

A REFLEXIVE APPROACH
DOING PRACTICE-BASED
RESEARCH *in* THERAPY
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ONE Real-life research

This chapter outlines the characteristics of practice-based research. We look at the role research may play in our everyday life, with reference to overlaps and differences between 'private' and 'public' research.

- Theory
- Interpretation
- Inductive and deductive reasoning
- Therapeutic modalities
- Countertransference, transference and projections
- Congruence
- Automatic thoughts

Introduction

Research plays a significant role in therapy today. From being steeped in mystery, psychotherapy has become a profession characterised by transparency and accountability. One of my favourite books during my own training was *The Analytic Experience* by Neville Symington. In it, Symington (1986: 9) boldly stated that 'it is as impossible to convey the sense of [psychotherapy] to another person, as it is to explain to an eight-year old child what it is like to be in love.' These kinds of comments seem out of place today. Ambiguities are giving way to 'evidence' and 'knowing'. Wheeler and Elliott (2008: 134) conclude that 'competent professional practice' involves:

- knowing what our methods are, and being able to discuss their merits and limitations
- knowing how to find new information from the literature (including electronic sources) that might help us with a particular client
- knowing how to access evidence to support our practice.

The discourse centred on the human mind is punctuated by certainties. Phrases that were earlier reserved for medical sciences, such as 'empirically supported' and 'clinically proven' treatments have become part of therapeutic reasoning.

This book is written in response to some of these changes and new requirements. It aims to demystify research and offers a step-by-step approach to conducting practice-based research, using current and relevant research as exemplars. The term 'demystifying' can have a sanitising ring to it. The aim is not to avoid the messiness and complexity of life. The book focuses rather on research – be it a 'private', everyday exploration or more systematically conducted studies – where the 'human factor' is taken into account. The research skills referred to in this book are linked to subjectivity and reflexivity. It will be argued that each piece of research will vary depending on the researcher who performs it. Reflexive awareness involves a deliberate attempt to position oneself as researcher in a linguistic, cultural, theoretical and personal context. Written with personal development as a guiding theme, the book encourages the reader to review, plan and find ways to take responsibility for her/his own learning and professional development in both research and clinical practice. The focus on personal development puts the researcher at the forefront; we are interested in how we position ourselves personally, theoretically and culturally in our research.

Public and private research

The term 'research' is used in a loose sense, akin to the definition suggested by Wengraf (2001: 4) in terms of 'getting a better understanding of the reality'. McLeod (1999: 8) asserts that all therapists by nature are practitioner researchers. Practice-based research is a broad concept; some of the key characteristics of practitioner research in therapy are:

- that the research question is triggered by personal experience and a 'need to know'
- that a goal is to produce knowledge that makes a positive difference to practice
- that an aim is to use reflexive awareness to access underlying meanings of the study.

Morris and Chenail (1994) offer a helpful distinction between private and public research. Private research involves 're-searching' interactions with our clients, on an everyday basis. Private research happens both in the moment, through our 'reflection-in-action' (Schön 1983) during sessions, and afterwards – through our case notes, supervision, peer support and continual professional development (CPT). Morris and Chenail (1994: 2) write:

By *private research* we mean the type of inquiry which is done every day by reflecting practitioners in the course of their daily practice and they re-search their interactions both during conversations with clients and afterwards. The purpose of this research is to share the results of the inquiry with practitioners and clients. These studies are usually conducted informally and their results are used to make decisions in and about treatment.

The term 'public research' refers to a re-search process which is 'more formal in intent, structure, and execution', as Morris and Chenail (1994: 3) state:

By *public research*, we mean those studies that are more formal in intent, structure, and execution. These are types of research that are presented at professional conferences and that are published in professional journals. The methods are clearly articulated, contexts of talk are analysed in intricate detail, and descriptions of clinical moments are rich and exhaustive.

Public research relies on private practice to progress, and vice versa. Clinical practitioners can, as Morris and Chenail (1994: 3) put it: 'private-ize' a whole range of methodologies and techniques to help them look 'beyond their private lenses'. It helps us, for instance, to trace our modalities to their underpinning, basic beliefs, and to challenge their consistency and more long-term implications.

