

Co. And enjoy the day… And what would you do?

Cl. Umm what would I do?

Co. If you had a day?

Cl. If I had a day to myself umm maybe just sort of savour the moment and its sort of just go 'ok'. Wouldn't listen tot eh radio or anything just maybe, maybe just potter and than take a long walk umm and feel, not feel the necessity to think about anything else, just be able to go 'oh I'll go for a walk', just enjoy the walk and maybe take a book and a picnic to the park and read for the afternoon.

Co. So it sounds like spontaneity.

Cl. Yes.

Co. And than being able to be in the moment

Cl. Yeah

Co. Rather than being behind or in front or….

Cl. Yes that's it.

Co. Or trying to worry about something…

Cl. 47. Yeah.

Co. So being in the moment would be…

Cl. Yeah and maybe just get on the National Express Coach and go 'oh lets go down to Brighton or Blackpool or something like that…

Co. That would be nice.

Cl. Just to be able to go 'yeah and I'll just enjoy the day' and that to me be would be like wow, yeah, a moment to just like throw off everything and than go 'yeah' but not know, well knowing the sort of the things that are round but being able to say, they'll be manageable. The fact is nothing seems manageable at the moment and because nothing seems manageable I don't feel I get that moment to myself.

3. Brainstorming.

Brainstorming was necessary for the creation of the tasks as it allowed us to collaborate all the information needed to create them. Brainstorming also allows both the therapist and the client to collaborate their ideas to create tasks that are meaningful for the therapeutic experience and relevant for the client.

4. Exploring hypotheses.

In order to reach tentative hypotheses we explored the possibilities. The possible hypotheses were sometimes created by the client, sometimes

created by me and sometimes created by an amalgamation of our ideas followed by a process of both of us exploring them.

The themes in relation to the methods being used that emerged from the transcripts were:

1. Solution Focused therapy.

The specific element of solution-focused therapy that was mainly used in this section was 'The miracle Question'. This is where I asked Mathew to imagine that he had woken up one morning and a miracle had occurred; his life was exactly how he wanted it. I then asked me to explain what his day looked like starting from when he woke up and I asked him to include as much detail as possible. Part of this day involved going to a park with some beautiful food and reading for the rest of the afternoon. Therefore I suggested a task where (after we organised his week so he could get everything done) he would pack up a picnic lunch and go to a park and read for the afternoon. Solution-focused therapy allows the client and therapist to concentrate on solutions rather than on the problems in order to create an environment of hope and possibilities.

2. Challenge.

In the transcripts challenge came up several times during this process. I feel the reason for this was that the client was conveying in the sessions that these tasks felt like a challenge for him. It seems it felt like the tasks we were setting felt like challenges to him. Therefore for this client the concept of the task was also a behavioural challenge as the tasks were things he wanted to do, but that he found challenging due to his anxieties. I also used congruence to challenge the client. I did this by 'naming' any possible incongruence that I saw in the room so we could explore this incongruence to see what it's function was and whether it was helpful for Mathew.

Co. Is that, is there a possibility that's why you came in quite bubbly today, that actually you do feel really down?

Cl. Umm, I think yes, yeah that's the other aspect, it's sort of umm…

Co. Cause that's I didn't pick that up in the beginning of the session… you did look so bright and happy but I just felt this sense of sadness somewhere as well and I'm wondering why?

Cl. It's, there is always that element on top going 'oh yes you've got to be bubbly and up there', but at the same time deep down there are still parts going, very, very down.

Co. So when you do get very, very down do you feel yourself going more bubbly for a period of time?

Cl. Yes.

Co. Increasing sort of the bubbly-ness?

Cl. Yeah it gets beyond, it becomes almost I suppose manic to a degree and than it will just 'tchh' flip.

Co. I wonder what it would be like to… to just be sad when you're sad

Cl. Umm

Co. Is there a fear there? I sort of feel like you look quite scared about doing that.

Cl. Yes, yeah I think that's it. It's the fear that I would just descend into just total, also like oblivion.

Co. And what would that look like?

Cl. Umm it would be messy and whether I could get out of it I don't know.

3. Brainstorming.
Please see explanation of brainstorming above

4. **Checking.**
Please see explanation of checking above

5. **Person centred therapy.**
Please see explanation of person centred therapy in Process One

PROCESS FOUR

REVIEWING OUR WORK INCLUDING THE TASKS: WHERE ARE WE NOW?

The themes that emerged from the transcripts were:

1. Review of 'Tiles Task' and 'One Day Task'.
We reviewed the tasks in order to explore Mathew's experience of doing them and what we might learn from them. It is an important part of pluralistic therapy to mark the end of a task or a goal in order to see it through to its completion. I feel this reviewing of the tasks was empowering for the client, as we were able to explore his 'success' in meeting the challenge of the tasks. I also feel it gave him a sense of achievement and hope.

Cl. And I think it's only doing what I did yesterday, putting up the tiles, that although I keep on coming back to it, I think that just, like did a little click to go, one second just get a pat on the back for that, and keep on patting yourself on the back for that, until you can actually fully believe that you've done that and accept the fact that you've done well.

Co. There's something also about the tiles, about it being visual that when you can walk in the bathroom, you can see it every day, so you're reminded of that you've done this and achieved this, there's something quite nice in there as well, I think that you….

Cl. It is, it is, it is, it's just a little thing, but it has, it's just completely transformed me in a way. Umm, and leading on…

Co. You said it was sunny that day as well, when you got up.

Cl. Yes. Yesterday.

Co. So it was sunny...

Cl. And I just like, got up.

Co. Any other differences in the day when you got up?

Cl. Umm, any other differences, the fact that I saw them there and I thought ohh, and I had this, and I had the glue to put them up with and everything, must have had it about two years, the glue, about two years or so….

Co. Hmm.

Cl. I mean it was just there, and going, oh this and that and a few tiles had come down in the kitchen and they'd just been there for years and it was like, I don't want to live like that, I want to make it, I suppose at that moment, I want to make it my home.

2. Reviewing where we are now with our hypothesis about personas and identity.

After the tasks and our creation of tentative hypotheses we reviewed where this left us. I feel this reviewing of our work together gave us a sense of what we had done and how far along we were to meeting the client's goals. I feel this review also gave us the chance to adjust any of our hypotheses after the completion of the tasks so we could integrate what we had learned. In relation to our hypothesis concerning Mathew's personas, this was where

Mathew started to truly feel that all of his personas were in fact parts of him. I feel this facilitated further integration of Mathew's personas; therefore we were also working towards Mathew's goals.

Cl. There's always been that doubt that no am not good enough tot do that and therefore as a result I created [says personas name] and so therefore in a way [says clients name] created [says personas name] to provide the appearance outside to sort of survive yet even though its [says own name] that's got the strength I suppose deep down.

Co. Yes… I feel like asking you to say that again (client laughs) '[says clients name] got the strength deep down', because it does sound like, this session it sounds like all of these attributes are you.

Cl. Yeah

Co. But it seems she's (Raven) used as the protector and the shield as well.

Cl. Yeah
Co. Which means even if she's (Raven) not taken seriously it doesn't get to [says clients name] its fine.

Cl. That's it, I think so. I think that's a good explanation.

Co. It sounds like between you and me we are kind of adjusting our explanation or our hypothesis about you and (personas name). But more and more this session am sort of thinking that [says clients name] actually….. it just feels like you are bringing to whole you in this session…. Not the different separate compartments

Cl. Yes, it does feel like that….slowly coming through a bit more. It's sort of, it's a start (laughs).

Co. Mmm, how does it feel to think that, yes you just said that you feel doubts about it but I can see you don't feel comfortable with that thought.

Cl. No, no

Co. But how is it, if you can describe how that makes you feel, that perhaps maybe that they are all just different parts of you?

Cl. Umm it sort of makes me feel sort of very weird cause it's sort of as I've said I've always put my strength in [says personas name].

Co. Yeah

Cl. Its now putting my strength in [says own name] is a complete, in a way a turn around. It sort of sounds like it's right and yet I'm still a little scared to put all of the parts together.

Co. Yes. I can see that.

Cl. And its hard to sort of equate them both as myself but it slowly, bit by bit I suppose that with time I'll get closer and closer to actually bringing them fully together.

Co. And do you still have hope that they can be brought fully together? Is this still something you want?

Cl. Umm yes

Co. You do?

Cl. 71. Yeah I do. I know I don't sound like I do but it's just hard. But I really do and I feel like it's happening and so part of me wants to avoid and part of me wants to accept it all happening.

Co.72. Yeah, I see. So at the moment you want to integrate the parts of yourself and yet it's really scary to.

3. Reviewing where we are now with our hypothesis about anxiety and stress.

This review also allowed us to see where we were in respect to our hypothesis concerning Mathew's anxiety. The information we gathered from the tasks somewhat disproved Mathew's belief that he wasn't capable of doing all the things he needed to do in life; he was able to do them.

4. Processing feelings and emotions.

During our reviewing our work together we also reviewed and attempted to process the emotions that were created through our work together and through doing the tasks. This was so we could process the whole experience of therapy rather than just the content of what we had done together.

5. Reviewing goals.

At this time we also reviewed the goals as it seems that our review of the work was suggesting that they had changed slightly. Mathew wanted to approach the process of integrating his different personas from the perspective that they were all parts of him rather than attributing some parts to him, and others to parts of himself that he had created or 'made up'. He now felt they were all parts of him.

The themes in relation to the methods being used that emerged from the transcripts were:

1. Person Centred Therapy.

Please see description of person centred therapy above

2. **Summarizing.**

Please see description of summarising above

3. **Relational Depth.**
Please see description of relational depth above

4. **Existential Therapy.**
Please see explanation of existential therapy above

PROCESS FIVE

EXPLORING DIFFERENT PATHS

The themes that emerged from the transcripts were:

1. Exploring different approaches to stress and anxiety.
This process was a creative time where we took all the data that we had about Mathew's stress and anxiety and we began exploring different paths and different ways of coping. This included instead of using avoidance to calm his anxieties (which wasn't working for him) we created ways that he could do the things he needed to do and then take time out for himself to relax.

2. Exploring new/old effective coping strategies and integrating them.
We also explored the effective strategies he used to use and see if we could incorporate them into his new coping strategies. For example, Mathew's new way of coping with anxiety was to create a plan where he could get everything he needed to get done and then reward himself with something that brought him joy. He used to use the things that brought him joy as a way of avoiding what he needed to do, thereby creating anxiety. The things he loved to do were read, play video games, cook and be creative around the house. Therefore he incorporated these things that brought him joy into his week.

Cl. The difference is that I feel more in control now. I didn't feel in control ten weeks ago, I would say I was umm totally lost and that I just couldn't focus on anything, couldn't see anything. Nothing seemed to be umm anything I tried to do I wasn't, I was more being critical of myself in everything I did to the point where am going 'oh no its not gong to work, it's not going to work,

everything's going to fail', and as a result within that it was adding to the depression

Co. Yeah

Cl. As well as the stress umm it's like looking back on it now I can like see there's a, I've taken several steps forward. I wouldn't say I was completely out of the woods but I've taken, further forward than I was ten weeks ago. Ten weeks ago I seemed to be right in the heart of the forest with no way of seeing any light.

Co. Yeah

Cl. 45. And now I can see light and it seems quite a big light that I can see now and each week it seems to get a bit brighter so I feel am stepping forward. I mean there's still a lot around to try and sort through, to try and see clearly and get out into the open but….

Co. Yes

Cl. I feel I've advanced a long way from where I was.

Co. So how do you feel in your like, like to me this feels like quite a big achievement this, this play particularly.

Cl. Umm it is.

Co. You're directing and acting in it?

Cl. Mmm (laughs slightly) and for that it's like, only assistant director but he was, so sort of, it's a large leap but what it, what to me it's given me the confidence to say 'oh maybe I can phone somebody up as a sponsor or do this' and that is something I would have done years and years ago when I first

started doing cabaret I had the confidence to just pick up the phone and go 'hello, da, da, this is me and this is what I've got to offer, boom' and go 'alright, fab, yes', um whereas I would say for the last umm two, three years I wouldn't, nowhere near the confidence that I would, I feel is now starting to remerge umm and it's sort of as I say I don't want to be too overconfident at the same time, I feel that there is a lot of confidence within that which I feel yes its quite solid and its looking back from what I've done in the past and being able to draw from the strengths that I had in the past. I can be assertive. I don't need to avoid things and I can do like what we talked about….. setting small goals and then getting there in my own time. It's not like everything I've learnt here has been new…… it was surprising how much of these strengths I already had….. I had just forgotten about them and avoided them

Co. And correct me if am wrong, this does sound like it is confidence from you maybe? As in the whole you?

Cl. Yeah I think it's umm…..

Co. Or is that not quite right?
Cl. I would say it's umm maybe confidence from….. that's coming forward I would say…… I guess it's a mixture of both….. I mean a mixture of all of me.

Co. So it's a mixture of all of you. Not from one section or another?

Cl. Yeah.

Co. This feels difficult to put into words.

Cl. Yeah rather than just… the personas not taking over……. It's both. I can't really explain it.

Co. Which was one of your goals actually at the beginning was to sort of well actually one of the goals at the beginning we talked about first was getting, to be able to integrate the two personas.

Cl. Yes. It sort of feels like it's happening. Slowly, but happening.

3. Exploring different approaches to integrating different parts of the client's identity.

We continued to explore the integration of Mathew's different personas and we came to realise that this was not something that was going to be 'finished' in therapy, but would be an ongoing process in Mathew's life. Mathew felt that his new perspective on his personas was 'good enough' for now to start the process of integration in an organic and natural way.

