A case for taking the dual role of counsellor-researcher in qualitative research.

(Abstract – will complete last).

Introduction

> "Practitioners of counselling and psychotherapy routinely witness peoples' pain, struggle, courage and joy in a depth and detail rarely possible in psychological laboratories".
>
> (Stiles, 2007, p126).

Theory-building case studies, which draw upon counsellors' clinical experiences, are a legitimate forum for theory building research (Stiles, 2007). Practice-based data provides convincing evidence for counselling research as "it captures the miracle of therapy in a way that statistics and randomized controls cannot" (Dallos and Vetere, 2005, p131). This model of research "gives voice to clients to tell their stories in their own words" (Grafanaki, 1996, p336) and closes the gap between research and counselling practice (Rennie, 1994).

However, such clinical research is not unproblematic; the counsellor-researcher generates a dual role conflict between the goals and focus of therapy and research (Gabriel, 2005). Such roles may be viewed as incompatible, with the conflict difficult to overcome (Beauchamp * Childress, 1994). Some researchers advise against dual relationships of researcher-counsellor based on the assumption that the obligations of each role have different expectations, which cannot be easily resolved (Kitchener, 1988).

In comparison, others argue that with sufficient reflection such difficulties can be conquered. For example, Gabriel identifies a set of requirements for the counsellor-researcher to manage such role conflict: providing clear information for contributors; forming an effective research alliance; having a clear policy on confidentiality; and cultivating self-reflexivity (Gabriel, 2005, p47-48). Counsellor-researcher dual roles are therefore a legitimate and valuable form of data gathering when the client's needs are paramount and the therapeutic process is not compromised in any way (Etherington, 2000; Wosket, 1999).

This article will refer to a case example from a current multiple case study illustrating how taking the dual role of counsellor-researcher can be a legitimate approach in short-term sand-tray therapy. A discussion of the ethical implications and the opportunities and challenges of this qualitative method of research will also be explored.

A Case Example

The case example referred to in this section, illustrating the dual role of counsellor-researcher, is taken from an ongoing multiple case-study research study using sand-tray with adults in short-term therapy. Sand-tray therapy is a creative way of working involving a collection of objects and a sand-tray. When a client prefers to work creatively, or is unable to express difficult issues or feelings in words alone, the objects placed in the sand, acting as symbols, can aid exploration. Clients may engage in touching, moving and burying objects in the sand and using this method can bring new understanding and relief through emotional expression.

The client-participant

Shirley was in the age group 18-29 years, was of African origin and currently attending university in Britain. Her presenting problem was one of anxiety and her goals for therapy were for her to talk about some difficult things she had not spoken about previously and to be able to manage her anxiety. Cooper and McLeod (2011) suggest, "a client will often have a clear appreciation of the steps that they need to take to make a difference in their life" (p89). These problems appeared equally important to Shirley and my view was that the most helpful therapy would be to address both. I suggested I could work with her to identify some relaxation techniques, which may help her manage her anxiety on a day-to-day basis. With regards to her speaking the unspoken, I informed her that working creatively using the sand-tray and objects might be helpful in that endeavor. The tasks of therapy were agreed giving us a central focus (Cooper and McLeod, 2011) for the agenda in the sand-tray sessions in tackling her issues.

Procedure

Recruitment

Shirley (a pseudonym) responded to an advertisement seeking people to take part in a project exploring the use of sand-tray therapy. Shirley was provided with an information sheet and a pre-therapy meeting was arranged to discuss the project aims and methods and answer any questions. Shirley was offered therapy with or without involvement in the project and provided written consent to take part in the research

Pre-therapy session

Shirley was assessed for risk during the therapeutic contracting stage in the pre-therapy session and informed about the boundaries to confidentiality. A breach may occur if there was a potential risk to her or others as stipulated in the British Association for Counselling and Psychotherapy (BACP) Ethical Framework for Good Practice in Counselling and Psychotherapy (BACP, 2013). In addition, the Short CORE-10 measure (Twigg and McInnes, 2010) questionnaire was completed with Shirley. This questionnaire can contribute to

the discussion between counsellor and client about risk, given that statement 6 refers specifically to it. In the case of such risk being identified, the participant would have been directed towards their local MIND Counselling Organization for referral and not included in this study. Shirley did not fall in the 'at risk' category so could be included in the research.