Re-searching practice

Barkham et al. (2010) refer to practice-based research as a 'bottom-up' research. Practice-based research takes place on a grassroots level and involves practitioners and clients in a real-life setting. Practice-based inquiry involves revisiting and re-searching everyday events and as such often becomes both a 'personal journey of discovery' and a 'continual transformation process', as du Plock (2010: 122) reflects below:

We get into difficulties, it seems to me, when we ... begin to see research as something different and separate from what we are already intimately involved in. ... We need to take more seriously the idea of research as a personal journey of discovery, or perhaps re-search, a continual transformation process rather than a discrete event.

We don't need to look far to find something to research. Practice-based research is, as suggested, an intrinsic part of our everyday life. Let us return to what can be described as 'private research', and to an example which highlights the complexity involved in 'assessing' situations and clients.

There is nothing so practical as a theory

Theory has, for many, got a dull ring to it. It tends to come across as something outside the practice. There is, as Lewin (1952) once addressed, 'nothing so practical as a theory'. Theories are the 'intellectual tools that guide practitioners' day-to-day and minute-to-minute clinical decision' (Stiles 2010: 91). Theories are 'ideas about the world conveyed in words, numbers, diagrams or other signs [which] offer distinct sets of assumptions and principles about the nature and sources of [for instance] psychological problems and about approaches and interventions to address them' (Stiles

2010: 91). Practice-based research encourages us to consider the choices we make with our clients in more detail. For instance, on what basis do we build our interpretations? How do we infer and reach conclusions regarding what may be true and false, right and wrong, in therapy? And do you test your theories in systematic ways? Or do you make a point of suspending any prior explanatory models when you are with your clients?

Our everyday life and practice is full of research. Sometimes the terms 'inductive' and 'deductive' reasoning are used to highlight whether the researcher starts his/her study with an open mind or with a plan to test a potential explanatory framework on something in the reality. This can be applied to clinical practice too. Inductive reasoning is typically characterised by 'unbiased' observations; it starts with an open mind and a deliberate attempt to suspend explanatory models or 'theories'. In contrast, deductive reasoning starts with a theory, or a well-formulated hypothesis, which is to be tested on selected sample groups.

Activity

As therapists, we are requested to choose between different theoretical orientations. How do we do that? On what basis do we arrive at knowledge and 'truths' within therapy? Read the case study below and consider the issues we have raised in the Reflection that follows. If possible, discuss how you might approach your work with Bill with a fellow student or colleague.

Case study

In spite of the door bell, there is a faint knock on the door.

'Hello, I've probably got the wrong house?' asks the man, as the therapist opens the door to let him in.

'Mr Gantt?'

The short, rather stocky man in his mid-30s nods in reply and continues talking while entering the room.

'Have any of your clients ever gone into the wrong building by mistake?', he chuckles.

'Have a seat ...'

'Anyway, yes, I am Mr Gantt. Call me Bill, by all means.'

Bill is wearing a suit and keeps flicking some invisible dust on his left thigh. He looks well attended to, with a crisp, white shirt and a tie. He sits with his legs wide apart. As he opens his mouth again to speak, tears begin to roll down his cheeks. He looks out of the window and speaks fast. Although he is crying, it is as if the tears have got nothing to do with him – as if they are not there.

'As I said on the phone, I've got a couple of issues at work that I'd like to discuss. There's been a promotion ... and, well, I'm also thinking about getting

married. It's the second time around. My first wife attacked me with her high heeled shoes on our wedding night, so I'd rather avoid going down that route again!' He chuckles through his tears.

At this stage, the therapist decides to....

Reflection

What would *you* do at this stage? Some therapists start their first interview with an assessment questionnaire. Others aim for things to develop more 'organically'. Some may, for instance, argue that a relatively unstructured beginning allows valuable information about the client's way of relating to new situations to develop.

Would you, for instance, choose to let Bill develop his narrative further, uninterrupted – perhaps hoping to gain information about how Bill deals with new situations and people? Or would this be a good moment to change tack and bring out an assessment sheet or address some standard questions, perhaps with the view of considering mutual aims and objectives at as early a stage as possible? Or, is it likely that a different scenario would have emerged altogether had you been at the door to meet Bill? The way we approach our clients varies depending on our modality, personality and general approach to practice.

The psychoanalytic approach

A psychoanalytic therapist might, for instance, work with an object-relationships theory in mind. Hinshelwood (1997) addresses the 'point of maximum pain' in his assessment model. Where does the 'pain' or the problem really originate or belong? He suggests that we approach a client with a tripod in mind, where relationships to significant others have become a potential blueprint for subsequent relationships. Hinshelwood (1997: 157) writes:

Clinical material is best approached as pictures of relationships with objects. There are then three areas of object relationships which I try to bear in mind:

1. the current life situation
2. the infantile object relations, as described in the patient's history, or as hypothesised from what is known;
3. the relationship with the assessor which, to all intents and purposes, is the beginning of a transference.

