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Terry MacCormack
terrymaccormack@yahoo.com

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Abstract

This paper describes how a group of counselors and counseling lecturers at a rural university in New South Wales, Australia, initiated an exploration of their personal experiences as health care providers using an innovative research approach in which they engaged in a series of open, tape-recorded conversations with one another about their work. Their method also included transcribing and analyzing their narratives in a search for underlying themes in the thoughts and feelings that they shared. The intent behind their project was to find a way to voice how health care providers are affected by their work, and in so doing to make public the kinds of concerns, disappointments, fears, and difficulties they encounter -- feelings that are seldom mentioned in the literature. The group was also hoping that their approach might invite other health care providers to engage in similar dialogues about how they, too, are personally affected by the work they do.

Introduction

Recent authors have pointed to how the literature in the social sciences generally seems to ignore the subjective experiences of health care professionals and what it is like for them to do the work they do (Conran & Love, 1993; Frank, 1992; McLeod, 1990; Reimers & Treacher, 1995). As McLeod (1990) suggests, ask most counselors and psychotherapists, for instance, about their personal experiences of counseling and psychotherapy, and they will probably share with you the thinking behind their interventions, or the techniques they use with certain clients (see also Sells, Smith, Coe, Yoshioka, & Robbins, 1994; Wark, 1994a, 1994b). They might also openly tell stories of their successes and how they have helped people to dramatically change their lives. More often than not, however, they will be reluctant to share their more difficult personal feelings of failure, incompetence, frustration, and disappointment (Mash & Hunsley, 1994; McLennan, 1996). Notable exceptions, however, are to be found in Coleman (1985), whose edited volume directly addresses experiences of failure among a diverse selection of family therapists (see also Bohart, 1996; Bot, 1997; Gold, 1996; Stricker, 1996).

This is not to say that counselors, psychotherapists, or other health care providers do not experience such difficult personal feelings. Indeed, even if we were to rely on personal and anecdotal evidence alone, it would seem obvious that they do. It appears, however, that there is a general but unspoken code of silence that tends to prevent them from publicly voicing such feelings, much less write about and publish them. Even for counselors and psychotherapists whose work is often subject to scrutiny and reflexive examination in supervisory contexts, it

seems difficult to admit that this unspoken and generally unacknowledged silence applies as much to them as it does to others in the health care field.

According to McLeod (1990), one explanation is that therapists and counselors report becoming so immersed in their sessions with their clients that they find it difficult to remember their experience. They also claim that their therapy and counseling experiences are elusive and hard to "pin down," so that they have to struggle to put their activity into words (Timms & Blampied, 1985). McLeod speculates that part of the reason for this therapist silence may lie in the reluctance of therapists to publicly examine the experiential dimensions of their role, and in so doing to disclose the "mystery" of their craft (see also Spinelli, 1996). Gergen and Kaye (1992), however, imply that for some therapists and counselors, it might also be connected to their hesitancy to give up their positions as objective, impassive observers in their counseling and psychotherapy encounters, and thus their privileged roles as so-called experts on people's lives (see also Conran & Love, 1993; Frank & Frank, 1991).

Invitations to Share

Not surprisingly, this lack of personal sharing in the literature has not gone unnoticed. Indeed, a growing chorus of voices has been calling for a more open acknowledgment of the first-person experiences of therapists, counselors, and others in the caring professions (Frank, 1992; Moursund, 1992; Pickett, Brennan, Greenberg, & Licht, 1995; Porter, 1995). More recently, this invitation has been augmented by an increasing body of literature whose authors have been commenting on and investigating phenomena such as stress, burnout, compassion fatigue, secondary post-traumatic stress syndrome, and secondary traumatization among health care providers. Included here are the subjective experiences of therapists, counselors, nurses, doctors and other health care professionals who routinely work with trauma survivors such as war veterans and people who have been physically, emotionally or sexually abused, as well as victims of violence, crime, disaster, and other traumas (Figley, 1995, 1996; Pearlman & Saakvitne, 1995; Stamm, 1996).

As this writing has underlined, caring can sometimes take its toll on those who are on the giving end (see also Smith, 1997; Sussman, 1995). It is interesting to note, however, that few of these authors tend to join with their research participants in sharing their own personal experiences of the work they do. Rather, implied in their comments and investigations is a sense of the same invisibility and lack of personal ownership of the kinds of feelings and experiences they are exploring in their respondents. This is unfortunate, as the absence of the first-person singular in their writing in effects fails to model the kind of openness and personal sharing of experience that their work seems designed to stimulate and explore (see Frank, 1992).

With this in mind, the following account documents an attempt by a small group of counseling lecturers to find a way to describe and share their personal experiences as a part of an ongoing self-reflexive research endeavor. Although unaware of any similar kinds of exploration at the time, we acknowledge that our endeavor can best be described as falling within the arena of the autoethnographic approach advocated in the work of Ellis (1991, 1997; Ellis & Bochner, 1996; Ellis & Flaherty, 1992), the memory-work approach used by Crawford, Kippax, Onyx, Gault, and Benton (1992), and Heron's (1996) co-operative inquiry. Each of these approaches tends to

challenge and, in somewhat different fashion, attempts to integrate or blend the researcher and participant roles.