The pre-therapy assessment also included identifying her expectations and goals for therapy and the planning of six sessions of short-term sand-tray therapy. Gabriel (2008) suggests that therapist-client dual relationships seemed more successful when there is some form of assessment, which appears to help with any relational consequences. Such consequences may include a lack of trust experienced by the client-participant or a weak therapeutic alliance being created. The therapy contract in the present study was discussed in detail and agreed and signed by both parties.

Sand-tray Intervention

The six sand-tray therapy sessions were an hour long and arranged weekly. During the sessions the sand-display and objects can represent a client's inner experience, their personal history, relationships with others and their relationship with the wider world. An object in the sand can act as a physical anchor, symbolizing an aspect of the client's experience. It is common for a client to engage with the objects once placed in the sand and will often touch or move them. Some clients "will often hold an object in their hands as they begin to talk and express their thoughts and feelings"(Fleet, 2015, p16).

With talking therapy alone, a client who is engaged in exploring edge of awareness experience (Mearns, 2002), thereby accessing material not currently in conscious awareness, can sometimes lose their trail of thought. Although some clients seem able to follow their thread easier than others, the physical anchor appears to act as a reference point, aiding the process of discovery. Such discovery can facilitate the integration of any insight gained into the client's phenomenological awareness.

Method of analysis

Once all 6 sessions had been completed and the recordings transcribed, the analysis was carried out. The raw data composed of audio recordings and photographs of sand-displays taken at the end of each therapy session. Grounded Theory (Strauss and Corbin, 1990) was employed with the aim to establish the underpinning theory of short-term sand-tray therapy. As well as the various stages of coding being undertaken outlined by Strauss and Corbin, it also incorporated continuous memo writing, which is an ongoing process in the larger multiple case study.

I am an experienced counsellor and counselling supervisor, possessing theoretical knowledge of counselling theory. Therefore, it was essential to analyze the data from a fresh perspective, avoiding any influence from existing theoretical concepts I held in awareness. This was managed by first engaging in open coding of the transcripts, then by identifying existing theoretical concepts in each session. A mind-map was then created of the overall existing concepts identified from the 6 therapy sessions. These steps made it more possible for me to focus soley on counselling during the 6 sessions ('bracketing'- my knowledge of existing theoretical ideas). Once the counselling sessions ended I was then able to go to the next stage (analysis), which involved identifying new concepts in the data, which is an ongoing process in the larger case study.

Reflexivity

An essential part of the research process involves the concept of reflexivity. Finlay (2003b) stresses the need for a qualitative researcher to be continually reflexive throughout the research process so as to avoid bias and to be aware when there is a risk of their own prejudgments and assumptions becoming part of the research. I addressed the requirement of reflexivity by writing reflexive memos, keeping a separate reflexive journal and exploring my process in research and counselling supervision.

Role-fluency

As stated earlier, Kitchener (1988) argues against dual relationships in research, claiming the challenges are too great. However, I managed these difficulties by adopting a 'role-fluency' approach (Figure 1), suggested by Gabriel and Casemore (2009, p15). During the preparation stage, including the initial meeting with the client-participant, I took on the dual role of counsellor-researcher as I needed to keep the obligations of both roles in mind; the ethics related to the therapy sessions and to the research process.

During each of the sand-tray sessions I adopted the role of counsellor, providing therapy to the client and placing the client at the center of the process. Once the six sessions had been completed, the data composed of audio-recordings of each session; photographs of sand displays and client feedback sheets were all stored securely. The process now became research focused and the audio-recordings were transcribed and analyzed with the participant being given a pseudonym.