The idea of 'transference' is an underlying principle for psychoanalytic practice. Transference was offered as a means of living through experiences, rather than simply thinking and talking about them. Freud (1940/1959: 41) considers the lived experience as a crucial aspect of the

talking cure and asserts that 'the patient never forgets again what he has experienced in the form of transference'. Together with his colleague Breuer, Freud discovered that clients' anticipations of their therapists often coincided with their experiences from earlier relationships. Freud (1940/1959: 38) writes:

The patient sees in his analyst the return – the reincarnation – of some important figure out of his childhood or past, and consequently transfers on to him feelings and reactions that undoubtedly applied to this model.

Transference contributes to the stereotype image of the silent, stern 'blank screen' analyst. The therapist's silence allows as much space as possible for transference. Transference 'comprises positive and affectionate as well as negative and hostile attitudes towards the analyst', writes Freud (1940/1959: 38). It is tempting, continues Freud (1940/1959: 39), to play into the role of a saviour, teacher and infallible helper, but we must 'shamefacedly admit' that it is often a question of the client's underlying 'aim of pleasing the analyst, of winning his applause and love' as means of repeating earlier patterns:

However much the analyst may be tempted to act as teacher, model and ideal to other people and to make men into his own image, he should not forget that it is not his task in the analytic relationship. ... He will only be repeating one of the mistakes of the parents, when they crushed their child's independence, and he will only be replacing one kind of dependency by another.

Deductive reasoning

The idea of transference and therapy as a space to relive, identify and challenge prior relationships (object-relations) reflects what, in research, is often referred to as a deductive reasoning; it becomes a theory to be tested and maybe refuted. Freud's deterministic model based on sexual drives is largely abandoned today; the term 'unconscious' is often used in a loose sense with reference to hitherto unexplored areas. However, psychoanalytic theory is increasingly incorporating neuroscientific theories on the 'unconscious', and these are guided by natural scientific and deductive reasoning. Neuro-psychoanalysis (Solms and Turnbull 2002) approaches the unconscious with reference to neurological processes, involving different kinds of cortices and memory functions. Kandel (2006: 281) asserts, for instance, that when we 'access' memories, core memories are 'elaborated upon and reconstructed, with subtractions, additions, elaborations and distortions':

[R]ecalling a memory episodically – no matter how important the memory – is not like turning to a photograph in an album. Recall of memory is a creative process. What the brain stores is thought to be only a core memory. Upon recall, this core memory is then elaborated upon and reconstructed, with subtractions, additions, elaborations and distortions.

Schore (2003) specialises in our capacity to develop self-regulating emotions and assess how others feel about things. He focuses on how our affective and emotional development is influenced early on in life, and how it can be re-developed at later stages depending on circumstances. Schore (2003: 43) refers to the right brain as the 'locus of the emotional, corporeal, and the dynamic unconscious' and links its 'ongoing maturational potentials' to our 'attachment-influenced early organization'. He asserts that the early social environment influences the evolution of structures in the infant's brain. Schore suggests that the maturation of the orbitofrontal cortex is influenced by dyadic interactions of the attachment relationship. A neglected or impaired affect regulation can, argue Schore, be recovered; for instance, through psychotherapy. The relationship combines a *felt* experience with verbal conscious and intense reflective experiences, based on actual experiences of relating to others.

Humanistic theory

The humanistic (for instance, person-centred) therapist would meet Bill with 'therapist congruence' in mind and with an emphasis on what, in research terms, is called inductive reasoning. To be *incongruent* involves deliberately concealing aspects, for example, in a way which the psychoanalytically 'blank screen' therapist could be argued to do if she approaches Bill with an already formed hypothesis in mind. The therapeutic relationship taps into something which is already there, 'implicit, but unverballed' in most clients. One of the overriding goals of therapy, suggests Rogers (1951: 150), is to work towards 'the dawning realization that the evidence upon which [the client] can base a value judgement is supplied by his [sic] own senses, his own experiences'. Not dissimilarly from what Freud proposed earlier, Rogers (1951: 151) noted that many of his clients struggled with evaluating experiences. Rogers (1951: 149) concludes that 'it seems to be true that early in therapy the person is living largely by values he [sic] has introjected from his personal cultural environment'. Again, not unlike Freud, Rogers warned against the temptation to leap in and 'take over'. Rogers (1951: 151) writes:

In therapy, in the initial phases, there appears to be a tendency for the locus of evaluation to lie outside the client. It is seen as a function of parents, of the culture, of friends, and of the counsellor. ... In client-centred therapy, however, one description of the counsellor's behaviour is that he consistently keeps the locus of evaluation with the client.