Briefly, the idea behind our project was to explore aspects of our own thoughts and feelings in the context of a series of ongoing audiotaped conversations among ourselves. Our intent was to then transcribe and analyze the narratives we collected so that we might better reflect on and make sense of our experiences. At the same time, we also wanted to find out what it would be like to engage in a different kind of research endeavor -- one that involved us as both researchers and participants in our own project at the same time. In addition, we felt strongly that this be a qualitative endeavor as such an approach seemed more suited to the kind of exploratory narrative work we were about to undertake.

Exploring Our Own Experiences

Initially, our project grew out of our work as lecturers in a counselor-education program at a rural-based university in New South Wales, Australia. As this was a fairly large-scale distance education program with an intake of approximately 80 students each year, our task sometimes involved revising, rewriting or creating brand new course or unit guides to be posted to students who were learning various counseling theories, topics, and skills. Towards the beginning of one spring term, it was decided that we needed a brand new advanced counseling theories guide designed to deepen and expand on what students had learned about counseling in their previous academic session.

Traditionally, the creation of these guides was an individual effort. In other words, one of us would generally be expected to research and write and/or revise them on his or her own. This time around, however, we thought it might be interesting to combine our knowledge and experience and put the advanced theories unit together collaboratively. In part, our motive was to get to know one another better and to be mutually supportive. At the same time, we felt that our collaborative effort might prove more interesting and give more diversity of views for students than if only one of us were to present his or her ideas.

To set our project in motion, five of us met to discuss the kinds of ideas we should cover in the guide, as well as to determine how we would put this material together as a team. Not long into our meeting, however, we found ourselves comfortably sharing stories about our experiences as counselors, talking about changes that we had undergone in our lives, our own theories of counseling and psychotherapy, our preferred models and ways of working with clients, our ideas about personality and so on, and how these related to our own notions of psychotherapy and change.

I'm not quite sure how it happened, but at some point in our discussion one of us suddenly suggested - only half seriously at first -- that maybe the very conversation we were having would make good material for the guide. As someone put it, maybe what we should be doing was tape recording our discussion and then transcribing it so that we could have it as the central element in our theories unit. That way, students would still be learning the course material by in effect "listening in" on our conversation. But it would be a much more natural and hopefully more accessible format for presenting our ideas. It would be far less didactic, and at the same time

much more interesting because of its personal flavor. In the process, it would model the generally social constructionist approach to counseling and psychotherapy (see McNamee & Gergen, 1992) that we seemed to be sharing in our talk. We also decided that students, meanwhile, could be invited to join in our conversation by way of various suggested activities and assignments that would constitute a part of their later evaluation.

Initially, this struck us as a novel but maybe far-fetched idea. But the more we thought about it, the more we decided to risk doing something different, and so went ahead with our project. We scheduled a time and place, and decided to both video- and audiotape another similar but spontaneous conversation that hopefully would reflect the same general experiences and ideas that we had just discussed and shared. The only difference, really, was that this would be a more deliberate conversation, although hopefully not an especially self-conscious one.

As it turned out, our second meeting seemed to go quite well. We felt we had more or less covered the material we wanted to convey in our dialogue, and that there was still a very personal stamp on what we had decided to talk about and share. Indeed, we learned that despite our shared backgrounds as educators and counselors, for instance, we each held very different perceptions of the quality of our teaching and therapeutic work and the meanings these endeavors held for us. We also shared some of our personal uncertainties and doubts, engaging in a conversation that for the most part felt fairly natural and free flowing. In the end, our sense was that students in the program would find it not only challenging and informative, but interesting to "listen in on" as well.

It should be noted here that this conversation enabled us to get to know one another in a way that was somewhat different from the "professional" associations that took place among us in the context of our academic environment. Although our talk covered some of what we felt worked as "content" for the theories guide we were collaborating to produce, there was much more of a personal flavor to the conversation and what we chose to share. Talking about the experience later, we all agreed that we had learned things about one another that we might not otherwise have known as strictly "colleagues."

One of us, for instance, admitted to feeling somewhat anxious presenting herself as an "accomplished" therapist to students, given that she had only recently completed her post-graduate program in counseling. Another confessed that despite her many years of experience seeing clients, she still entertained "all sorts of doubts" about her therapeutic effectiveness. Yet another who had taught counseling skills for more than 15 years touched on some of his feelings of failure as a therapist following the suicide of one of his clients. Another, meanwhile, told the story of his evolution as a therapist, moving from taxi driver to high school teacher, journalist to parliamentary correspondent, and finally a Ph.D. in clinical psychology before becoming a lecturer and therapist. Another member questioned the whole enterprise of counseling and psychotherapy, basing this on her work at a community mental health setting where she had begun wondering if she was really just an agent of social control rather than someone who was able to help people change.