Counsellor-researcher's therapeutic approach

My theoretical counselling orientation is Humanistic/Pluralistic (Cooper & McLeod, 2011), informed by Person-Centred (Rogers, 1957) principles. Rennie (1994) argues that Humanistic therapy promotes client empowerment and as such, working collaboratively with the client is most appropriate in this type of research. The Pluralistic approach argues that drawing on methods from a range of orientations and incorporating those ideas when establishing the client's "goals, tasks and methods of therapy" (Cooper & McLeod, 2011, p8) is a useful

way of meeting the client's needs. The Humanistic approach and the Pluralistic approach both acknowledge the client's uniqueness and place the client at the centre of the therapeutic process. Person-centred thinking aims to facilitate the client to become self-governing so it could be argued that this idea is compatible with the Pluralistic approach, which views the client as the active agent of change. This thinking is inline with my stance, with the quality of the therapeutic relationship viewed as significant in facilitating client change. My aim is to offer the core conditions of empathy, unconditional positive regard and congruency (Rogers (1957) to the client. Working creatively is also a substantial aspect of my practice, with socratic questioning being incorporated into the sand-tray sessions to aid guided discovery (Padesky, 1993).

This process and analysis of the data led to me developing theoretical concepts and for this case example, two of those concepts will be referred to.

Intra-phenomenological process

This term refers to movement in the client's phenomenological experience in terms of their relationship with Self. This self-mode comprising of 'I think', 'I feel', 'I believe', 'I am'.

Over the six sessions Shirley progresses from feeling hopelessness and being overwhelmed to a sense of happiness and anticipation for the future. This change was evidenced in her choice of sand-tray objects and the narrative recorded during the sessions. In session one, Shirley began talking of feeling overwhelmed and hopeless. She represented this by choosing a small female figure, laying it face down in the sand, with a shark object bearing down over the female. Shirley began to express her fear and stated,

> "It's never going to get better…I feel like I have just given up sometimes".

She continued to talk about how hard it was to manage her anxiety at university. I responded with immediacy and offered to facilitate a relaxation technique at the end of the session, which she could try during the week. She readily accepted this offer and the breathing technique was incorporated at the end of the session. This was an example of having a therapeutic focus during the session and placing the client at the centre of the process by being genuinely interested and responding to her needs (Mearns and Thorne, 1999).

As the session progressed, Shirley began to unpack a wide range of issues: her worst fears, her personal history of living in Africa, moving to Europe and now of her life as a university student in Britain. During this part of her discourse, she disclosed the particular country and region she came from in Africa. At this point she looked somewhat worried and stated,

> "I don't want that going in".

Once again I responded with transparency and immediacy and reassured the client with the tape-recorder still running that this would be omitted and asked her what she would like going in instead? The client replied,

> "I would like you to say I am from Africa".

My response seemed to serve two functions; the first respecting the client's right to confidentiality but also attempting to equalize the power-balance in the relationship by communicating the message that she was a priority. Also, it was important that the client be asked again at the end of the session if she was still happy for the session to be included.

By session four, Shirley appeared to be moving in her thinking, she symbolized this by choosing an object of the three wise monkeys and placed them in the sand. She stated,

> "Maybe if I don't blame myself for the things I did, then I might be able to stop those negative thoughts".

This seemed to give her a glint of hope and the possibility that she may gain some control over her anxiety.

Previously, in session two, Shirley had placed a small wooden decorative box in the sand, leaving the lid closed, symbolizing her feeling trapped by her anxiety. In session five, she chose the same wooden box but this time with the lid open, representing an indication that she was now facing her fear, expressed in her communication.

> "There is some kind of progress…I'm finding new ways to cope instead of running away from it….I'm feeling more relaxed…not panicking…..overall, it's been awful but it has taught me a lot….I guess there is a good side to everything".

This change in her discourse indicated not only movement in terms of her feeling happier and more in control of her anxiety but also an acknowledgment that she had learned from her pain.

For the final session, she chose an object resembling a network of inter-mingled branches,

> "Like branches…I'm reaching out…I might be going places…like every day is a new day…new experiences…I'm looking forward to it…I'm looking ahead".

The shift in Shirley's intra-phenomenological experience involving a process whereby she gained some clarity of thought and relief in her feeling overwhelmed had clear benefits for her. In the final session she communicated she was feeling happier and looking forward to the future.

Inter-phenomenological process

This term is described as movement in the client's phenomenological experience. This 'self-others' mode, involves thinking and feeling in relation to others.

Over the six sessions Shirley progressed from blaming other people for her anxiety and her need to hide away to her later taking on the responsibility for change. Again this change was evidenced by her choice of objects and the narrative recorded in the sessions. In session one, Shirley picks out an object of a hedgehog and an object of a person sitting cross-legged, hunched over with its head in its hands. She describes herself feeling judged by others and wanting to hide away. She states,

> "It's like a form of a shell…I want to be protected…don't want to come out and socialize".