The themes in relation to the methods being used that emerged from the transcripts were:

1. Normalising.

Normalising was important part of this process as we were to explore the concept of 'good enough' and that even though Mathew's new coping strategies seem to be effective and working for him, there would still be days where he could not cope one hundred percent of the time. We explored the fact that this is normal and that coping 'perfectly' was probably not really a constant in anyone's life. Additionally, the literature concerning HIV positive clients suggests that these clients needs can change over the course of a lifetime as new issues can arise that they have to cope with. Therefore I felt the concept Mathew's coping strategies being 'good enough' for now was important to explore as well as attempting to normalise that new issues may arise.

2. **Person Centred.**

Please see explanation of person centred therapy above

3. Solution Focused.

Please see explanation of person centred therapy above

4. **Exploring the client's coping strategies; movies, reading, cooking and performing.**

By exploring the client's coping strategies we were able to incorporate them into the client's new coping strategies. I feel this meant that these new coping strategies were relevant to the client and his life. I also felt that a consequence of this was that the client seemed to feel there were different choices and that these choices were flexible and adaptable to his lifestyle.

5. **Exploring new coping strategies; 'good enough', 'one day', and taking time out.**

We also explored the concepts behind the new coping strategies that we had explored. 'Good enough' is the concept that you can only really do your best and that this is 'good enough'. This concept also advocates an acceptance that your best really is 'good enough' under the circumstances. We also reviewed the concept of 'one day'. This was a concept created through our therapy where we decided that taking 'one day' every now and again for relaxation and joy was not too much to ask for and not too difficult to do.

CASE STUDY THREE: PETER

PROCESS ONE

ARE YOU WITH ME? : TRAVELLING TO 'PLANET PETER'.

The themes that emerged from the transcripts were:

1. **Exploring emotional and psychological experience**.

This exploration of the client's emotional and psychological experience was an important element of being able to 'travel to planet Peter'. It was a vital element of me truly understanding the client and it gave the client the space to explore his emotional experience in depth.

Cl. Yeah, but I just feel terrible. I just… (sighs deeply) I feel terrible. It's nothing that I don't know what to do about. I just, I feel, you know I feel, especially my physical being, I just feel like my body's so cramped up, its so you know…

Co. So your in… your whole body's sort of in pain as well?

Cl. Yeah.

Co. Was there anything that started this (says clients first name), was there anything …….for, five days ago that started it?

Cl. I don't know, I really don't know. I can't tell you anything… But am just in this mood, I just feel depressed and I don't feel like being with people. I just really don't want people any more.

Co. So you just feel like being on your own?

Cl. Yeah and… I can't tell you what started it. Am just, I just feel down and since I felt that way I've seen the increase in my, you know my health is just deteriorating and am feeling terrible.

Co. Do you know what started first? Do you know if it was the low mood? Or do you know if it was your physical?

Cl. Yeah I think it's my physical.

Co. So you start being very very tired and achy and the pressure and than you started to just get down?

Cl. (makes sounds in agreement) Yesterday I had a bad fight with my wife as well. It was one of those…

2. Exploring experience of HIV.

Being HIV positive was part of the context in which the client lived his everyday life and therefore an important element of truly understanding the client. The literature suggests that people's experience of HIV can differ hugely; as can the way that they incorporate (or don't incorporate) HIV into their experience of who they are.

Cl. Its really depressing, you know you don't, just, am somebody who (sighs deeply) am a jolly person normally, my mood, my job, sort of a character who plays, laughs with people, joke about and tease people but am not that kind of character if am, yes am, sometimes I'm you know I can be quite and I can be reserved to a certain level but when I open up I become silly and stupid…

Co. And fun

Cl. And fun and that's me but when am reserved, am just reserved and you know, but…

Co. You feel like you can't be fun at the moment.

Cl. I don't know how to get over. I just need to get out of this situation. I need this body to cope and be at its old state. I don't mind the HIV being I my body but I need it to be at its old state.

Co. What you just said there, you don't mind the HIV being in your body, but you just want to be at your old state…

Cl. Because I know I can't get rid of it.

3. Exploring physical experience.

Exploring the client's physical experience reoccurred several times in the transcripts, as it was an important part of his present experience. When the client arrived in the therapy room his main goal for therapy was to understand the symptoms he was experiencing and to reduce these symptoms. Therefore in order to truly 'travel to planet Peter' a shared understanding about his physical experience needed to be created.

Cl. And than am left with the question at the back of my head, feeling that (pause)… There's a feeling I get that you know like it's a pressure, like a feeling at the back of my head, but it doesn't occur all the time. It occurs sometimes.

Co. So it comes and it goes.

Cl. Goes, yeah umm when it comes it's really a bad feeling. Just you know you feel pressure, you feel like (pause) I just feel like am tired and am worn-out and you know. It's a bad thing, I can't even explain it.

Co. Yes cause it sounds like it's difficult to explain. It doesn't sound like it's a headache.

Cl. It's not a headache

4. Exploring identity and culture and family.

Peter's felt his experience of his culture and his family had a significant impact on his identity, his beliefs and how he coped with life. In order to facilitate this process of 'travelling to planet Peter' it was important to explore the context in which Peter grew up, the impact that this had and how it was now affecting his experience of who he is today.

Cl. So it means, it's only, it's like a proverb and its like, it states that you know, it's like umm that the more older you become, the more wiser you become. So it means in life you've got a way, you got experience and over certain issues you know and umm…

Co. So there is huge respect for elders.

Cl. Yes

Co. In your community, huge respect?

Cl. Oh yes, yeah, definitely yes.

Co. And it's very wrong to disobey, to not respect?

Cl. Yeah. You can't…

Co. You can't.

Cl. You can't because even my father before he died he say, he called me and he sat with me and he said 'you know am sick and I don't know what my time is' and he said one thing, 'am going, you're my last child and the only thing, advice I can give you now is that always when you see older people talk to them, sit with them, talk to them'. You might not realise that you get something out of them, they've got wisdom. You'll get knowledge imparted in you. I mean you'll get something, you'll just get something out of them that will help in the future. Sort of a guide.

Co. What do you feel about that? Does that feel true for you?

Cl. Yeah, I believe in it.

5. Communicating his goals for therapy.

Peter came into the therapy room with quite clear goals for his therapeutic experience. These goals were clear and complex. Therefore during Process One the client communicated these goals and wants to me which further facilitated my journey to truly understand what it was like to be Peter within the context of his life.

The themes in relation to the methods being used that emerged from the transcripts were:

1. Person centred therapy.

Person centred therapy allowed us to explore all the different aspects of the client's experience while creating an environment that was based on acceptance. I was mostly non-directive and allowed the client to lead the therapy in order to explore the elements of the client's life that were most relevant to him. This non-directive stance also allowed us to explore the client's goals 'as they were' at that present moment in time. Some of the main tools of person centred therapy that occurred in the transcripts were clarification, reflection, paraphrasing, empathy and unconditional positive regard.

2. Creating shared understanding.

Creating shared understanding is one of the aims of pluralistic therapy in order to create a therapeutic experience that is relevant to the client. Through creating shared understanding the therapist can most effectively work with the client from within their frame of reference.

3. Creating a relational depth.

By working towards creating a relational depth between us during this initial process I feel I was also working towards being on the same page as the

client emotionally. One of the client's goals was to experience genuine empathy and a sense of being cared for. I feel that relational depth includes truly understanding the client, feeling an authentic empathy for the client and the client feeling this sense of being completely understood in a way that helps them understand themselves with even greater depth. I also feel this relational depth strengthened our relationship and made the therapeutic space feel like a safe place.

Co. So you're not only left feeling incomplete, but your sad as well because you feel as though you haven't lived up to his standards. But you never wanted to anyways so it's kinda… (Client and counsellor start laughing slightly) I don't even know if am making sense right now am so confused… but there feel like there's a sense of sadness and confusion…

Cl. Am just laughing cause you hit the nail on the head

Co. Which part do you feel was the nail on the head?

Cl. Everything you said, you know it's just the truth and that's what I feel. Actually you know… it's what I feel and (sighs) I'll have to look for a way to move on, to let go.

Co. Well I mean at the moment its difficult isn't it? Cause it is so confusing it's… your dad had this treasure box of dreams for you, they weren't even the ones you wanted, but they were very important to you

Cl. Yeah because he made them important to be honest.

Co. Because he was important to you?

Cl. Yeah and I looked at it as a priority

Co.Yeah so this treasure box of dreams, that you don't even really want

Cl. Yeah

Co. You worked really hard for

Cl. Yeah

Co. And you got no recognition that you worked hard for

Cl. No

Co. And in the end you really… you don't have a treasure box anymore.

Cl. No

Co. But it wasn't the treasure box you wanted anyway.

Cl. No

Co. It wasn't (says client's first name) dreams anyway.

Cl. 208. No

Co. It was your dad's?

Cl. 209. Yeah (sighs). It absolutely was.

Co. You've lost something that you worked really hard for but never really wanted.

(silence)

Cl. Yes

Co. And you seem very tried again right now.

Cl. (Laughs and counsellor joins in) yeah now I can feel the affect of the…

Co. You can feel it now….. you mean the affect of talking about this on how you feel physically?

Cl. Yeah

Co. You are holding your head. You can feel the pressure in your head perhaps?

Cl. 213. Yeah. Wow. That's so strange.

4. Grounding technique.

The use of a grounding technique came up several times in the transcripts. Peter would become sometimes become overwhelmingly tired in the sessions; especially if he was discussing something that made him very emotional. This tiredness would sometimes be so overwhelming that Peter would have to close his eyes, his speech would slow down and there was one point where he fell asleep. Part of 'travelling to planet Peter' was understanding this tiredness and working with it in the sessions while also making sure that Peter was cared for. There were some moments when Peter became overwhelmingly tired that we would take a break. Other times, through exploring why Peter felt tired, Peter suggested that it felt like his body was shutting down to try and avoid talking about what we were talking about.

It seemed to be almost like a freeze or flight response to something that felt dangerous to Peter. It was these times that I introduced Peter to the grounding technique. I would ask Peter to put both feet on the floor and pay attention to his breathing. I would ask him to keep his eyes open and looking up. I then asked him to pay attention to his body and how it felt in the room. I then asked Peter to look around the room and name the things that he saw. This technique lasted no more than 5mins. Peter reported that when he did this in the sessions he would often feel refreshed, like he had had a nap.

Co. You're seeming really tired right now, do you want to take a minute like we discussed?

Cl. Yeah

Co. Yeah. So put both feet on the floor. Just put your hands on your lap. I just want you to take a minute. You can keep your eyes shut, doesn't matter.

Cl. Yeah

Co. And just breathe in through your nose… and out through your mouth. In through your nose…and out through your mouth. (Long pause) Now I want you to open your eyes, with your hands on your lap and I want you to say things round the room. So there's a clock….

Cl. Clock

Co. Just say things around the room

Cl. A board

Co. Yeah

Cl. Dustbin

Co. Yeah.

Cl. A chair, phone….

Co. Yeah.

Cl. Table…

Co. There is…

Cl. Chairs…

(silence)

Co. Ok. That seems to be it. Lets leave it there.

Cl. Yeah (Laughs)

Co. Umm yes I noticed you were getting very tired talking about your first wife.

Cl. Yeah

Co. It looks like that's a heavy subject to talk about.

Cl. Yeah.

Co. And I know today you're quite tired cause you've been rushing around but we'll do that little exercise whenever you need to, maybe we'll take longer next time as well.

Cl. Ok.

Co. If we need to. How did that feel for you?

Cl. Yeah was…

Co. Do you feel a little bit more in the room?

Cl. Yeah, much energized actually.

Co. Really?

Cl. Yeah (laughs)

Co. Interesting. All we did there was some breathing exercises and we allowed you to stop. It's called a grounding exercise and can sometimes help to relax and help you to come back into the room.

Cl. 96. Yeah. Well it did that (laughs).

5. Collaboration.

Collaboration is an important part of pluralistic therapy as it creates an environment where both the therapist and the client are working together towards a common goal. In this process collaboration was both of us pooling information together in order to create a shared understanding about what the client wanted and what his present experience of his life was like.

PROCESS TWO

PROCESSING THE NARRATIVES OF THE PAST

The themes that emerged from the transcripts were:

1. Exploring and processing the client's experience of his father.

The client's experience of his father was a significant aspect of the context in which Peter grew up. Therefore we explored narratives and experiences he had had with his father and then I would direct the session to processing the emotions within these experiences.

Cl. He was a jolly man. Having remembered, remembering him he used to be a jolly person. He used to sit with me for hours and have a chat with me when I wasn't in school, he was not only my father he was my friend. I mean we used to have you know normal chats and have fun, talk and laugh and he was more than a dad to me.

Co. You treasured him.

Cl. I did a lot. I loved my father dearly but the thing is you know we had a connection, we had that connection between us but the way he just left, it left me pending you know, am left pending…

Co. It sounds like your dad had in him because of the way he directed you, it sounds like he was like a treasure box for all your hopes and dreams. He was sort of in control of them but he also held them.

Cl. Yes

Co. And than when he died that treasure box closed.

Cl. Yeah

Co. And you don't really know where your hopes and dreams now are.

Cl. It's like he left me the keys somewhere and am looking for the keys.

2. Exploring and processing the client's experience of watching his family die.

This was a significant and traumatic experience within the client's life that occurred over a long period of time. It was an experience that contained a vast amount of strong emotions that the client felt he had not processed and were affecting his experience of his life today. Therefore we explored the content of these narratives and then tried to process and make sense out of the emotions within these narratives.