The person-centred therapist will, however, bring Bill's here and now to the forefront. Rogers (1951: 151) emphasises the importance of relating to clients in such a way that our responses, attitudes and phrases 'indicate that it is the client's evaluation of the situation which is accepted'. Rogers (1951, 1961, 1995) addressed certain core conditions for therapeutic change. Therapist

'unconditional positive regard' is a key core condition. The therapist is prepared to consider whether or not she is able to step into Bill's shoes and accept him unconditionally, without judgement, in order to give him space to explore his own 'locus of evaluation'. Unconditional positive regard is, asserts Rogers (1995: 116), about 'non-possessive caring'. Rogers writes:

The therapist is willing for the client to be whatever immediate feeling is going on – confusion, resentment, fear, anger, courage, love, or pride. Such caring on the part of the therapist is nonpossessive. The therapist prizes the client in a total rather than a conditional way.

Rogers (1995: 14) compares congruence with being 'real':

In place of the term 'realness' I have sometimes used the word 'congruence'. By this I mean *when my experiencing of this moment is present in my awareness and when my awareness is present in my communication.* (italics added)

Rogers believed in the impact of empathic understanding. A sense of being cared for by a genuine, honest person who aims to see things through the client's eyes with a 'no strings attached', unconditional interest became the bedrock of person-centred therapy.

Cognitive behavioural therapy

Cognitive behavioural therapy (CBT) includes a variety of approaches and therapeutic systems, some of the most well-known of which are cognitive therapy, rational emotive behaviour therapy and multimodal therapy. Cognitive behavioural therapy is based on collaborative effort to the extent that the therapeutic alliance is often compared with 'negotiation' (Gilbert and Leahy 2007: 92), although like the psychodynamic therapist who works with a hypothesis in mind, CBT is guided by deductive reasoning. Questions which a CBT therapist asks Bill may revolve around what logical errors could be involved in the way he perceives himself, his future and the world around him. Bill's therapist might use cognitive techniques such as examining the evidence and thought records to identify and change maladaptive cognitions. The therapist may also use behavioural methods to reverse ways of avoiding certain things through systematic exposure techniques. The term 'consciousness' is used in CBT as a state where rational decisions can be said to be made with full awareness. 'Automatic' thoughts are often used to describe an opposite form of making decisions. These refer to what Beck called 'private cognitions'. Much of Bill's cognitions could be described as automatic thoughts. They are shaped by his prior experiences and have become core beliefs or schemas which create templates for the way he processes information in the present. CBT refers to a Socratic method which encourages clients to contribute by asking questions of themselves: 'How do I really know that all people are dangerous? What is the logic in that? Could they seem threatening

because they are in a bad mood or because I have approached them in a reserved, maybe defensive, way?', and so on. Homework is likely to become a part of Bill's therapeutic process if he undertakes CBT. He and his therapist will agree on tasks which Bill can do in between sessions to explore his automatic thoughts in terms of facts.

Beck et al. (1987: 50, 54) assert that 'therapeutic interaction is based on trust, rapport and collaboration' and they view it as a 'vehicle to facilitate a common effort in carrying out specific goals'. As Beck et al. (1987) contend, cognitive approaches often seem deceptively easy. Both Rogers' core conditions and Freud's idea of transference are noted in his approach to the 'therapeutic alliance'. Warmth, assert Beck et al. (1987: 46), is essential to establish a therapeutic relationship, although 'it is crucial to bear in mind that the patient's response is his [sic] perception of warmth rather than the actual degree of warmth expressed by the therapists'. Beck et al. also emphasise genuineness and empathy: the therapist must be able 'to experience life the way the patient does' at the same time as being 'careful not to project his [sic] own attitude or expectations onto the patient'. This empathic understanding will, continue Beck et al. (1987: 48), be balanced with 'objective checking of the patient's introspection against other sources of information', such as 'testing the logic involved in the patient's inferences and conclusions'. However, CBT emphasises overall the collaborative problem-solving approach which Beck et al. referred to above.