She expressed her pain and loneliness,

> "I'm hiding away…they don't understand…no one gives a shit anyways".

As the therapy progressed Shirley began to move from this helpless position to acknowledging that her and only her has the power to bring change,

> "I am the one who got me into this…should have asked for help…I have to accept and be strong enough to stand up to them".

She goes on to acknowledge the effort she will have to put in to bring change,

> "no…can't blame them….I have to step out of the comfort zone to have a better life rather than be scared all the time….have to put yourself in their position and understand where they are coming from".

There appeared to be a change in Shirley's inter-phenomenological perspective in how she saw others. She moved from blaming others to now demonstrating her empathy towards them and realizing that she has to take the responsibility for change. It was apparent that Shirley did benefit from being involved in the research and in the end-of-therapy feedback sheet stated, "I am feeling more relaxed…not panicking…looking ahead".

Counselling supervision was helpful to reflect on what was happening in the therapy sessions with Shirley. One of the aims of supervision is to help the counsellor to be more effective in their therapeutic interactions with the client (Page and Wosket, 1994). My clinical supervisor agreed for me to work creatively in supervision, at times using the photographs of the sand displays and at other times using the actual sand-tray and objects in concordance with the therapeutic intervention used in the research. Lahad (2000) argues that working with such creative symbolism "is likely to change internal reality or can bring about change in perceiving external reality" (p15). Therefore the

supervisee can be helped to see "a situation from new perspectives and broaden alternatives" (Lahad, 2000, p90) which could result in the counsellor challenging the client such as encouraging them to see things from a different viewpoint.

During supervision, I worked with the same objects used by Shirley, either with the photographs or using the sand-tray and objects and my supervisor would facilitate me to explore various issues relating to my work with her. An example of this involved Shirley's use of the ornate wooden box with her closing the lid as she picked it up, in session 2. In a particular supervision session, which took place three days after session 2 with Shirley, I focused on the closed box in the photograph of the sand-display and my supervisor asked, "What is in the box?" This question helped to broaden my perception of Shirley's process and after some moments reflecting, I replied, "her fear….her anxiety…it's trapped within her…hard to get out" My mind moved to her panic attacks and I said " It's like she lets out some of that fear…..feels some of it but then becomes completely overwhelmed". My supervisor then asked me, "what is going on for you right now?" I replied, "I want to help her escape from this (looking at the box in the sand)…. but I wonder if she will ever escape". This clarified my worry that she may be stuck and that I had some fear myself that I may not be able to help her. My supervisor helped me explore my fear and we both came to the conclusion that I had to stay alongside her and hold on to the hope that she would break free in her own time. I did believe she needed to face her fear in order to deal with it but I acknowledged that I should not push her but to let her set her own pace in the process. Rogers (1961) would appear to support this as he states,"…it is the client who knows what hurts, what direction to go, what problems are crucial, what experiences are deeply buried….I would do better to rely upon the client for the direction and movement in the process" (pp11-12).

I believe this exploration in supervision helped me to empathize more effectively with Shirley and fostered her self-reliance as she set her own pace. This approach proved to be beneficial as in the following sessions she began to unpack the fears she had been avoiding and in session 5, she used the box again but this time it was open. She stated, "I am coping rather than running away from it…need to stop running away from it".

With regard to the client giving feedback on the sand-tray therapy I was concerned that she could be as open as possible so I encouraged her to be as honest as she liked. I facilitated this by leaving the room while Shirley completed her feedback and her sealing the form into an envelope prior to my return. At the end of the last session 'renewed consent' (BPS, 2014, p21) was sought, with Shirley being asked again if she was still happy for the recording to be included in the research, with her reporting she was happy to. Grafanaki (1996) describes how a good research alliance between client and counsellor-researcher would include 'process consenting' (Streubert, & Carpenter, 2011, p455) with consent being assessed throughout the research. BPS (2014, p21) state that "renewed consent from participants" (p21) may be appropriate for studies, which involve repeated data collection.