Cl. Because they thought I was just being lost and I couldn't see it. But you get, you put yourself in a certain, you know, you can enter a relationship you know with a clean hat, trying to be you know, just trying to focusing, to make it work. And then it gets to a certain level you come to understand that no matter how I try this won't work… But to cover shame and to cover, to cover shame you say 'I won't put my dirty linen' you know 'out in the community, so what I'll do, I'll try and resolve it. I make (incomprehensive speech) in my own way, in my own way.' So what I did, I think I did, I was in denial that I was being used... And I knew I was being used but I was in denial. So when she dies that's when I discovered a lot and a lot of things came out and even one of many things about her that amazed me, that even I didn't just know who she was. I was living with I'd say an imposter, it was just, and it really gave me that shock but not to a bad level but I came to realise I was in denial about the whole thing.

Co. Do you think you're angry at yourself, that you denied it or do you think you're angry with her?

Cl. Am angry at her… and am angry at my self because I would, if I had listened to some of my friends who said 'don't go out with this woman, she's not a…' maybe I would have not been in that trouble.

Co. And the reason, just to clarify, the reason that you didn't was because you were ashamed actually that it wasn't working and so part of the shame was that you were going to hide it and try and resolve it?

Cl. Yeah

Co. Within the family?

Cl. Yeah

Co. Because you were ashamed?

Cl. Unfortunately yeah, but it never worked that way um so you know my bitterness for her is when she died… when she died that money I never got to see. I had to bury her with my own, I had to borrow. I had to sell so of my things to bury her.

Co. That must have been so difficult.

Cl. It was you can't, I can't tell you, I can't give you that picture. I wish you would have been there to see what I went through and the shame and (sighs)

Co. This was a person that used you and than you had to sell your own things to bury her.

Cl. And people laughed at me in the community and people you know they just and it was (sighs)

Co. People laughed at you cause you chose to sell your things in order to bury her or that you chose to go through with it till the end.

Cl. Yeah I cause I chose to go through it. I just chose to be with her and I never listened to what they said

Co. So the idea of the community was, 'well that's your fault'

Cl. Yes

(a few minuets later in the text)

Cl. Yeah and so I couldn't understand why she… and on her deathbed in hospital I went and sat with her and said 'you know what I love you' and I knew the money I would not find, I knew she's dying. I looked in her eyes and I could tell she was going and so she said to me 'could you bring me bananas in the morning?' and I knew in my tradition, if somebody asks for certain foods

Co. Yeah?

Cl. They are dying. It's a way, it's a sign

Co. Really?

Cl. Yes

Co. If they ask for a particular something?

Cl. Yeah, yeah and mostly hey ask for a traditional food

Co. Oh right I see.

Cl. And that food that she wanted there was a certain way she wanted it cooked and it was from her own, you know culture.

Co. It's almost the memories, they almost connecting in back home

Cl. Yeah. That's a good way of putting it.

Co. By ordering the particular sort of….

Cl. Yeah so I knew she was going and I went out and cried and came back and I said 'alright I'll do it, I'll bring it' and I said to her, this is the most challenging part, I said to her, I looked in her eyes and I said to her, I said '(wife's first name) have you got anything that you want to tell me?' and I thought that even in her dying bed she would still go and open up and tell me this and that. She said nothing, she said 'what do you think I want to tell you?' she was becoming aggressive. And I said 'look you're sick, calm down, stop being silly.' And I said 'the reason why I've asked you this, is because sometimes people, you know there are certain things you go, you know people, there are certain things you find people would like to do, for instance they have time to prepare their lives, their death'

Co. Yes

Cl. 95. And you could see she did a lot on that panel of time, because she knew actually what she wanted to do and she knew she's dying. And here is somebody, you know you are dying and you know, you've got issues but the only person who's closest to you I believe is your partner. So somebody you are sharing your life with is the person you can tell you know here this is what I want you know and I thought that certain things, but I was asking in particular, I was, and I knew actually what I was looking for, I was looking for her to tell me 'please my husband forgive me, for I never treated you the way I should have treated you'

Co. And you were wanting to give her forgiveness at that point.

Cl. Yes

Co. And that would have made you feel better…. Sorry, better is the wrong word….. It's something you wanted to do as an ending sort of?

Cl. Definitely

Co. To forgive her before she died. You wanted that for you?

Cl. Yeah

Co. And to hear the sorry.

Cl. And I said to her, I was, I said to her, I said, it just came out of me and I said to her 'I love you despite what you've done'. I never said this before in front of her but I just said 'I love you' and I looked in her eyes and I knew she can see me and I knew she knew she wouldn't wake up out of that bed the next day but I said to her 'I love you despite everything and I don't like seeing you this way, it hurts me, despite our little differences' and I waited for her to just give me that, she didn't. She, and, you know, and this is the aspect more challenged that I want to go and study, how humans think because sometimes I can't understand how people think because am somebody who if I give wrong to you, am somebody who would go and sit and think about it and I would like to make amend quickly and see what can I do to bring that relationship and leave it at par… And so she just, she died but a lot came out, you know, so there is one friend of her, she told me (laughs) than I talked with her and I said 'look (friends name) do you think there's anything my late wife…' she only told me a few things which were silly but is not exactly what I was looking for.

3. Exploring and processing the experience of contracting HIV.

This theme was linked to theme the previous theme but it occurred in the transcripts as a separate entity also. We attempted to explore the content of this experience and then try and make sense of Peter's emotional experience

of it. The literature suggests that each person makes sense of their diagnosis in a different way and this can affect how they live with HIV in the future. Therefore this theme highlights our work trying to establish what having HIV meant to Peter.

4. Exploring and processing the experience of growing up within his family and his culture.

Cultural beliefs were an important aspect of how Peter thought about himself, his diagnosis and the choices he made in life. Therefore we explored these beliefs and his experience of being a part of his family and culture. While processing how he felt about these beliefs it became apparent that Peter struggled with the fact that he didn't feel a connection with these beliefs anymore and yet felt that he 'should' still follow them out of respect to his family. These feelings of dissonance made it difficult for Peter to make choices about his life that was relevant and important just for him.

Cl. I do accept because (sighs) if he told me not, if he had listened as a child, I mean to me as a child and listened to what I wanted to be and what I want to do I think you know it would have come to a compromise and he would have supported me towards my goal. That's what you do to a child, your own child.

Co. I also feel at the moment that from out last couple of sessions actually that, remember when we talked about the treasure box?

Cl. Yeah

Co. And we talked about the fact that it didn't really sound like you were treasured and you'd like to be treasured, you'd, you're a very sort of proud man who has certain standards and you'd like to be treasured for that.

Cl. Yeah, yeah, very much so.

Co. And that actually some of the standards that your dad um brought you up with, these inherited principles actually don't really work for you anymore.

Cl. No

Co. Yet you still feel like you have to meet them.

Cl. Yeah

Co. There's still a desire to meet them

Cl. 20. Um hm (agrees and sighs)

The themes in relation to the methods being used that emerged from the transcripts were:

1. Person Centred Therapy.

Person Centred therapy was used during this period of exploration and processing. I remained non-directive in respect to the content of Peter's experiences however; I became more directive at times in order to further facilitate processing of these experiences.

2. Bearing Witness.

Peter had never explained the story of his life to anyone in the depth in which he did in our therapy. Part of what he wanted out of therapy was someone to listen to his story and bear witness to what he had been through. Therefore this bearing witness was an important part of our work as it further facilitated shared understanding, genuine empathy and also allowed the client to hear his own story in full.

3. Mind and body monitoring (Rothschild, 2000).

The process of mind and body monitoring was an important part of our work together. While Peter was exploring some of the traumatic experiences in his life he would experiences physical symptoms within our sessions. According

to Rothschild (2000) people can experiences physical reactions to traumas. The theory is that the body remembers this trauma and continues to react. The body can continue to react as if it is still 'in danger' causing responses such as 'fight, flight or freeze'. The fight response is where the body is in a constant tense state ready to fight off danger, the flight response is where the body is ready to run from or avoid danger and the freeze response is where the body shuts down in order to disassociate from the experience (Rothschild, 2000). During one session during exploring his physical experience Peter suggested that his body felt like it was constantly scared all the time and that it was always preparing for a dangerous situation. This manifested itself within Peter's body as a tightening of the muscles, muscular pain and jerking in his legs. We also identified that when we were discussing events that made Peter very emotional that his body 'shut down' and this manifested itself with the reaction of wanting to sleep and avoid discussing the experience further. I explored Rothschild's (2000) theory about the body's reaction to trauma with Peter in one of our sessions and he felt that it very much fitted with his experiences. Rothschild (2000) suggests monitoring these physical responses and the feelings that evoke them or occur during them. The idea is that a greater awareness of the body and how it is reacting is created. Therefore we monitored these reactions within the sessions and Peter began monitoring them outside the sessions. This occurred throughout our sessions.

Co. I just noticed that when you're talking about your first wife and you were getting angry both your legs and hands were shaking

Cl. Yeah me too.

Co. Both of them shaking. That was one of the things we talked about at the beginning wasn't it? That your hands, that you had uncontrollable shaking?

Cl. Yeah but my legs, I think I shook them…. Or they shook themselves.

Co. Sounds like your not sure. Do you know why they shook?

Cl. Yeah… out of anger.

4. Narrative Therapy.

During narrative therapy both the therapist and the client take a stance of 'curious investigator' in order to collaboratively explore the client's life narratives. Part of narrative therapy also involves 'bearing witness' to the client's experiences (as discussed previously) in order to create an environment where the client doesn't feel alone with their narratives and it also facilitates deeper understanding of these narratives for both the client and the therapist.

Cl. That's very very good, very good, you know it was built by Canadians as a college but than they transformed it into a high school. So I found, one of the factors I found, it was funny, I found people being bullied and it um it was the culture anyway in secondary school for people to be bullied and you'd be bullied for no reason

Co. Just for the sake of bullying.

Cl. Yeah, the second year in high school, the bullied the first year, they would bully the first year. Everybody would bully you and so lucky enough I had a friend that went to the same primary that I found in this high school and he, he sort of you now, sort of stood by me, sort of not a lot of people bullied me. Understand the captain of the school liked me, I don't know why, he just liked me, and so he protected me, sort of. Some places I used to be bullied a bit, but some places I was never bullied. It was not a bad bullying because they would call you, you know, somebody would call you and they would just sing a song, if you don't sing they would hit you or somebody would just tell you 'give me your pennies and go and buy this, a loath of bread at the canteen school,' something which was not, the money was not enough to buy the loaf of bread.

Co. Right

Cl. And if you don't do that they'd beat you up, so it was sort of, you know silly bullying and I got to the second year, the third year in secondary I was assistant captain of the school so, and than I joined the club and I become the chairman and then from that I sat down with the, with some of the teachers and I sat down with the principle, and I sat down with the prefects and I said bullying would end and I would make sure it stops. We had six year six dormitory, and for me I was in the sixth and they were named after mountains in (Africa), so me I was in (can't be added for reasons of confidentiality) house and I my house, so I just talked to them, when the first years came I was assistant captain, so what I did I just said 'nobody was going to bully them', I made them relax and I made them feel happy and I made them feel at home. I said 'nobody is going to bully these kids, their here to study, their parents have paid money for them to come and live comfortably, just as we have.' And so you know if I found somebody bullying a first year which they used to call them form one, I used to call them in my room cause I had an office, sort of an old kingdom, and because I had power, I was allowed….

Co. You were allowed to do that.

Cl. I was allowed, so once I'd done that it stopped.

Co. It stopped completely.

Cl. People stopped bullying these kids, these kinds now the tendency was that they came to love me and they came to do their chores, cause in the morning we wake up five o'clock in the morning, six o'clock in the morning we had to go and wash the dormitories, make our beds, six thirty be in the bathroom, seven o'clock be in the dining hall, take our, you know, whatever it was to take, porridge in the morning I think, and than seven thirty we had to be in preps for study and that was the system and so the kids they tended to love me and I changed the atmosphere with my influence with other perfects,

we changed the atmosphere. When I left that year I found most of the kids were appreciating me and so I did understand them because I said I would not like them to pass what I passed through, because I felt there was no reason for bullying so….

Co. But not only did you not want them to do it, you wanted, you felt you had the power and you were able to change it.

Cl. Yes and I did

Co. And you did.

Cl. So you know that's one of things so I… It's being my nature that I am somebody who likes putting myself in other peoples shoes and I don't judge.

Co. I would call that a high level of empathy. I would call it a very high level of empathy and that sounds like that's something that is very much part of you and who you are. Does that sound right?

Cl. Yes. It's something just from me….. not from my father.

Co. It's always, I was just thinking, that's such a great story by the way, think that's something to be really really proud of that story, and its something that sounds to me, I've heard a lot of things so far about what your father wanted but I haven't heard a lot about you actually. I've heard bits and pieces about what you are like now and sort of that you are very proud and that you have standards, but the things I was thinking of through out this are that you're…. from that story that sort of says to me that you seem to be a leader, you're not a follower.

Cl. I've never been a follower.

5. Collaboration.

Collaboration within this process involved Peter and I sharing and pooling our thoughts about how to process and make sense of his narratives. We also collaborated on ideas to investigate his experience further such as monitoring his physical and emotional responses.

6. Grounding Technique.

Please see explanation in Process One

PROCESS THREE
EXPLORING AND CHALLENGING BELIEFS

The themes that emerged from the transcripts were:

1. Exploring and challenging beliefs about 'the self, the world and others'.

Through Process One and Two several beliefs that the client held about himself, the world and others emerged. The client identified that was questioning many of these beliefs because he felt they were created by his father, his culture and his life experiences: he wasn't sure however, if he truly believed them anymore yet he was living his life by them. Therefore we explored what these beliefs were, how they were created whether they were relevant to the client's life. We then began challenging these beliefs.