Growing rabbit ears

Yalom (2002: 52) writes about 'growing rabbit ears' right from the start to pick up on the often subtle, but 'informative idiosyncratic responses' brought by his clients to same-situation scenarios. He describes, for instance, how walking down to his office along a winding path from his house has helped him 'accumulate much comparison data':

You must grow rabbit ears. The everyday events of each therapy session are rich with data: consider how your patients greet you, take a seat ... [T]he patient's idiosyncratic response is ... a *via regia*, permitting you to understand the patient's inner world. (Yalom 2002: 52)

Yalom's observations illustrate an attempt to be guided by each client's unique responses, and to approach meaning-making processes with as open a mind as possible. In research terms, this is often referred to as 'inductive' reasoning. Yalom (2002: 52) continues:

My office is in a separate cottage about a hundred feet down a winding garden path, I have over the years accumulated much comparison data. Most patients comment about the garden ... but some do not. One man never failed to make some negative comment: the mud on the path, the need for guardrails in the rain ... [When] the latch on my screen door was broken, preventing the door from closing

snugly, my patients responded in a number of ways. One patient invariably spent much time fiddling with it and each week apologised for it as though she had broken it. Many ignored it, while others never failed to point out the defect and suggest I should get it fixed.

A therapist informed by object-relations theory might, for instance, attempt some deductive reasoning to make sense of why the lady 'fiddles' apologetically with Yalom's door and hypothesise that she is transferring some of her earlier relationship experiences on to the therapeutic relationship. If this theory is refuted by another explanation, the therapist may consider eliminating it from the search. Humanistic therapists, like Yalom himself, would typically approach their clients for the first time with an open mind and put explanatory frameworks to the side. Humanistic psychology developed during the 1950s in direct opposition to the idea of therapy as a form of 'excavation'. Yalom (1980: 10) writes:

To Freud, exploration always meant excavation. ... Deepest conflict meant earliest conflict. ... There is no compelling reason to assume that 'fundamental' (that is, important, basic) and 'first' (that is chronologically first) are identical. To explore deeply from an existential perspective does not mean that one explore the past; rather it means that one brushes away everyday concerns and thinks deeply about one's existential situation.

Inductive reasoning is favoured where a sense of explanation grows in the context of each individual client. The therapeutic frame can still be used as a 'base line', as Yalom (2002: 157) puts it, to learn something about the variations and differences between clients and their reactions:

I develop baseline expectations because all my patients encounter the same person (assuming I am reasonably stable), receive the same directions to my office, enter the same room with the same furnishing.

Activity

Every session is a piece of research

McLeod (1994, cited by du Plock 2010: 122) reminds us about how we are constantly engaged in 'practice research', as part of our daily clinical work:

A counselling session with a client can be seen as a piece of research, a piecing together of information and understandings, followed by testing the validity of conclusions and actions based on shared knowing.

- Try to think about a session with a client as a piece of research. Consider how you piece together information and understandings, followed by testing the validity of conclusions and actions based on shared knowing.

How open can a mind be?

The prospect of suspending explanatory models in favour of *unbiased* observations, as in the case of Yalom's walks towards his private practice at the end of the garden, assumes that prior knowledge and expectations actually *can* be separated from what we see. An often-addressed problem with 'inductive' reasoning is, for example, as Warburton (2004) asserts, that our knowledge and our expectation affect what we see. Warburton (2004: 112) writes:

the simple view assumes that our knowledge and expectations do not affect our observations. [However] seeing something isn't just having an image on your retina. ... Our knowledge and our expectations of what we are likely to see affect what we actually do see.

The therapist as a person

A particularly important aspect in psychotherapy is to challenge our pre-understanding, with a focus on our emotional, affective responses and expectations. Countertransference was initially a concept designed to understand what the therapist felt in relation to the client's transference. It was regarded as something that always 'came', or was projected, from the client. Racker (2001) asserts that psychotherapy always involved a fusion between the past and the present for *both* therapists and clients, and he refers to different types of countertransference, for instance, Concordant and Complementary countertransference. At times, reactions in the therapist will stem from the client's transference and projection towards the therapist. It is important, argues Racker, to acknowledge how some issues tap into the therapist's own history. Clarkson (1995: 9) suggests that therapists need to listen to their reactions in terms of 'reactive' and 'proactive' countertransference.