Reflecting on the case example, I argue that it was essential to have a therapeutic focus during the counselling sessions rather than have a research focus at this time. It was also necessary to stay close to the client's meaning in terms of the symbolism of objects used. Acknowledging the client's own process appears to help them stay with the exploration in the here and now, increasing the likelihood that the client moves into new territory and in turn increasing the possibility of gaining insight. The concrete examples in the case example provided illustrate that this approach has been effective.

I argue that due to this knowledge emerging from analyzing data sourced directly from the client's discourse in the therapeutic context, it is highly relevant to clinical practice. Furthermore, this qualitative clinical case study method was vital in understanding the client's phenomenological experience. A randomized controlled trial would not have captured the client's complex and in-depth experience in the same way. The clinical example referred to in this article will contribute to the larger case study, aiming to build an over-arching theory of short-term sand-tray therapy with adult clients.

Ethical Considerations

Unlike other research methodologies, a clinical case study involves the client-participant exploring their personal experience in depth, so a high level of client self-disclosure is inevitable, which needs careful consideration by the researcher planning such a study.

Shirley explored her fears, stemming from her own cultural background and of being a young black woman living in Britain. Due to this level of self-disclosure it was necessary to inform her that her anonymity was a priority. In addition, the issue of confidentiality had to be explicitly communicated along with the boundaries to this regarding any risk to self or others. These ethical commitments were met in the initial appointment with Shirley but also re-visited throughout the process.

Bond (2004) also states that "avoiding harm to research participants should be an over-riding ethical concern" (p6). In order to avoid harm to clients taking part in research, The British Association for Counselling and Psychotherapy (Bond, 2004) established the Ethical Guidelines for Researching Counselling and Psychotherapy for the counsellor-researcher, essential to good practice. The five criteria when taking this dual role are summarized in the table 1.

Table 1

	Criterion
1	Care is taken to ensure that the undertaking of any research by the

	practitioner is both beneficial to the client and also consistent with the integrity of the research.
2	Thorough consultation, with both a research consultant or ethics committee, and the practitioner's counsellor or psychotherapy supervisor, is undertaken before the research commences and continues throughout the duration of the research.
3	The challenge of obtaining free and informed consent in these circumstances is adequately considered and the procedures for obtaining consent outlined in section 3.1(Consent, page 6-7) followed.
4	The impact of the dual relationship is carefully monitored and, when appropriate, addressed in any reports of the research process and outcomes.
5	The use of any records is restricted to the purpose(s) for which they were created and authorized by the client's consent.

(Bond, 2004, p9)

Criterion 2, identified by Bond, is for the counsellor-researcher to have consultation with an ethics committee and their counselling supervisors before the research commences and continuing throughout the research process. This is likely to contribute to avoiding harm to the client. Bond views this as ethical, where issues can be addressed, lowering "the exposure to adverse risk(s) for both research participants and the researcher" (2004, p6).

In the present research study, the University Research Ethics Panel granted ethical approval and the researcher is supervised each month by three experienced research supervisors who oversee the research process. This involvement, by other professionals, serves to enhance the main researcher's reflections in terms of ethics and avoiding harm to the participants. In addition, the counsellor-researcher's clinical supervisor supported the research with monthly clinical supervision, focusing on the client-participants involved in the sand-tray therapy.

Confidentiality and how the privacy of the individual is protected are key ethical concerns in case-study research exploring clinical reports (Gavey & Braun, 1997). However, for pre-planned case study research, the practice of disguising a client's identity to protect them may not be sufficient and informed consent to participate in research is required. In the present study, prospective client-participants responded to an advertisement for clients who were seeking therapy and who may be interested in becoming involved in research, so informed consent was obtained before any therapy went ahead. In addition, empowering Shirley to choose which information about her was revealed contributed to maintaining her anonymity.

Other necessities include providing a thorough and clear information sheet for prospective participants, which indicates what is being requested of the client, obtaining informed consent (Table 1, criterion 3) and the right to withdraw. In

the present study a commitment to confidentiality and clearly communicating the boundaries to this was made clear. In addition, Shirley was given the choice to change any particular content, which would indicate her/others identification. BACP (2004, p7) and BPS (2014, p15) clearly indicate the requirement for participants involved in research to have a right to withdraw or modify their consent. Shirley was also given the option to have six sand-tray therapy sessions without being involved in the research. It was made clear that she could make this decision anytime during the six sessions so as to modify her consent to be involved.