2. Exploring and challenging beliefs about emotions.

Through Process One and Process two we also identified that Peter had some strong beliefs about emotions. Peter identified that he felt emotions were 'dangerous' and he felt that expressing emotions meant that he was a weak person. He also identified that he thought that emotions made him vulnerable and that vulnerability scared him. Therefore we explored these beliefs in order to make sense of how they were created and whether they were relevant and helpful for the client.

The themes in relation to the methods being used that emerged from the transcripts were:

1. Cognitive Behavioural Therapy (CBT).

We used CBT to identify Peter's beliefs through the 'Thought Record' method and through exploration. We explored several of the traumatic experiences Peter had experienced in this way in order to identify the possible beliefs that had been created as a consequence. This involved exploring the experience, identifying any negative automatic thoughts that occurred during the experience and then the beliefs that were formed. We then tried to explore possible alternative thoughts and what the consequences of these thoughts might be (Padesky and Greenberger, 1995). However, I felt it was inappropriate to use this method with all of Peter's experiences. For example, Peter felt betrayed by his wife. He also felt anger towards her. We both felt that these were 'normal reactions to an abnormal situation'. I felt it was at the very least inappropriate to challenge Peter's experience. However, some of Peter's thoughts and beliefs that were a consequence of this experience were that he was unlovable, that it was all his fault and that he had betrayed his family. We both felt it appropriate to challenge these thoughts and beliefs as Peter felt they were unhelpful and were negatively affecting Peter's experience of his life today.

2. Empathy.

One of Peter's goals was to experience empathy and someone truly understanding his experience. Through creating a shared understanding in the previous processes I was able to show Peter this empathy in an authentic way. I feel empathy was also created and communicated to Peter through the mind and body monitoring within the session. Peter suggested that this made his feel as though I was taking his physical experience seriously and that I cared about how he felt both physically and emotionally.

3. Relational Depth.

Please see explanation in Process One

4. Challenging ego defence: splitting.

Through identifying some of Peter's beliefs about himself, the world and others it became apparent that Peter seemed to sometimes group elements of his life into either 'good' or 'bad'. He explored that he believed life choices, people, ways of living and emotions were either 'good' or 'bad'. This sort of thinking reminded me of Freud's thoughts about the ego defence of 'splitting' where someone will categorise things into 'good' or 'bad' as it is difficult for them to integrate experiences that may contain both 'good' and 'bad' elements. Therefore we explored what 'good and 'bad' meant and we tried to explore his experiences in a depth that assisted us to see the experience as a whole rather in than just in the categories of 'good' and 'bad'. This was also in order to further process Peter's experiences and further integrate them into Peter's whole experience of life so far.

5. Meta-communication.

Meta-communication can be defined as communicating about communication. In other words we would sometimes take time in the sessions to talk about how we were talking, or how we were exploring Peter's experiences in order to check whether the way we were communicating was helpful. This is an important element of pluralism as it allows both the client the therapist check whether they are working in a way that is relevant to the client and I found it further facilitated exploration about other possible ways of working.

PROCESS FOUR

CREATING TASKS

The themes that emerged from the transcripts were:

1. Inviting the client to explore an idea for a task.

This involved introducing the concept of a possible task to the client and inviting him to explore whether it was relevant, useful and possible for him to do or for us to do in the session.

2. Creating the 'Journal Task'.

I invited the client to use a journal that I provided in order to have somewhere to write any thoughts or feelings in between sessions. This was also to further facilitate processing outside of the therapy room. This task was also created and used to have somewhere the client could express difficult emotions. Peter found it challenging to show emotions and he suggested that the journal felt like a safe place to do this.

3. Creating the 'Activity Schedule task'.

The activity task was created in order to further understand Peter's overwhelming fatigue. This involved Peter keeping an activity schedule for a period of a week in order to assess his sleeping habits and where there was space in his week for self-care and time and space to relax. It was also created so Peter could further understand the impact of his week on his ability to function and live with HIV.

4. Creating the 'Meditation Task'.

This task was created as a way of meeting Peter's goal to understand his body and create space where he felt in control and relaxed. I provided Peter with a meditation CD and we discussed when he might be able to do this (with the help of the activity schedule) and where in his home he might use it.

The themes in relation to the methods being used that emerged from the transcripts were:

1. Brainstorming and Exploring.

Brainstorming is a method within pluralism to create ideas in a collaborative and creative manner. Brainstorming in this process involved me suggesting tasks and then both of us exploring how we might make them most relevant to the client, how they might take place and what they might achieve.

2. Collaborating on ideas about the task.

Collaboration about the tasks meant that both the ideas of the client and the therapist were melded together to create something relevant for the client.

For example, the client didn't feel the usual format of an activity schedule suited him and therefore he created something more relevant to his life. This involved the client using his journal to record his week in more depth.

PROCESS FIVE
MONITORING & CHECKING & MAKING LINKS

The themes that emerged from the transcripts were:

1. Hypothesis Creating and Testing.

This was a collaborative effort between Peter and I to create hypotheses concerning his issues, in particular hypotheses relating to his physical symptoms. We then monitored, tracked and tested these hypotheses and slightly adjusted them throughout the course of therapy.

Cl. It is, I've come to realise my anger comes from (sighs deeply) ….I think it emanates from again that, love. If I don't receive, if I judge, from my judgement, from my own judgement, perception, if I judge and see that am not loved enough in certain situation, whatever the situation may be, be it workplace, be it marriage, be it, and I feel a lot of pain and I feel a lot of sadness and sadness and pain. And so what the affect that comes out of it is that my body you know starts fearing what will happen and I think the body, am coming to understand it slowly, the body.

Co. You feel you are coming to understand your body.

Cl. The body you know the body….. my body is in fear …..what it does it tries to you know sort of umm build tension and against you know against the feelings and it's quite….. it's quite ready for something to happen all the time.

Co. I think you've just done my job for me there actually. That's a very interesting hypothesis of what you go through cause I can now, I can give you the words in psychology now of what that is and that is very interesting you've explained it that way. If I've got this right, you experience pain and sadness

and than you sometimes experience this in your body. Also you feel like your body is in fear and therefore it holds this tensions all the time. This response of the body, the body's response to fear is either fight or flight in psychology. The fight response is you stand tense and you stand tense ready to fight. The other response is to avoid, you'll run away (client laughs). It sounds like you're saying that your body is ready to fight, you'll stand there and you're ready to fight.

Cl. The adrenaline makes me ready. I feel like my body is prepared all the time….. it's exhausting.

Co. So what you're saying to me which I think is a really interesting hypothesis for us to go on because fight or flight response is a response to fear and stress in the body and is very physical. It is a physical response to an emotion and a traumatic experience.

Cl. Yeah. I've come to analyse and find myself that the anger I release from, from the point that am somebody who's, who likes you know taking things to a greater level you know despite that I cannot fight physically, I don't like physical fighting….

Co. No

Cl. But you now the anger and the, will just come out and I'll go… things will happen in my body….. like the shaking.

Co. You just held your breath there by the way.

Cl. Yeah. I feel like I need to take breath in.

Co. So your body is constantly putting or your body feels at the moment if we're going on this hypothesis we could suggest that your body is in fear.

Cl. Yes, it is

Co. Your body is afraid.

Cl. Because my wife did, she just held me three days ago. We went to the embassy, we want to register her about three days ago I don't know I went with the documents and I was, she had put them and I was removing them, I was showing them to this lady and fear just caught me and I looked in her eyes you know and than I just gave them and we talked and from there when we came out my wife just held me. She said 'honey why do you fear, sometimes I could see the fear in you, why?'

Co. She could see it in you?

Cl. Yeah and she said 'why cant you just be brave and' and I just in denial, in denial but in the end I laughed, I said 'you've caught me out'

Co. She really saw you in that moment

Cl. She did, she understands me, she's seen me several times lately.

2. **Monitoring and checking tasks.**

Part of this monitoring and checking was monitoring the tasks, checking to see if they were helpful and relevant to the client and checking if we had any new data to work with. For example, while Peter was continuing to do the meditation task outside of the therapy rooms we monitored his experience of the task and whether it was helpful. One of the consequences of this task was that the client felt a sense of some control over his body in that he could take time out to relax if he chose to and use the meditation CD. We were able explore, monitor and check this feeling in the sessions. By checking Peter's experience we were able to identify that even though Peter still had to live with all of his symptoms a sense of hope had been created through the task.

This was because it gave Peter the hope that even if the symptoms did not go away completely that he might be able to manage and cope with them.

Cl. Am tired, like I woke up, I can't sleep at all and I woke up four in the morning because am having these nightmares and I woke up four in the morning and I said, I went and took that meditation CD and I put it in and I tried to meditated and I did I went almost half way (laughs) and than I just slept.

Co. Wow, wow, so it was worthwhile for you?

Cl. Yeah

Co. It relaxed you?

Cl. Yeah

Co. That's great

Cl. I've done it four times and that's what it's doing. I just start, I go, I follow, I follow, I follow and than am gone.

Co. So how long does the CD go for before you…?

Cl. It's about… it goes about umm about fifteen minutes

Co. Wow, ok so just the first bit, where you're actually just going out to the sea, just going out to the ocean…

Cl. You're floating…

Co. When you're floating…

Cl. Yeah

Co. And than you're going down to the ocean

Cl. Yeah I go down and than I come back up

Co. You come back up?

Cl. Yeah, I get on the…..

Co. The raft?

Cl. Yeah

Co. And so at that point…

Cl. At that point am gone….. (client sighs)

Co. You're gone?

Cl. Yeah

Co. That's fantastic

Cl. Yeah

Co. So it seems that the mixture between visual, cause it's very visual isn't it? You can see where you are and story maybe?

Cl. And it's hard to visualize sometimes you know it needs a very I was thinking I would get something like a walkman and go out somewhere, like the park, somewhere quiet, sometime when am free and just go and sit somewhere. I'd need somewhere very quite for you to visualize.

Co. Sure

Cl. for you to, where you just can't hear no noise you know, where it's just… yeah for you to be concentrating cause even at that time cause my flat is just next to the road so….

Co. Right

Cl. And you hear (laughs)

Co. You hear all the traffic

Cl. All the traffic yeah

Co. But it sounds like it's, I like your idea actually of going to the park or something where it's very quite, that sounds like a nice idea.

Cl. It's a vey nice idea, somewhere because am a person, am somebody who used to stressed even back in Africa. I used to go out in the forest and sleep for hours and hours. I used to go and look, there was this specific spot that had a little waterfall and I would go and sit there for hours

Co. Beside the waterfall?

Cl. Yeah I would just go and listen to the water fall.

Co. Ahh it was the sound of the water falling

Cl. Yeah and than the birds and that you know

Co. How often do you get to go out it the park or just outside and just sit and be?

Cl. I don't do it anymore because of my schedule and its pathetic… now my body's actually tell me it wants a break. I can feel my body now, I know when my body tells me 'I need a break'. Even I told my wife yesterday, 'you know what if I had a choice I would even take a break for a week.'

The themes in relation to the methods being used that emerged from the transcripts were:

1. Mind and Body links (Rothschild, 2000).

Please see Process Two for a full explanation

2. Grounding Exercises.

Please seem Process One for a full explanation

3. Meditation.

Meditation was used as a task as described earlier but it also became a method that facilitated further understanding of mind and body links. Peter would use the meditation CD in order to listen to his body and his emotions. He would also use meditation to make his body and mind feel like they were 'on the same page' or working together.

4. Exploring hypotheses and tasks.

In order to create and hypotheses and tasks we explored possibilities. This involved exploring data that the client brought and data that I brought. For example we explored the client's physical experience and the ways in which

he felt it connected with his emotions. We then explored Rothschild's (2000) theory concerning somatic symptoms and tested whether this theory fitted with Peter's experience. From the amalgamation of the data Peter brought and the data that I brought, hypotheses and tasks were created.

5. Empathy.

Please refer to full explanation in Process Three.

6. Congruence.

Congruence created and environment where I was genuine and authentic with the client however, it was also a necessary method in order to monitor, check and make links within the therapeutic experience. For example, if I noticed Peter getting tired I needed to be congruent about my experience of Peter and check what was going on for him. This was particularly crucial in the beginning stages of monitoring and checking because Peter sometimes found it difficult to be fully aware of what was happening for him physically in the sessions; therefore it was important for me to be congruent and share my experience of Peter with him so we could explore it.

7. Transparency.

Transparency about what we were doing in the therapy room was important so we could effectively collaborate and create the most relevant therapeutic experience for the client. For example, I decided to share with Peter Rothschild's (2000) theory about some of the somatic symptoms that can arise from trauma and how these might manifest physically. This was so he could he could assess the theory and see if this theory was relevant for his experience. We were then able to make choices about how we might work together.

APPENDIX [4]

THE FEEDBACK SESSIONS

FEEDBACK SESSION WITH 'B'

After I had written the pragmatic case studies I had a two hour feedback session with B in order to hear his feedback about the case. This feedback session was seven months after the last session of therapy.

There were three main points that B made in the session. Firstly, B stressed the important of the initial process of creating shared understanding about what he was bringing to the therapy room. B stated that without this initial process the therapy would not have been relevant to him and he would probably not have engaged in therapy to the extent that he did. Secondly, B questioned my description of Process three (Becoming the client's student and challenger). He also questioned my description of our relationship when I explained that I felt he was in the role of expert. B stated that our relationship and Process three were more fluid and changeable than what I was suggesting. He felt that our relationship sometimes changed to me becoming the expert in the room and that this was something he valued just as equally. He suggested that our relationship moved between these two roles of 'teacher and student' and that because of the initial process of creating shared understanding he trusted in these changing roles.

B also stated that being able to be open about and work towards two contradictory goals was important to him. He felt that by acknowledging these two goals and my openness to work on both of them gave him space to explore why they were there and what he really wanted. B also suggested that my willingness to work with him towards both goals gave him the sense that I understood the complexities of his life and that this made the therapy more relevant to him. He also stated that by bringing in these two contradictory goals the therapeutic space reflected what was happening in his life and therefore he was able to explore what was really occurring rather than a version of it.