- *Reactive countertransference* describes the psychotherapist's feelings which are elicited by or induced by the patient.
- *Proactive countertransference* refers to feelings, atmospheres, projections, etc. which can be said to have been introduced by the psychotherapist him/herself.

What if, for instance, one of the clients 'fiddling' with Yalom's door triggers some of Yalom's own old memories? What if the person is an overweight, middle-aged woman? The terms transference and countertransference helps us to conceptualise the impact that prior relationships can have on the way we experience people later on.

Although Yalom works within an existential framework, he stresses that countertransference and transference can be useful 'tools' (i.e. theory) for conceptualising how emotional pre-understandings impact our observations. In one of his case studies, Yalom (1991: 87) captures some of the

strong feelings involved for him as a therapist when he meets Betty, a client with weight issues:

The day that Betty entered my office, the instant I saw her steering her ponderous two-hundred-and-fifty frame towards [me], I knew that a great trial of countertransference was in store for me. I have always been repelled by fat women. I find them disgusting: their sidewise waddle, their absence of body contour ... everything obscured in an avalanche of flesh. ... How dare they impose that body on the rest of us? The origins of these sorry feelings? [W]ere an explanation demanded of me, I ... would point to the family of fat, controlling women, including – featuring – my mother, who peopled my early life.

Yalom (1991: 87) concludes that knowledge about the therapist's emotive responses to their clients is an essential aspect of 'the inexhaustible curriculum of self improvement':

The world's finest tennis players train five hours a day ... the ballerina [endlessly aspires] to consummate balance, the priest forever examines his conscious For psychotherapists that realm, that inexhaustible curriculum of self improvement from which he never graduates, is referred to in the trade as countertransference. Where transference refers to feelings that the patient erroneously attaches ('transfers') to the therapists but that in fact originated out of earlier relationships, countertransference is the reverse – similar irrational feelings that the therapist has towards the patient.

Self-awareness is, for a therapist, the equivalence of 'consummating balance' for a ballerina; it is, as Yalom (2002) suggests, a significant part of the therapist's 'inexhaustible curriculum of self improvement'. This kind of self-awareness is, however, often a neglected area in research. Emotional responses are something which traditionally have been regarded as obstacles rather than as something which informs and enriches the inquiry.

Activity

Time travelling

Real-world research is based on the world that we live in. The world we live in involves the past, present and our future – whether we are clients, therapists, research participants or researchers. This writing exercise is about one of the many cornerstones of your world and reality. In this activity, you are encouraged to write for ten minutes without stopping. As Winter et al. (1999: 11) describe:

Uninterrupted writing [means] to get down and write. If you cannot think of the next word, then repeat the one you are writing until the one you need occurs to you. Don't spend time wondering what to write next.

Continue writing from the sentence below for five minutes without stopping!

'I remember it was a school day, maybe a Tuesday or a Wednesday. I was sitting on my bed, looking for a sock, thinking that ...'

When you have finished:

- Trace how you are feeling right now.
- What came up for you?
- How old was the person you wrote about? What happened to that person, at that time?

When I have undertaken this exercise with clients, some clients have expressed surprise over the amount of detail that comes out in the writing, such as smells, sounds and other vivid memories linked to time and place. Others comment sometimes on how little comes out. For instance, in one writing group, a member described feeling almost paralysed, unable to write a single word. He was later able to reflect over how this actually coincided with his feelings both at home and in school at this particular time. Many describe how strong feelings can return in their writing, such as sadness, helplessness and loneliness – or, indeed, in some cases, excitement. One person remembered the day his mother was being hospitalised and memories of trying to make sense of all this when he came to school flooded back. This triggered a discussion about how many in the group were 'wounded healers', who could recall a sense of leading a double-life as children, with a messy household and an urge to fit in and be a 'normal' child at school. Often, the writers are surprised afterwards to recognise that the age wasn't specified in the exercise, and that the feeling they had about being asked to write about themselves with a special age in mind was linked to their own way of prioritising events. In one writing group, a member said afterwards that she found it easy to write: 'It was the grey sock that did it for me' she said. Only afterwards did she recognise that this was in response to what had come up for her, rather than being specifically addressed in the question.

Recommended reading

McLeod, J. (2013) *An Introduction to Research in Counselling and Psychotherapy*. London: Sage.

McLeod gives an excellent overview of the different stages and angles to counselling research.