Unanticipated ethical issues are likely to occur when there is an over-lap in the roles of counsellor-researcher, which need adequate attention (Hart & Crawford-Wright, 1999). It has been proposed that by prioritizing the role of counsellor over that of researcher, conflict between these two roles can be managed (Etherington, 2000). However, others argue that dual roles "pull in different directions and present both conflicting obligations and conflicting interests" (Beauchamp & Childress, 1994, p441).

This conflict was overcome in the present study by incorporating 'role fluency' into the research process (Figure 1). This meant that the different obligations and interests of each role were met. During the planning and initial meeting the dual-role of counsellor-researcher was a priority, thereby being faithful in avoiding harm to the client-participant along with a commitment to the research integrity of the study. During data collection, the dual role was suspended and the role of counsellor was adopted. However, counselling supervison was an ongoing process and during supervision there was a stepping in and out of counsellor and researcher roles as the theoretical ideas were developing. This blurring of the boundaries between counsellor and researcher was managed by keeping a reflexive diary and memo writing, a significant feature of the grounded theory approach. This aside, the therapy sessions with Shirley met the therapeutic obligations, with her being the focus and a priority. In the case example, Shirley's disclosure of her finding it very difficult to cope with her anxiety on a day-to-day basis was managed by offering to facilitate a relaxation technique at the end of the session which she could try out during the week. Shirley took up this offer and the techniques proved to be helpful for her. The final part of the process involved the researcher role being assumed to meet the research goals of transcribing, analysis and write-up.

Bond (2000) argues that counsellor-researchers need to practise the state of 'ethical mindfulness', which should be an ongoing process, including the supervision context. Adopting this attitude is likely to foster transparency and immediacy in the relationship. Therefore, any dilemma, which may emerge during the therapy/research process, is given sufficient attention with an aim to resolving the issue. In the present study, an example of such 'ethical mindfulness' was when Shirley disclosed her religion and then wanted this replaced with the more general term, "my faith". This issue was dealt with using immediacy by the counsellor-researcher and with the tape still running it was agreed to only use the term 'my faith' in the transcripts and subsequent writing.

Opportunities and challenges for the dual role of counsellor-researcher

In this section the intention was to avoid using the terms advantages and disadvantages, inferring a polarity but instead to use the concepts: opportunities, which identifies the benefits of the dual relationship; and challenges, which concerns issues that will need to be negotiated, to avoid potential fractures to the therapeutic relationship. A potential fracture may result in the client or counsellor becoming disengaged in the therapeutic alliance. For example, an ethical dilemma not dealt with sufficiently by the counsellor could result in the client having a lack of trust or the counsellor having a lack of empathy. In the present study, if the two issues regarding Shirley's request to change the terms regarding her religion and her country of origin had not been addressed using immediacy, this could have resulted in her losing trust and becoming disengaged in the therapeutic process or possibly withdrawing from the study altogether.

Producing research-based knowledge relevant to practice

A key opportunity of taking a dual role of counsellor-researcher is that it arguably produces research-based knowledge that is highly relevant to practice. Such case-study work "generates knowledge in context", which is essential "for understanding practice expertise in action" (McLeod, 2010, p7). Researchers using randomized controlled trials (RCT's) would have difficulty capturing the "complexity and subtlety of the therapy process" (Stephen, Elliott & McLeod, 2011, p57). Such acknowledgment of the benefits of case study research has culminated in renewed interest in the case study as a "credible vehicle" (Fishman, 2011, p511) for counselling research, complementing quantitative research. The case example provided demonstrates how clinical case study research can successfully generate knowledge in the therapeutic context and has led to the theoretical explanations of how the therapy worked.

Therapeutic benefits

A further opportunity is that clients involved in this type of research may receive therapeutic benefits. Shirley, by her own admission found the six sessions of sand-tray therapy helpful in terms of bringing new understanding and managing her anxiety. Evidence suggests research can benefit clients who take part, as the process is often an empowering one for the client with them making progress with their problems (McLeod, 1994). The client who participates in case study research brings a personal issue, which they want help with. Successful therapy may bring insight, emotional relief or improved coping skills for a particular problem.