B stated that the case study was a good representation of what occurred during therapy. He also mentioned that it was a positive experience for him to

have our work recorded in this way. B also felt that the process of being a part of the research and being audio recorded made him feel that his story and our work was somehow preserved in a meaningful and honest way.

The following is sections from the feedback session about the main points that were raised by the client.

Co. Counsellor
Cl. Client

IN THIS SECTION OF THE TRANSCRIPT I READ FROM THE CASE STUDY ABOUT OUR RELATIONSHIP AND SOME OF THE TIMES DURING THERAPY THAT TESTED OUR RELATIONSHIP. I THEN ASKED B FOR HIS FEEDBACK.

Co. Yes and I think that disagreement that we had, and it was disagreement, we were not agreeing at that stage about…. what I thought was enmeshed and I was concerned for you, and you were trying to state, in fact I've gone in to that a little bit more in my case study, because my thoughts and my knowledge as you taught me grew about the relationship.

Cl. Yeah

Co. But as you taught me more, then I learnt more, there was, it was not so easy. It was not so easy. This other bit, I'm sort of interested to hear what you say as well. So I put down that there were two contradictory goals that became evident that we decided to work on.

Cl. That's exactly right and… that is exactly how… it is… today. But even more so in terms of the erm risk of safety to myself, but also wanting to protect my home, my family and myself and my property as well as Anthony's safety. And as much as I was being abused, I could also see that there was

someone in a lot of distress who needed help. And however much hurt I was having, I was his partner and… he needed help. And all I could do was do my best to ensure that… I couldn't help him.

Co. How does it feel to hear the case study read out to you in this way?

Cl. Urm… I couldn't have put it better myself .. is the honest answer. I think it's spot on. It is a, it is an extraordinary dilemma, and it is , for me it's a very real, tangle of so many emotions and there's a a kind of a, if you look at it very… take out any emotion, then there's a very simple answer, just walk away and it becomes easy. Or life isn't easy and sometimes you have to deal with very unnormal challenges. And some of them are beyond your control, like having blood clots in your legs develop or they manifest themselves within your partner who is clearly in a lot of distress because of his mental health

Co. Mmm

Cl. Which problem do you walk away from?

Co. Yes and I think that's what I, and what I said is that I eventually came to that. It's not even a conclusion. It's just seeing that there is a dilemma instead of seeing that there is a clear solution. And that doesn't mean that solutions can't happen, I'm not saying there is no chance of that. But I started to see the dilemma with much more depth and clarity than what I did in the beginning.

Cl. Yes

Co. Erm… yes. This is another point that it, this took me a while, that I, that I've tried to. I'll just read it to you and see what you think (READS FROM CASE STUDY) 'Even though B wanted to be taken seriously and respected as an expert on his experience by professionals including me, what he really wished for was someone to be an expert with him'. How do you feel about the way that I have coined our relationship as student on teacher?

Cl. It's really interesting, because I…. I think it fits sometimes.

Co. Can you talk to me about that?

Cl. Because of the trust and openness and the er non-judgmental empathetic way that we were able to communicate, then it felt that I was more able to be challenged, to perhaps understand in a different way, or see a different perspective on my experiences. So I didn't always feel that I was your teacher, but I felt, erm.. I did feel that you got me and that that was very important. And in order for you to have got me, it was quite simple that you had to really listen. And not just listen, but hear me. And you really did. And I… I know what that is, I guess it's the.. there has to be a.. a trust which creates a bond

Co. Uh-ha

Cl. Which then is kind of where you.. it becomes sort of… not tangible. There's a chemistry

Co. mmm

Cl. and that chemistry worked

Co. Sort of an intangible process that goes on

Cl. Yeah. I guess some people might call it on a different level like maybe, is this where you think of like spiritual connections, or those types of, erm…. Erm… connections that you have with people that you don't necessarily…

can.. people say 'I'm really connected with you"… but you can't really actually explain what it is…

Co. Right…

READS FROM CASE STUDY ABOUT PROCESSING SOME OF THE CLIENT'S TRAUMATIC EXPERIENCES SUCH AS HIS EXPERIENCE WITH DEATH.

Co. Any thoughts about that section? I could see that it was quite emotional to hear that back.

Cl. Erm… I don't know. It was like, erm, having to explain an experience that we are conditioned not to acknowledge until later life and to have the ability to go through that with someone was, there again was trust… there, but I actually felt from my point of view that there was… what was important was not that there was another human being listening to the story, but that there was actually a professional listening to the story and that professional was then going to take what I was saying in to the professional work place. So to me it felt an incredible… point because it wasn't like you were just another person I was telling a story to

Co. Right

Cl. It felt like I was telling someone who was working in the profession something that might influence your work and also your understanding of other people. So it felt like, yes you were the very much the friendly human being I was interacting with, but also the fact that the possibility you were taking this in so fundamentally that you were going to perhaps remember this in whatever aspect of your future work.

Co. It sort of sounds like

Cl. It wasn't just a moment that was secret anymore.

Co. So it's not a secret.. it almost sounds like having this written down, and read and recorded and almost researched is, I'm not quite sure how to put it. It sounds like it was a positive experience to know this was going to get written down and taken seriously and recorded.

Cl. I guess because what was, the fact that you recorded things and you weren't writing things down, made things a lot easier. Because actually I forgot the recorder was there.

Co. Yes so did I.

Cl. And so that made things much more easier. There was not a barrier. Because often if there's a barrier, a simple barrier like a piece of paper or a pen, it becomes very difficult to connect. But the fact that you have … listened and actually recorded what I have said and put it down in to paper is actually really, it's quite erm, I guess, very powerful. And really quite important.

Co. The recording of this is important

Cl. Yeah. Because it think it is actually a very important tool to have in therapy rather than have someone scribble notes, which frustrates me. And I guess that it was then, I knew, I forgot about it, and so the fact that it's then been written up in a very thoughtful and respectful way, which reflects very accurately what had occurred, is very comforting.

Co. It's very comforting

Cl. Because you make yourself so very vulnerable, because I'm bearing, I'm giving you. Again the trust is there, I don't know what you are going to do with this, but I'm trusting you. And for you to make the space today to feed back, it shows I made the right choice. It was the right, I've never allowed it before.

Co. I think it was, I definitely felt that pressure as I was writing it, to do justice to my thesis and justice to our work. That was definitely a pressure, and a welcomed pressure. Because I think it really pushed me to, make sure I encapsulated the experience of what we did together. And I think it is important to have what we did together on paper. And I think it's great to hear that it's comforting as well. And that's not actually something that I thought of, but it is, I can see

Cl. But I think also you have to, well you don't have to, to acknowledge the fact that because I have my memory problems

Co. Yes

Cl. To have these as I said before, I can certainly remember a lot of the feelings I had regarding our sessions, but I can't honestly remember, I can't remember that we have discussed perhaps all of the things that we…

Co. Yes

Cl. So for you to erm… have such an insight, it's actually really quite fascinating. I can't really explain, it's hard, because I have memory problems and you're reading back me and its making me recall things in a quite positively.

Co. So this feedback session is actually…. It's a different session entirely. It's a different session entirely because it's not necessarily counselling, but there

does seem to be some element, it does create some comfort hearing this back.

Cl. Yeah

Co. Or some sense that I… knowing you, or understanding you?

Cl. I guess that you take a risk and put your trust and be open and vulnerable with the approach with the therapist and then they tell you that they are taking it for their research and you hope they do the right thing with it.

Co. Sure

Cl. And so the fact that erm this.. and I may never have even had this moment, but the fact that this seemed to have.. amazing amounts of synchronicity involved considering what has actually been going on recently. So it's almost reinforced the connection that I felt was so valuable at the time. Does that make sense?

Co. Yes it does. And I think I am definitely getting the sense, and I had the sense all the way through, that this was an important part of the process. Because you have trusted me with so much, and so much has been recorded that this was definitely an important thing that I wanted to do. Because this is our work. I wasn't in that room on my own. This was our work.

Cl. And the point that you have made is so comforting because although it's never been a point that I want to harbour on about, but it's such a crucial point that I have faced times when my mortality was there, it's impacted on my life so significantly the fact that you have said actually I've, this is something I want to focus on because I felt it was a really significant point, reinforces, yes she got me. Because you are absolutely right. It was, it is.

READS FROM THE CASE STUDY ABOUT THE PROCESS WHERE THE CLIENT IS THE TEACHER AND THE THERAPIST IS THE STUDENT

Cl. I think I'm struggling a bit with the teacher.

Co. Mmmmm

Cl. Don't know what. I… I don't know why.

Co. Mmm. how does it feel when I say it to you?

Cl. Because, erm… it feels erm… I guess because of my own experience of the teacher role is my own, is my own, I have my own feelings about that and I can't relate that to this because I didn't feel that. But I certainly perhaps felt like I was… the more of the expert in the knowledge and experience that I was trying to communicate to you and you were prepared to learn and yes you did challenge that but I never saw it as the teacher thing.

Co. I think what you are saying to me is it sounds like you are saying the roles of teacher and student don't feel comfortable to you or a comfortable representation but what you are saying is you certainly felt in the room that you were an expert?

Cl. Yeah

Co. On your own experiences and I was prepared to learn.

Cl. Because then there was times when you would challenge me and then you were the expert.

Co. Mm

Cl. And then I had to be open to be challenged.

Co. Yes. And I guess this is going back to what you said the first time when I first said this to you, this teacher student relationship, but yes but sometimes it was the other way round. Yes that's certainly something I'm going to add.

Cl. Because you… achem… erm… it's hard to try and put it down, but you are the expert as well in your field and bringing so much in to the room and it think I remember saying to you never underestimate what…

Co. Mm

Cl. Coz I remember I think there was a frustration may be in the early stages that you weren't quite sure what was… if you were being… I think you were, I was benefiting far more than I felt that you realized and I don't know if you really took that on board as a professional actually you were doing far more than you…

Co. So what you are saying maybe my coining of the phrase teacher and student erm also has a flip side to it, and actually the role even, doesn't feel, maybe it's the unbalanced power of the relationship like it's a student and a teacher it doesn't feel like it's a balanced relationship,

Cl. I guess the .. with me particularly, power has always been an issue that I have struggled with…

Co. Yes

Cl. … so the fact that the power seemed very evenly balanced in the room… was really important. And so to, this is where that, for that order to work, erm, it had to be that power had to be able to shift

Co. yes

Cl. it had to, there had to be the space to allow it to shift, the respect that it would shift, the trust that it would shift…

Co. so you are saying, this, what I have coined the relationship, was actually far more fluid and changeable than the way I'm putting it.

Cl. Yep. I think it is. It feels far too rigid. Because I understand why you are saying it, completely. But I think it was much more of a, much more, erm… pliable thing. It was, and it shifted… depending on what we were discussing and how we discussed it.

Co. That's really interesting feedback actually.

Cl. Not just what I was bringing to the room, but what you were bringing to the room.

Co. Yeah. That's great. Thanks for that.

Cl. Does it make sense?

Co. It makes lots of sense, and that's far more rounded, and three dimensional version, of what I have written actually.

FEEDBACK SESSION WITH MATHEW

After I had written the pragmatic case studies I had a two hour feedback session with Mathew in order to hear his feedback about the case. This feedback session was seven months after the last session of therapy.

There were four main points that came out of our feedback session. Like B, Mathew also stressed the importance of the initial process of creating shared understanding. He said that it felt like I had a good understanding of the two personas he brought in and that this was a vital foundation for the rest of our work. Mathew also discussed the tasks and stated that to him the tasks represented challenges and they opened up possibilities. He said that today he still uses versions of these tasks as coping strategies. Mathew said that when he is feeling low in mood and motivation his mind sometimes goes into a period of hopelessness but sometimes his low mood triggers what we did in therapy and he begins thinking about what 'tasks' he could do. It seems Mathew is suggesting that he now creates his own tasks.

I discussed my experience of our relationship by explaining Process Two (Creating tentative hypotheses: two scientists working together towards a common goal). Mathew felt a consequence of this relationship was that he started to 'tap into' his own strengths. Mathew explored in the feedback session that during therapy he realised that he had all the capabilities needed to cope with what he was going through. He created a beautiful metaphor to describe this. He suggested that it was like he had all the capabilities in his hands but that anxiety, stress and depression had put boxing gloves over these capable hands and he couldn't do anything. Mathew stated that therapy helped him to take off the boxing gloves so he could use his capable hands again.

At the end of the session Mathew started exploring the concept of creating shared understanding even further. He explored that because he is in his fifties his experience of HIV is very different from this generation of people contracting HIV. He experienced this illness when it killed people. He

watched many of his friends die. Mathew discussed feeling like he always had to be 'over prepared' in case he gets a cold or becomes unwell. I feel he was stressing the importance of understanding the client's relationship with HIV. I also feel he was saying that the anxiety and stress he feels about being 'over prepared' is real and comes from his personal experience.

Mathew said that the case study was a good representation of our work together. He requested some changes to the biographical details and these were made.

The following is sections from the feedback session about the main points that were raised by the client.

Cl. Client
Co. Counsellor

I ASKED THE CLIENT WHAT IT WAS LIKE TO BE IN THERAPY.

Co: Erm, I guess there's one question I really want to ask you to explore with me and I you know it doesn't matter if it takes you a few minutes to think about it, the only question I have before we move on to other bits of the case study, if you could describe what the experience being in therapy was like at that time.

Cl. Erm, at that time, the first thing about being in therapy was like, I don't need therapy,

Co. Mmmm…

Cl. Erm is, I would say the first thing because in the past I have always had coping skills, there's always been a shell that dealt with everything,

Co. Yes

Cl. From there, it's like what am I in therapy, I don't really need it, but at the same time, there's a part of me saying you do, and to be able to let the shell down, open out, yes I do need help, and then actually go in to therapy was a major, erm, turning point, I would say, because up to that point, it's like, and because from the Caribbean side, it's like you don't….

Co. Don't ask for help

Cl.…air your dirty linen in public. That's a, so you've still got that to cross. So to be able to go cross that barrier, was a major hurdle, but I feel it's been a better, been better having done that than not doing that.

Co. I think that's what I found even in the first session when you first came in, your, maybe because the biggest hurdle in therapy was getting to the room, was actually getting there and asking for help. Because when you arrived, you were very ready to work immediately, and seemed to have a strong idea about what goals you had for our work.

Cl. At the same time, I said, even on our first, don't forget there were two personas you had to extract from the other. There is an instance, like 'oh yes, I'm fine, yes yes'. And it's like, deflection, deflection, deflection, and it's only when you can see through the deflection, er one second, no.

Co. So , what you are saying to me is, we really had to get to know you first before any work could start. Because it's actually quite complex.

Cl. Very complex to get through, the initial sort of like, ok yes I'll come to therapy, but there's still the, it's a big ask, and its breaking through that.

Co. Do you remember the day you came in and you were overly cheery and I said "are you being overly cheery because you're sad" and you said "yes".

Cl. And that's where it's, it was a case of going, 'ah bless you'. Because in a way I had prepared you, or made you aware that there was this other side,

Co. You did

Cl. Coz I knew that, if I didn't say that, it would be just 'oh no no I'm fine', we wouldn't have progressed.

Co. No, I agree. But you're saying the work could never have progressed unless I got to know you first?

Cl. That's it. The therapist I had before hadn't quite, I tried to explain it, but he didn't quite get there.

Co. How do you know that I got it?

Cl. Erm, well you asked me

Co. When I asked you if you were really sad even though you looked happy?

Cl. That's it. It's a case of like…. Woooow. Ok, right, um, this is something different, just let it go.

Co. So, it was…..

Cl. It was a couple of weeks in, it was a case of like, yes I will tell you there are two sides, and I will try to open up, even so there is still going to be a bit, and when you can, after a couple of sessions, you were able to gauge how I was there, and you could actually figure, ah ha bing, and that was when….

Co. So you knew that I got it when I noticed you, I said, "you're speaking like you are really happy, but you seem really said" or when I said "you know, sometimes you put your hand on your heart when you talk". Was it that sort of noticing?

Cl. It was that sort of noticing… that it was a subtle thing that you picked up on and went, "ah ha that's something.. I will question you on, that's somewhere we should go, I started over here and you move over to that. So therefore you picked up on my avoiding techniques, you're avoiding, so I will bring you back…..'

Co. So you felt I stopped you from avoiding

Cl. Yes, very much so,

Co. And that was actually one of your goals that you said to me in your first session, that you wanted to stop avoiding.

Cl. Yep, and by stopping avoiding, I was confronting things.

I READ FROM THE CASE STUDY ABOUT THE TASKS AND ASKED MATHEW ABOUT HIS EXPERIENCE OF THE TASKS.

Cl. The experience of the tasks, because it was the fact of not being able to allow myself time to enjoy just being me, so being able to say 'no this afternoon I will go to the park and sit down and have a bit of a picnic, maybe

read, enjoy the sunshine. Get myself out of my own of my immediate environment and just not worry about anything else and just enjoy the moment outside, and to be able to just like enjoy having a picnic or reading a book outside, that was what was so good. And the fact of being able to do that, and to allow myself to do that, because I think a lot of the time, because there will be other tasks around me, I should be doing this, I should be doing that, I would do nothing. And then when I did say, no no I will allow myself that day, where I will go outside and have that picnic, that was a change because it allowed me time for me.

Co. I think we almost had to put you on your list of things to do

Cl. Yes

Co. Because your list of things was always quite large

Cl. And it was always involving other people and things, rather than me

Co. And to other tasks, so I think by putting in a task for you to do

Cl. And then I was able to just, you know, in a way I could switch off. Not realize that I had switched off, and not realize I had switched off, but at the same time enjoy the fact that I had been able to switch off and not have to worry about anything else around.

Co: It almost felt like you weren't being allowed, because you had so much to do

Cl. Being allowed, that's it. It was always trying to figure out, you can't just enjoy that, you have to keep on doing things rather than no take time out for yourself.

Co: but this was the thing with the THT. Because it wasn't getting solved, you kept saying to me, no I can't until this is finished.

Cl. Yes

Co. I can't until this was finished. But eventually you, we reorganized your week in a way, do you remember the phrase, me using the phrase good enough.

Cl. Yes, it was case of, the fact that it was sometimes, things won't always reach the end, but it's good enough to leave it for now, you've done as much as you can do, it's up to them to follow up, and you can force them to follow it up, you have to say, look I've done everything I can do, it's now in their hands, don think about. Which is good enough for you to then have time for time out. And that was a major thing, it's the fact that, "oh no I've sent them the stuff, they should have sent it back", and so it was the worry that was building on that, which built on to the anxiety. As soon as I could let that go, and say they've got it, and I can't do anything more at the moment, and therefore leave it with them, and maybe after a week if I hadn't heard then get back in touch with them, but at least you know you have done that point, which is enough for you to do. You can't constantly be there going, oh my gosh oh my gosh. It was allowing myself the erm… ability of being able to say, "no, ok it's theirs. It's not for you to worry about now"

Co. So are you saying that the tasks that we did do erm in a way challenged your way of thinking?

Cl. It did because it was always the fact that I always wanted to… if there was a task that wasn't completed, I would still want to get everything even if it was out of my hands at that point, it was still that I needed to complete it. So being

able to say it was in their hands, you can't complete it, they've got to do their bit. Once being able to allow myself, I can now say, that's stop now and I can move on to something else. I can maybe have some time to myself, but I can enjoy. And that was being able to, that was one of the major things that you were able to do .

Co. Was to put a bit of joy back in?

Cl. Rather than a constant, that hasn't been done… everything may not have been in my hands to complete. But it hasn't been and so therefore I always want to take it on board. So to be able to…

Co. Let it go….

Cl. Yes, let it go….

Co. Erm… I have talked about the tiling task and I have said in the case study that it gave you a sense of accomplishment and peace…Is this an accurate thing to say?

Cl. I still do.

Co. You still do… do you really?

Cl. Yes. It is, it's like every morning, oh, that's done, that's fab. And it does give a little boost in the mornings. And it does, it's just that little moment, yes ok. And so that's a major plus that's always there. It's a little boost that something that's always give me a bit of joy.

I READ FROM THE CASE STUDY ABOUT CREATING HYPOTHESES TOGETHER ABOUT MATHEW'S PERSON'S AND ANXIETY.

Cl. Yes, because the two dichotomies of the two characters was very very different. And always having like on persona on top of the other, which although is all me, is still moments every now and then you go, mmmmm, I still feel although, I also think it's an age thing, an age and cultural thing, to a certain degree. I think the strength of 'Raven' comes mainly from Dynasty and Dallas who had mainly strong women.

Co. Yes

Cl. And they were able to do what they wanted. That in the background as well. Whereas with me I'm always thinking 'oh no, I've got to be liked, everything's got to be perfect'. Whereas with 'Raven' there was that ability to be, coz it was a character, so therefore that was fine.

Co. And I recognize that as I was reading through our sessions, your goals for your identity changed during therapy. At first, your first goal was to put Matthew, you wanted Mathew to be in front and 'Raven' to almost go away a little bit.

Cl. To a fair degree..

Co. To step back were your words

Cl. That was it.

Co. And then it changed

Cl. To be more a part…… Yes, there the same person, but being able to have both aspects. I think we worked both goals, I think it was initially the fact that Raven being very much in front, it was very scary to bring Mathew forward, so I felt in a way I was being pushed to bring Mathew forward. But

towards, as we worked on par, I think we were matching quite well, Raven's always been the one that's been the major person in front.

Co. Do you feel I was challenging you to bring Mathew out?

Cl. Yes I think so. It's good in a way that you challenge me, so therefore I was able to reassess. Otherwise it would be a case of push Mathew to the front, everything is Mathew, everything is Mathew. And I wouldn't feel comfortable. Because Raven has always been at the forefront. Stripping away everything, and being totally bare, and not having the back up in a way,

Co. Yes

Cl. because even though the backup was there because it's all part of me, its wouldn't feel being able to fit in.

Co. so are you saying if maybe I had, because obviously I needed to get to know both characters, and its sometimes difficult to get Mathew out, although you were very open as well, it was an interesting mix. Do you think that, it sounds like what you were saying, if we had been working on what I thought should happen in therapy….

Cl. It would, I think you would, you would, dissipated. Because it would have been too scary, I think. But erm as time grew, as time went on, it was good to be challenged, to bring Mathew forward, but at the same time, it was maybe the fact that I was trying to push too far as well. You were just gently bringing me forward and I was like 'oh no, I've got to push him forward, push you forward', agh no I cant, it's like, blur, and so recoil a bit, getting a balance between the two, that's where everything started going 'oh yes, it is the right thing to do'. It was gelling much more. At first it was more of a shock to the system. And then being able to bring it so it was actually something that could work.

Co. Something more balanced.

Cl. Yes.

I READ FROM THE CASE STUDY ABOUT MATHEW'S ANXIETY AND WHETHER WE REACHED HIS GOAL OF UNDERSTANDING IT AND COPING WITH IT.

Cl. I've learnt… through our sessions, when things are going wrong. And there are little points that go ping, like an alarm going off, very quite at first, but it gets louder and louder and something will kick in

Co. And how do you think the therapy made you more aware?

Cl. I think therapy enable me to know that certain things, when they kicked in, it was like, this is your alarm system going off, whereas other times, to a certain degree, somewhere in my subconscious, it automatically went, 'oh' moved on to another direction, a little path, but you weren't dealing with it. When we set up the little systems for coping, ah an alarms going off, you may be going off in that direction, there's an alarm going off, we'll flag it up, and then maybe you'll come back and go 'ah ha I see what's happened'

Co. What I said is, what I've talked about our relationship almost like at times, two scientists working together, or two therapists working together. I found that both of us started to study what you did, how you coped, and then we both started rearranging it.

Cl. Yes. That's it exactly. I found it easy to look outward but looking inward was very hard. I was always able to look out and go 'I can see what your problem is over there' but somehow I could never turn it back on myself.

Co. So you think that the therapy helped you to

Cl. .. be able to look at myself, rather than always look out. And therefore by able to be looking in, I was able to say 'ahh that is what is happening', and therefore be able to build or face certain anxieties or certain things that were bring you down.

Co. How do you feel about me saying that our relationship was like, at times, because at times I think I was very challenging as well, but was at times like two scientists, two therapists, working together?

Cl. I think that is very much so. Because I feel it was that sort of thing. Because there are a lot of good things that I know are in here sometimes, the solutions, but it is not always being able to get them out. It's like I mean to describe it, it's like a whole load of telephone wires, and having boxing gloves trying to. And that's the sort of thing, I can see a similar sort of thing, it's like building a house, and you've got all the tools and you know how to put it together, but for some mysterious reason it's not connecting, being able to, so you need someone else to say, I know what's going on here'

Co. So did therapy… how did it make that process easier?

Cl. It made it easier as in the case of having boxing gloves on me, ok 'now Ill undo that boxing glove so you can put that hand in there and twiddle that wire in there'

Co. What's the boxing glove represent do you think? Taking off the boxing glove?

Cl. Taking off the boxing glove represents it's all fuzzy up there, the tools… you have the hands to be able to do that… but for some reason you're

completely clouded, by the boxing gloves, the bigger they were the more clouded you were. That's what I need to be able to do that.

Co. I think that's a really great explanation. Because I do feel that, I feel like you've had all the capabilities there, and it's not because you didn't want to use them, it's because you had boxing gloves on, you know. It was very very difficult….

I READ FROM THE CASE STUDY AND ASKED MATHEW'S VIEW ABOUT THE CONCEPT OF CREATING SHARED UNDERSTANDING.

Cl. You needed to know the real me rather than the façade that everyone normally sees, oh no, there's two personas, there's Raven the outside, and Mathew the inside. And it's being able to go inside and be able to actually go in and tweak and go, ahh, this is what we need to do. And to be able to do that is when therapy is going to work.

Co. so once you feel, once we had that shared understanding, that's when we were able to work, not before.

Cl. It's because… it needed that, because there will always be that initial 'oh hello, yes I'm fine'. And until you could actually see through that, that's when, …to be able to allow, … to … from the start to be able to say I need help, there are times when there would be the persona, and there will be…. And if you can see through that persona, then we'll be ok. And if you can't see through that persona, it wouldn't have worked.

Co. It wouldn't have worked.

MATHEW AND I DISCUSSED HOW HE IS COPING TODAY.

Cl. And I think that is the thing that has been, although recently down, I think has kicked in again, so therefore it is still there, the therapy that we actually did last year is like 'oh ok, it's going ping', it may, the moments where it seems

to be in the background, but then something kicked in. and because something kicked in, therefore going 'aaaagh', so therefore we were on the right track, we have had… it's utilizing the skills that we built up together, that therefore I'm able to access, those moments where you think 'oh no', it's because there has been the outside, from your help, it's not just me going round and round in circles, which it was before. Before therapy it was me going 'I'll analyse this', and I'll analyse, analyse, analyse.

Co. So how is it different now?