Confidentiality

Before beginning this type of research a number of challenges for the counsellor-researcher need to be addressed. The British Psychological Society (BPS, 2014) state "participants in psychological research have a right to expect that information they provide will be treated confidentially" (p22). With regards to counselling research, BACP (2004) state, "honoring any promises about confidentiality carries special weight because this is central to practitioner and researcher trustworthiness in this field of work" (p7). McLeod (2002) argues it may be more challenging to maintain confidentiality in clinical case study research due to the volume of rich data accumulated from the client's disclosures in the interviews. However, the counsellor-researcher in the present study argues that holding a state of ethical mindfulness throughout and adopting role-fluency helps to manage this challenge. Assuming the role of counsellor during the therapy sessions places the client at the center of the process and fosters their personal autonomy. The therapeutic relationship aims to build trust and can empower the client to challenge the counsellor-researcher and communicate what they want excluded from the transcripts. During the initial meeting in the present study, Shirley was also informed and agreed to a therapeutic contract, with the issue of confidentiality and its boundaries clearly communicated in addition to the research consent form.

Time-consuming process of transcribing

Furthermore, although time-consuming, the counsellor-researcher in the present study would also advise that the practitioner themselves should be the one to transcribe the recorded sessions. This will serve to address two points: it will be the researcher whom maintains the state of 'ethical mindfulness' (Bond, 2000) when transcribing the data and secondly, the researcher will immerse themself in the data which is a necessary first step in qualitative analysis (McLeod, 2003).

Omitting and adapting a client-participant's disclosure

Avoiding harm to the client-participant should include them having the option of omitting any material they do not want to go in the final report. This was the case with Shirley, her wanting to exclude her particular religion and country of origin. Using immediacy and adopting a transparent attitude by the counsellor-researcher is essential. As is, clearly communicating responsibility to protect the client-participant's identity in the research, prior to them giving consent. In addition, any reference to other people the client refers to should be anonymised. These steps will contribute significantly to the issue of maintaining confidentiality.

An appropriate focus in the therapy sessions

Another challenge involves having an appropriate focus in the therapy sessions to avoid corruption of the therapeutic alliance. The client should to be aware that their needs are a priority, so the counsellor-researcher having a therapeutic

focus in the actual counselling sessions is favourable. Thomas (1994) recommends taking the stance of being 'a counsellor first" when adopting the dual role of counsellor-researcher. This involves the therapist offering empathy and staying alongside the client in their exploration. Thus, being in the role of therapist in the sessions and only once the final session is completed, then moving into the role of researcher. Wosket argues for the requirement to put the needs of the client ahead of the research requirements and to respect and accept a client's decision to discontinue with the research (1999).

Gabriel and Casemore (2009) suggest that such 'role-fluency' is a factor in dual relationships. These authors argue that few practitioners would disagree that counsellors are "morally, ethically and professionally responsible for their clients" (2009, p15). Therefore, taking the role of therapist in the sessions with the client seems more compatible in honoring the ethical duty to the client.

Reflexivity

Reflexivity in practitioner research is vital (Bager-Charleson, 2014). This requires the practitioner to engage in exploring their self-awareness, based on their personal process when counselling the client. Increased reflexive awareness enables the counsellor-researcher to bracket off their own process more effectively, enabling them to stay closer to the client's frame of reference. The supervisor in clinical supervision can facilitate such in-depth reflexivity.

Experienced counsellors who have an empathic attitude are relatively practised at bracketing-off their own thoughts and feelings, when working alongside a client in their attempt to see the client's world as the client perceives it. Reflexivity is a core concept in therapy (Hedges, 2010). Hedges describe how our communication stemming from our own assumptions can impede the therapeutic process. Therefore, self-reflexive practices are essential not only when conducting research but also to deliver ethical counselling practice. Insight gained from personal reflection and during counselling supervision will contribute to the counsellor's ability to be "fully present" (Mearns & Thorne, 1999, p96) with the client so they experience the counsellor as attentive and genuinely interested in them. Mearns (1999) links the counsellor's presence with establishing an environment of "safety, trust and respect" (p176-177).