Cl. Now it's because we've been able to explore various different ways of coping, I'm able to look at things in a different way, I can think 'well normally I would just analyse and analyse, but one second… when we were in therapy, we did… agh, maybe rather than analyse and analyse and analyse, why don't you go down that road?". And I will try a little therapy that we tried, and things will kick in and 'oh, yes' and that's where the strengths lie now, whereas before I don't think they were there. Because it was, in a way, a destructive cycle…

Co. Yes – it just keeps spiralling down

Cl. And that said, there would be moments where things would kick in, for instance 'oh, I just suddenly watch films', no wonder why… oh. And it would be somewhere up there it will be 'you needed to do this to get your mind off that'.

Co. So what you are saying is almost sometimes, not all the time, because in fact lately it's been very difficult for you, particularly it's been very difficult for you coming up to the anniversary of your mum's death. But there has been times where you have almost automatically used coping strategies when they've been known

Cl. That's it. That's exactly it.

Co. Coz you know you've got to do something different, or add some joy, or take a moment… Great.

Cl. And it think that was something that came during therapy, it's like being allowed myself to have those moments of joy. Whereas before it may have happened and id be thinking I'm doing this, but I should be doing that, rather than enjoying that moment. Whereas actually, by doing this, you are actually having this moment, and your minds off and you're concentrating on what you are doing there. From there it allows me the ability to say 'yes, it happened that moment' and enjoy it, and not something like 'I should do this' and create that anxiety.

Co. How does it feel to talk about all of this today right now?

Cl. Erm, it's weird but at the same times it's very good, because …

Co. Is it reminding you?

Cl. Its reminding me a lot what we talked about, and in a way it's refreshing some of the things that may have slipped a little bit, and it's a sort of , it's that moment 'one second, oh yes, we can pick up that', I must admit in the last couple of days I've read a couple of books straight off, because I think that's also partially because I was quite down, but it was also 'switch off', you need….

Co. You need to take a break

Cl. Just take that moment. Literally two books in a two days, no a day and a half.

MATHEW THEN STARTED TO TALK FURTHER ABOUT THE CONCEPT OF CREATING SHARED UNDERSTANDING. HE STARTED TO TALK ABOUT HIS EXPERIENCE OF HIV OVER HIS LIFESPAN.

Cl. other things, because when it first started, at the beginning

Co. when there's nothing

Cl. there's nothing, and you are seeing your friends die left right and centre,

Co. yes

Cl. it's like, when am I going, when am I going?

Co. This is the thing that I'm writing in my thesis as well… , we didn't talk about HIV that much. But the fact of the matter is, with HIV, it has been linked to periods of depression and stress, because there is so much you have to do. And there's so much, you have to be a scientist and a doctor and a therapist and an organizer.

Cl. That's right.

Co. And making sure everything's online all the time, just in case, because you are more vulnerable, physically... not physically, but your immune system is more vulnerable

Cl. It is, it is… and it's trying, and also that it's going at the benefits system, 'you're a single person, oh right' and it's like, the incapacity stopped and I had ESA and it didn't come through, and I had to get a crisis loan. So I phoned up for a crisis loan, and say we've had a cold snap, my electricity is off, that

means everything is off. They then say fine we will give you a small crisis loan, but they didn't give me the top amount that I'd asked for two weeks, so of course my electricity went out again, the food that was in the freezer….

Co. And then you've got to go back to the beginning

Cl. Went back to see them and said you know it's not quite made it for that period of time, (a) it was a very cold snap and because I'm all electric I have to keep everything going and of course it's like 'no', you don't and then the following week it's like 'yes'…. and they adjusted it

Co. This is the thing, I think that part of… part of also being HIV positive I've heard from clients and I think I'm hearing from you in a way, is that it's an invisible illness. You look well, and you can seem very well, and seem very capable. But the thing is its , just because you don't necessarily look like your immune system is vulnerable and having no electricity for a week is a big deal, it's a big deal, and it's.. it's also because you know, I know that you would, your body would react physically to stress and depression as well. So you do have to be your own scientist and your own expert. And it's a lot of work.

Cl. but things happen, like for instance I know that if I'm over stressed, I get herpes attack and that's the instrument. I think 'ok, I'm having a herpes attack, I'm over stressed, why am I overstressed ? It's trying to….

Co. You diagnose it…

Cl. It's instant diagnosis, you have to be able to do that.

Co. And I think this is what I'm really talking about in my thesis and my case studies, is I'm trying to say that actually… and maybe you can give me what your feedback is on this, is that in the beginning when you are working with an HIV positive client, it's a really good idea to sit there and listen because they are actually more of an expert than you

Cl. They become more of an expert. And also because it's also age group as well. Because I'm 50, I've seen it from the start. And I've lost virtually the majority of my friends.

Co. So what HIV means to you is very different to maybe how it means to me?

Cl. Because the young generation is like 'you've got drugs now for it', but things I'm thinking is the point is this kills. When I was first on the scene it was killing my friends, and I saw it killing my friends, and I went to so many funerals, it got to the point where you couldn't cry anymore. Every week you would be looking in the papers or every day, it would like 'so and so died' and you went 'oh, why haven't I got it, or when am I going to go.

Co. So because this illness has changed, and developed, and there is still a lot of stigma an there is so much that goes with it, you … yes…

Cl. It's still very very hard to be able to deal with all the aspects of it.

Co. And I'm not going to know all the aspects that you, Mathew, needs to deal with, unless I, unless I sit there and listen. If I came with all my knowledge of HIV and put it on to you immediately thinking it would be all very helpful…

Cl. I could still say there is more, there are aspects, there are still the emotional aspects of the baggage of my age group, that we have on board, that younger people don't have.

Co. So you're saying that the part of the baggage of HIV and your age group is the fact that this did kill people, and that won't go away in your mind, and that won't go away no matter how many drugs come forward.

Cl. That's it. I mean, we seem better, we live longer, but the thing is the stresses are still there. And because it seems more erm… I suppose.. treatable now, it's not …so serious… whereas before it was 'oh my gosh'…

Co. Still very serious to live with it though…

Cl. It's still very serious to live with it and it's been sort of lessened as a an actual illness. And that's the problem, because people are sort of 'oh, don't worry about it'. And it's like 'no, this still kills', and if the right things aren't in place, it will kill you. Because your immune system, it's the slightest thing, you can I mean.. like… whatever.. you are more susceptible than someone else. You can catch a cold and it can lead on to something else if you are not properly prepared. And that's one of those things that doesn't seem to click to a fair degree in the younger generations mind, because it's treatable and you get the drugs and that. The point is, if you get it at the wrong point, and you don't have the back up, then….

Co. I guess what you are saying is the uncertainty and the unpredictable nature of it

Cl. Yes

Co. That means that you have to be prepared, you have to be actually…..

Cl. Over prepared

Co. Over prepared, and you have to be an expert on you all the time

Cl. That's it

Co. Otherwise…

Cl. You're… I mean you could have a cold, and that could actually affect you, when you sneeze on the next person, nothing happens to them, but because your immune system is damaged, it might be, you are overly stressed, that will allow even more pressure to you. So it actually becomes 5 times or 10 times worse than the average person. But it doesn't correlate with most people, because it's like, oh, oh…

Co. It is part of the reason why you are busy all the time.

Cl. Mmmm

Co. You have to work. It's almost a full time job keeping everything going to make sure you have the ability to be prepared.

Cl. That's it. It's a very hard thing to do. But at the same time, it also becomes second nature to a certain degree.

Co. But then there are going to be times when you are going to get tired from doing all that…

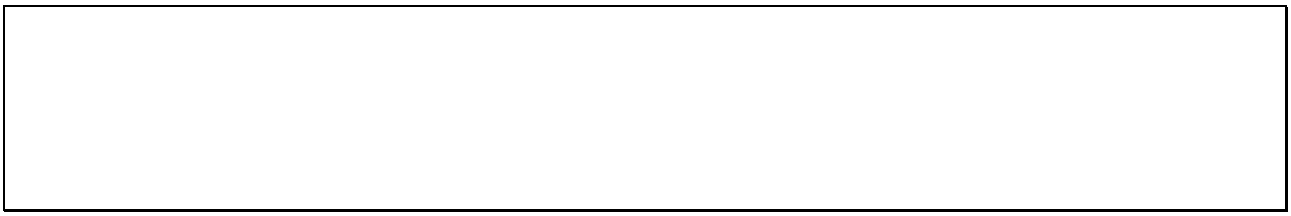
Cl. That's it…

Co. … and have a down time.

Cl. Mmmm. And it is, and knowing that backups are there and the support's there, then ok 'fine, yes I'm having that moment'….

Co. And also putting I think, I still feel it's really, I think it's nice to have those moments of joy, and time for you.

Cl. Yes.



FEEDBACK SESSION WITH PETER

After I had written the pragmatic case studies I had a two hour feedback session with Peter in order to hear his feedback about the case. This feedback session was seven months after the last session of therapy.

Peter didn't really interact that much with what I was saying about the case study. He was more interested in discussing his experience of the therapy. There were four main points that emerged from the feedback session with Peter. He discussed his experience of being in therapy and he likened the process of therapy to a 'mirror'. Peter suggested that therapy felt like I was holding up a mirror in from of him and then giving him the space to explore what he saw. He said the phrase 'I have come to realise….' Many times throughout the session and I only picked up on this when I transcribed the audio. I would have liked to mention this to Peter to see what he thought because it seems to me that this is the main thing he got out of therapy; new perspectives and realisations.

Peter also discussed that the therapy was not what he expected. He thought that he would come in and get answers and techniques that were tried and tested and would definitely take his symptoms away. He suggested that he thought therapy would be a one-way relationship and that the relationship we created was very different to this; he felt it was very much two-way in nature. I asked if this was disappointing. Peter was very disappointed that his symptoms did not go away completely. He felt they had improved and he was coping better but that he was still struggling. However, Peter stated that he was not disappointed with the therapy as he felt it made him accept his situation instead of constantly fighting it and being angry about it. Peter has since returned to hospital as his new hypothesis is that his symptoms are partly psychological in nature and partly something else. He is currently going for tests to see if he has Myalgic Encephalopathy (ME) which is also commonly known as Chronic Fatigue Syndrome.

Peter stated that challenge was hugely valuable to him during the sessions. He suggested that challenge allowed him to explore a different perspective and a consequence of this was that he started to challenge his thoughts and perspectives between the sessions also.

Peter felt that the case study was a good representation of our work together. He requested that some of the biographical details be changed and these changes were made.

The following is sections from the feedback session about the main points that were raised by the client.

Cl. Client
Co. Counsellor

THIS IS PETER DISCUSSING HIS EXPERIENCE OF BEING IN THERAPY

Cl. well it's, like first I didn't want to. Because I was not sure that erm it had anything to do with my psychological side of me. But later, I came to realize that my psychological side had been affected, and erm… but I knew that the extent of the damage that had been done was for me to get back to normal, would take a long long time. I might never become again, I might live with some…. Side effects… of the trauma that I underwent. So, having said that, I was hoping… I came always with hope that, you know, I'll get better. Each day that I came to therapy I came with hope, thinking I'd get better. Eventually after the whole session ended, I came to realize the it's about me accepting the way I am. Nothing much has really changed. I mean I have changed – I'm improving, my energy levels have gone up, I feel much better, some days I sleep, but I'm coping. So it means that that therapy helped me. So the techniques that you taught me, you know, and trying to relax my body, and I can relate the big part of it is anger. Anger is the main cause of my problem.

Co: Mmm. I mean what I've got in the case stuffy is that there was one session where we realized actually in the session you were talking about something that made you really angry and your legs starting jerking.

Cl. Yes… so it's…. even now, it still happens. But I've come to realize it's for me to try and just… accept… I'll be better. The only thing I can't say… I've come to realize that I have to accept and say I'll be better and think positively. It's not easy, but that's the only solution to it.

Co. So you came each week in to the therapy with hope.

Cl. Yeh

Co. That you would get better.

Cl. Yeah.

Co. And actually by better, you mean completely better?

Cl. Not even completely better, but at least my symptoms would subside a bit. Erm.. because most of my physical symptoms… I think somebody who knows me can spot my symptoms easily

Co. Mmmm

Cl. Like when we met outside, you could spot them. So it's symptoms I can't control.

Co. In the therapy, when you were getting tired

Cl. Yes

Co. Or when you were.. not able… do you remember when we did that grounding exercise when I got you to put both feet on the floor and name things around the room and take a moment.

Cl. Yeh

Co. And we also added the meditation CD as well

Cl. Yes. I came to realize the meditation is a big help to me, because it makes me relax. Once I'm relaxed, then you find I can.. I can… my body calms down.

Co. What was the experience like of having… of experiencing those symptoms in the session?

Cl. Erm…. It for me it was embarrassing to be honest. Because you feel like, why should I go through it? Why should somebody else see me going through these symptoms? Because the symptoms themselves are quite… I feel like its…. I get embarrassed actually. I came to realize there is nothing I can do about it. So, the only thing I can do is try and cope… the symptoms the way they are. It's not my making.

Co. No… I've actually got in the case study again. There were two different goals that you kept on bringing. One was that you want to fight the fact that I have these symptoms. And the other one was I want to accept and cope with. But both those… and it's all right to have those two, they are contradictory goals, but they were the two goals that were in the room…..

Cl. Yes, and we did work on both of them. We did. Because erm… eventually I've come to… there are days I sit there and accept… I've come to accept the whole thing. But sometimes when I sleep on the bus… like yesterday when I

slept… there were two old women stood next to me, and I could hear… they mentioned something funny… about me… I was deep sleep but suddenly I heard what they said. And they were talking about me. So, when I opened my eyes, looked at them, they looked at me, they looked at each other, and I felt, because they said if they only… it's not my making, it's not what they think, I'm going through .. erm I'm going through a problem. If they would understand that, it would be…. But again I came to… why should I… erm… why should I fight with the world. Try to prove myself?

Co. Why should you fight with the world?

Cl. Yes, Because I'm trying to fight with the world, trying to prove to myself that I'm ok. But I'm not.

Co. So… no. But did the, so I think what your saying is that your experience of going to the therapy room every week, did that give you some space… what did it give you… did it give you some space where you could work out whether you want to fight or accept? What did you think you did in therapy?

Cl. It give me.. yes.. it give me space to want to fight it. Yes, I wanted to fight the symptoms and get better. But at the end of the therapy, I came to realize, it's not that easy. It will take time. Of which , I don't know when or where I will get that. But I wanted to fight the symptoms.

I READ OUT THE SECTION OF THE CASE STUDY DISCUSSING CHALLENGE AS A METHOD

Co. Was it helpful for me to challenge you in the sessions?

Cl. It was helpful.

Co. How was it helpful?

Cl. It was helpful in a sense that you were like a mirror to me. You were reflecting some… some things … to me. So I was trying to… to… you know… to… you know… my views…

Co: Can I check that for a second, because I think that's a really interesting way of putting it. I was like a mirror to you. Are you saying by that that I was almost holding you up to you? Like this is what I see of you, what do you actually thing?

Cl. Yes… ah ha

Co. And what was it actually like to have that?

Cl. It was… it was difficult for me to understand. But again, I had to take on board whatever… because here I am trying to try to find a solution to my problem…

Co. That was your goal of therapy

Cl. Yes, that was my my my aim and goal. To find a solution to this problem at hand. So if I didn't come as an open book, then I would not, it would not be helpful for me. Because I wanted to get answers.

Co. Yes

Cl. And the only way to get answers to my problem is sometimes to be challenged and to be reasoned with somebody and try to understand…. Sometimes I would look at myself in a different way. But…. certain times … I don't… people look… even for instance… my wife… she was challenging me and she's been challenging. And I cant refuse, but later I've come to accept that this… is the truth… I'm rejecting the truth. I mean in the therapy itself… I came out… those challenges made me become stronger…

Co. Mmmm

Cl…. yes… and they made me reflect and look and view the whole problem differently.

Co. Mmmm, so it's all… you were saying you were looking at the whole problem and then looking at it differently… looking at it from a different perspective…

Cl. Yes… rather than from my own perspective

I READ FROM THE CASE STUDY AND ASKED THE CLIENT ABOUT HIS EXPERIENCE OF THE TASKS

Cl. It was helpful because… the… the tasks that you give me, I looked at them as a challenge to me…

Co. Mmmm… so they were challenge… how were they challenging

Cl. They were challenging to me in the sense that, they are…. They are….it's… they are thing that I wanted to do.

Co. So the tasks were things that you wanted to do?

Cl. To do… but I.. I… I was in fear…

Co. Mmmm

Cl. Like…swimming… I was in fear to go learn and swim. But again, it was a challenge that I wanted to learn, but I was in fear.

Co. So the tasks were almost like things that you wanted to do so that they were things that you… but the therapy set them up and gave them to you as a challenge to do. And how did it feel to, for instance writing in the journal and the mediation task, to do them and then come back in to the session and discuss them.

Cl. It felt… It was not easy…

Co. Mmm

Cl. To do that… I mean to do that task. But again, I had to do it, for the sake that I was trying to find out… if I do them, what would be the outcome….

Co. Mmm

Cl. And would the outcome benefit me? And in what sense?

Co. So you were… and you were throughout the whole of therapy… you were very open to try things…

Cl. Yes…

Co. To see what information they would give you. So it was almost like you collecting information by doing those tasks.

Cl. Yes..

I ASKED THE CLIENT ABOUT HIS EXPECTATIONS FOR THERAPY AND WHETHER THESE EXPECTATIONS WERE MET.

Co. Was therapy what you expected it to be?

Cl. To be honest no.

Co. What did you think therapy would be?

Cl. Therapy… for me… therapy would be… I would come in, explain what I'm going through, then I would be given sort of… I mean… that I would be given certain… I would be taught how to cope with the whole things… in certain ways. But I came to realize… it's totally different… it's not what I expected.

Co. And so what… so did it.. is it… I supposed that could be quite disappointing that it was not something that gave you all the answers…
Cl. No, actually, it was not disappointing at all. Because it was… what I enjoyed was… I came in expecting I would be taught techniques to cope with my problem. Or talk about my problems…

Co. Mmm

Cl. …would make me feel better. But I came to realize, it's about, it was about a two way thing. For me to express my experiences…

Co. mmm….

Cl. … and for you.. for us to come back and discuss about them. So the whole thing was a two way, take and give, you know.

Co. So it was a two-way relationship, and you thought therapy was going to be a one-way…

Cl. One-way…yes.

Co. I guess what you are saying is, you thought therapy might be… you come in and I give you all the answers, where as it was…

Cl. … it was for me to explore the whole process of my problem.

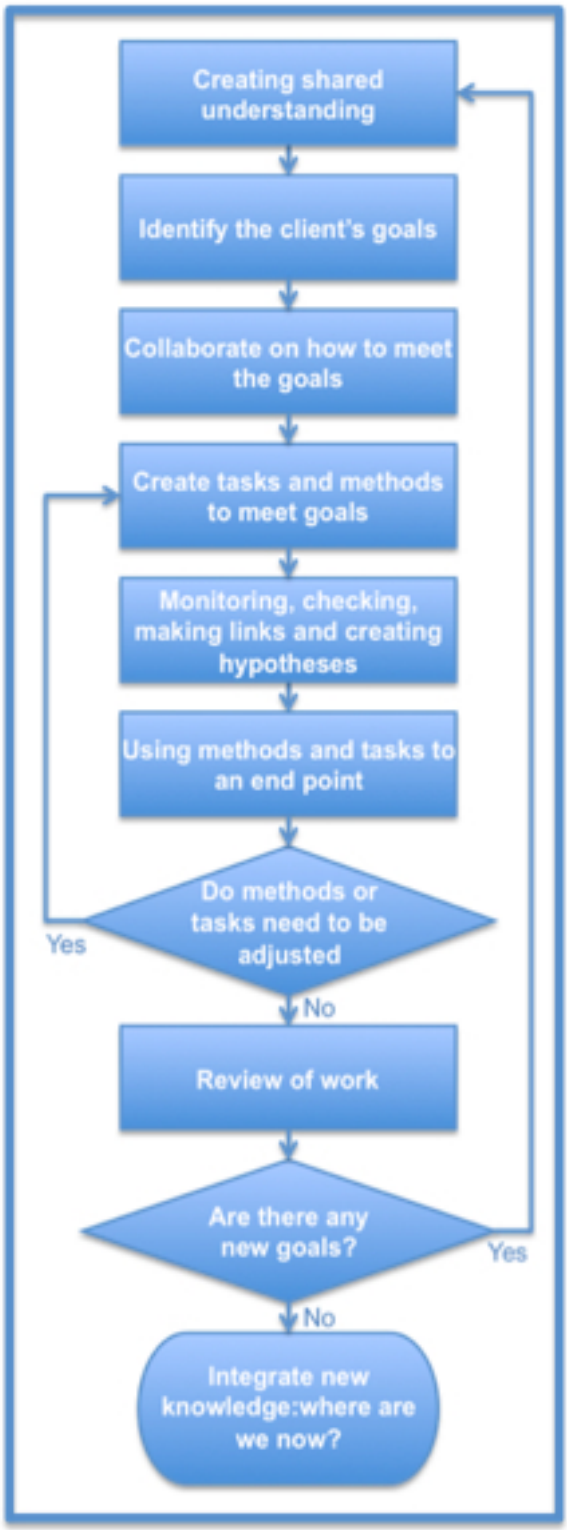
Co. mmm…

Cl. … for me to get in there and try and… and work out… together we would work out… but it was for me… if I was not willing to talk about it, if I was not willing to go through it… then I would never get to where I got.

APPENDIX [5]

A PRACTITIONER'S GUIDE TO PLURALISTIC THERAPY WITH HIV POSITIVE CLIENTS

The following is a practitioner's guide based on the research findings of this thesis. It describes a 10-step process of working pluralistically with HIV positive clients.



1. *Creating shared undertsanding*

This part of the process that occurs between HIV positive clients and pluralistic therapy is mainly led by the client. Pluralistic therapy advocates that you start the therapeutic experience from where the client is, you create goals that are immedeate and relevant to the client and you attempt to work from within the client's frame of reference. Creating shared understanding about the client and the context in which they live is the foundation on which pluralistic therapy can be built. This first step is also the foundation of the therapeutic alliance. I think it is poignant to consider the client the expert of his experience at this point in order to identify the goals that the client truly wants to meet; but I feel this initial creation of shared understanding where the therapist considers the client the

expert of his world facilitates the creation of a relationship that is specific and relevant to the client also.

This section of creating shared understanding reminds me of the beginning process of creating a grounded theory. Instead of being led by existing theories you are led by the data that the client provides. In this sense pluralistic therapy could be seen as a 'bottom up' way of working rather than a theory driven 'top down'. More simply, instead of trying to fit what I know about HIV or anxiety to the client, I create a theory or hypothesis with the client that is grounded in the data he presents while also being reflexive and transparent about the knowledge that I bring into the therapy room.

2. *Identify the client's goals*

   This section of the process between the client and the therapy is interactive and there is an emphasis on collaboration. The therapist and the client explore if there are any specific goals, life goals or relational goals. This part of the process not only identifys the goals of the client for therapy, but it can also provide the therapist with vital information about the sort of relationship they want. Contradictory goals may also be important to identify and work with. The idenfication and acknowledgement of contradictory goals allows the therapist to work with ambivalence and give respect to the complexities of the client's world.

3. *Collaborate on how to meet the goals*

   This is a highly creative part of the process where the client and the therapist brainstorm about how the goals might be most effectively met. The sort of relationship that has been created by this stage will effect the way this collaboration takes place. This section allows the therapist and the client to identify ways in which they can work inside and outside the therapy room. A consequence of this collaboration is that an environment of 'possibilities' and 'choices' is created. It has been documented in the literature that being HIV positive can involve periods

of confusion and uncertainty and I feel this section of the process helps to facilitate an environment where clarity is created.

4. *Create tasks and methods to meet goals*

   The possibilites within this section of the process are almost endless. A common element that I found with all three clients was that the goals tasks and methods were not mutually exclusive. When creating goals, tasks and methods with HIV positive clients it may be important to explore relational goals and possibly use and consider the therapeutic relationship as a method for meeting these goals.

   This section can also be described as a time where the client is encouraged to be a therapist with the therapist. In this section two therapists are better than one, particularly when one of the 'therapists' is actually experiencing the issues that you are both trying to work through. Clients have a range of creative and relevant ways of working that can be idenitfied, explored and integrated into therapy to create a truly bespoke therapeutic experience.

5. *Monitoring, checking, making links and creating hypotheses*

   This section of the process is a vital part of pluralistic therapy. In order to effectively use what could be called the 'extra-therapeutic' factors that the client brings to the therapy room, consistent monitoring and checking needs to take place. This is in order to track changes, new ideas, new goals and to make sure that you are continually collecting the 'data of your client'. While both the therapist and the client are monitoring, checking and making links we are both integrating this data into tentative hypotheses. Again, I feel consdiering these clients as experts in the field of living with HIV is helpful in creating a relevant therapeutic experience. If I am collaborating with an expert on some research I would need to know her hypothesis and research question and the methods she thought were most adequate to use. We would probably also have several meetings about the research process; we would be monitoring, checking, making links and creating hypotheses

about our data. I feel a similar process occurs with HIV positive clients enaging in pluralistic therapy.

6. *Using tasks to an end point*

   In this section of the process the tasks were completed and then reviewed in another part of the process. It is important that tasks have an end point so they can be reviewed and the new data be assessed and integrated into the therapy or into the client's life.

7. *Do tasks or methods need to be adjusted?*

   Part of the process between the HIV positive clients and pluralsitc therapy also involves both the therapist and the client asking the question 'do we need to adjust the way we are working?'. It is important to also check if the methods or the tasks being used to meet the clients goals need to be adjusted. Reviewing methods may also include a review of the therapeutic relationship and whether it is working as an effective method and how it might be changed it if it isn't effective. If the tasks and methods do need to be adjusted then the work will need to return to the 'creating tasks and methods to meet the goals' section of the process.

8. *Review of work*

   By reviewing what has been done the therapist and the client are better equipped to see if they have met any of the client's goals. This review also includes a review of the therapeutic relationship and whether the way they communicated and worked together was useful for the client. This review involves meta-communication where the therapist and the client 'talk about talking' or open a dialogue about the way in which they are communicating and how it feels to communicate in this way.

9. *Are there any new goals?*

   A specific element of working with HIV positive clients or indeed clients with a chronic or terminal illness could be that new goals may develop as the person and/or the illness evolves. Goals such as 'creating a

quality of life' could be viewed as an ongoing process that may require the use of different tasks and methods at different times in the persons lifespan. It seems new goals could constantly emerge in the process of using pluralistic therapy with HIV positive clients. If there are new goals then the work will need to return to the 'creating shared understanding' section of this process in order to explore what the goals are and what they mean to the client.

10. *Integrate new knowledge: where are we now?*

This section of the process between pluralistic therapy and HIV positive clients involves integrating what the therapist and the client have learnt from the therapeutic experience (inlcuding their relationship) into the context of the client's everyday life. This section also allows the therapist and the client to be transparent about 'where they are now'. It may be an important part of the therapeutic process that both the therapist and the client are open about the fact that there is still work to be done; even when therapy has come to an end. Therefore the ending may include an exploration of the things the client wants to continue to work on.

PART V

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