Willig (2008) identifies two types of reflexivity, the first being 'personal reflexivity' reflecting on our own values, beliefs and experiences which shape our research (p10). This reflexivity can involve the counsellor-researcher having a questioning attitude when identifying meanings throughout the research process and exploring any possible influence from their own values and beliefs. The second, 'epistemological reflexivity',Willig defines as the researcher being encouraged to reflect on the "assumptions (about the world, about knowledge) that we have made in the course of the research" (p 10) and its implications for our research findings. Engaging in epistemological reflexivity may include the practitioner questioning how the research question has limited the findings and how it could have been investigated in a different way.

Clinical and research supervision

With regards to supervision, the counsellor-researcher may experience complementary or conflicting messages from their research supervisors and their clinical supervisor. Consideration of how the practitioner brings these various perspectives together and when and how to keep them apart needs to be established, with sufficient time being devoted to exploring these boundaries with all supervisors. The counsellor-researcher needs to have a transparent approach in both academic and clinical supervision so as to address any ethical issues head-on. Any fracture in the dual relationship such as the client and/or counsellor becoming disengaged in the sessions, needs to be carefully monitored in supervision and addressed directly with the client-participant (Gabriel & Davies, 2000). Wosket (1999) suggests that such dual role research can work well when there is good clinical and research supervision in place. The focus of supervision sessions should include an exploration of the impact of the dual relationship on the therapy and research aspects of the process.

In the case example provided, counselling supervision was an essential element in the research process. The supervisor facilitated the counsellor-researcher's reflexivity. At various times this had a positive impact on the level of empathy offered to Shirley, contributing to her benefiting from being involved in the research. Supervision also contributed to developing the theoretical ideas evident in the analysis. Supervision in counselling research monitors ethical practice, is a factor in delivering effective therapy and contributes to establishing theory.

Conclusion

This article has presented a case for the dual role of counsellor-researcher in qualitative research. From the case example presented, the client benefited from the experience and explored a range of concerns. In the initial assessment session she set the goal of talking about some difficult issues she had not previously addressed and wanted to be able to manage her anxiety more effectively. My response was that I would help her explore those difficult things she needed to speak of and that we could incorporate some relaxation strategies, which may help her, manage her anxiety on a day-to-day basis. It appeared she achieved these goals and by the end of therapy had a more positive frame of mind, looking forward to the future.

I would argue that being involved in the research had a positive effect on the client-participant. Her feedback stated "I'm feeling more relaxed…not panicking…I have explored things in my life which I initially had a problem talking about". Further more, I as counsellor-researcher clearly benefited from the process, in terms of acquiring a rich data set for analysis with an aim to contribute to research.

Be that as it may, such dual role research is not for the faint hearted. The amount of effort required by the counsellor-researcher to conduct ethical and effective clinical research is challenging but in my view, well worth the struggle. Much consideration needs to be devoted from the early planning stage, right through to completion of the study. The BACP Ethical Guidelines for Researching Counselling and Psychotherapy (Bond, 2004, p9) identifying five criteria for the counsellor-researcher, provide a useful framework for good practice.

In addition, I suggest that the researcher adopts a 'role-fluency' approach throughout the process. In particular, to adopt the role of counsellor during the actual therapy session/s, with the client being a priority. In addition, I advise that the researcher engage in 'process consenting' throughout the research, with the client being reminded throughout that they can withdraw at any time. I would also argue that the counselling relationship should have come to an end before any analysis of the data begins so it does not interfere with the counselling process. Finally, I would echo Bond's (2000) message of the researcher adopting a state of 'ethical mindedness' throughout the whole process.

Ethical dilemmas emerge in therapy as well as therapeutic-research and there needs to be an appropriate ethical response by the practitioner no matter what the context. Care for the client and doing no harm has to be a priority whether it is in the context of therapy or therapeutic-research.

Although qualitative research appears to be gaining ground as researchers seek robustness in their approach, the question remains; as a counselling profession should we be satisfied with research, which is restricted to counsellors' perceptions or quantitative questionnaires? I argue for the need to include clients who want to engage in counselling and who are happy to contribute to research. The clients' discourses in therapy providing the raw data producing findings, which will contribute to research-based knowledge and in turn being highly relevant to counselling practice.

(6.808 words)

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Figure 1: The Role-Fluency Process in Clinical Case Study Research