Satisfied that we were on the right track, we then transcribed our talk. Our next step was to use grounded theory (Glaser & Strauss, 1976; Strauss & Corbin, 1990) as our method of analyzing

the qualitative data our conversation had generated. In doing so, we adhered to the process of first open, then axial, and finally selective coding typically used in grounded theory to organize and make sense of narrative material. In conducting our coding, separate copies of the transcripts were given to each member of the group for analysis. Each level of coding then generated a discussion among us about how the categories, codes, and eventual themes emerging from the narrative material ought to be named or described. These discussions continued until consensus was reached.

The coding process for our collaborative narrative eventually generated five major themes that seemed to emerge from what we described as our personal and professional discussion together. These were: (1) Why people go to counseling, (2) The process of change, (3) Ideas about the self, (4) Therapeutic moments, and (5) How counselors are changed/affected by counseling. We then asked our program director, whose training was in teaching and research in clinical health psychology, if she would read our transcript and add her voice to the dialogue. In doing so, she shared her impressions and responses on paper, addressing and responding to some of what we said but also contributing ideas we hadn't discussed. Analysis of her narrative generated yet another theme for us to consider: Other ways of knowing and changing.

Getting Feedback

After our study guide was published and distributed, students said that they both enjoyed and appreciated this unusual format for their new course unit. They noted that they felt more like participants in the conversation when they were completing their assignments. They also said that they especially liked the personal elements in our talk, which they felt had allowed them to get to know us better. As they noted, it was as if through the vehicle of our conversation we had revealed aspects of ourselves that we might otherwise never have got to share with them.

After we had reflected on this experience and the feedback we received, we wondered what it would be like to have further extended conversations about other topics related to counseling and psychotherapy. In our initial talk, for example, we had touched on the issue of therapeutic failure and what that meant for each of us. We had talked about intervention versus non-intervention, and the pros and cons of solution-focused therapy. Then there was what it was like to be a therapist and do therapy, and the ways in which we had been influenced and in some instances changed, both personally and professionally, by our work with some of the clients we'd met.

This led us to decide to have a second conversation, with therapeutic failure as our more focused theme this time. As with our previous talk, we also planned to video- and audiotape our discussion. Our aim now, however, was to make this the first of a series of ongoing conversations that we would then transcribe and analyze. But this was not with the intent of gathering yet more material for another subject guide. Rather, we were purposely setting out to explore our own subjective thoughts and experiences related to our work as counselors and psychotherapists - or at least, how we represented these in narrative terms. In effect, we were putting ourselves in the position of being both the participants and investigators in our own research, curious to discover what we might learn about ourselves from this, and then are able to share with others.

Coincidentally, around the time we were planning our conversation on therapeutic failure, a colleague at the university asked if I would present some of my current research to a group of health care professionals attending a series of advanced workshops on research methods at the university. I mentioned this to my conversational companions. Together, we wondered if this might not be a good opportunity to share our research venture with an outside audience. As we saw it, we were exploring the boundaries of qualitative research, and decided that perhaps a demonstration of one of our conversations might be an effective way of generating a dialogue with others about what we were up to. As our colleague seemed intrigued by this notion, we decided to go ahead with our conversation about therapeutic failure, but to do it before a live audience this time.

As we introduced ourselves to our audience, we learned that the eight attendees at our colleague's research workshop had backgrounds in nursing, social work, gerontology, counseling, and health care management. Following our introductions, we then gave our audience a brief explanation of what we were about to do, and asked them if they would mind sharing their impressions of our conversation by afterwards engaging in a dialogue among themselves around what we had discussed. While they did this, we would just listen in. We clarified our invitation by describing the reflecting team model to them (see Andersen, 1991), and said that we would be interested in hearing their thoughts and impressions much like clients do when members of a team comment and reflect on what they've seen and heard in the conversations clients have had with their therapists.

As it happened, all of this proved to be an interesting but somewhat unsettling event for us. As we experienced it, our conversation itself went very well. Although we felt under the spotlight, we thought we were nonetheless able to be quite open and honest in our talk. Our interactions felt ingenuous and spontaneous, rather than stiff and planned. We took some genuine risks in sharing some of the things we revealed about ourselves and our feelings of failure and disappointment. We laid bare, for instance, some of the warts we felt we had as both professionals and as people - times when we had to admit we actually disliked some of the clients we were working with or found them difficult to "truly hear." We also talked about our doubts and misgivings about our own competencies, and the pressures we experienced to be "experts" on people's lives. As one of us commented:

"Who do I think I am that I feel I know more than some of the families or clients I'm seeing? I mean, just 'cause I've got this degree..? All it is is a piece of paper hanging there on the wall like some kind of security blanket for me."

"But that's the way we've been socialized in our training as these so-called professionals, right? We're taught to put on our invisible white lab coats and eventually we get to the point where we don't dare take them off."

"Yeah, like maybe there's nothing underneath and we'll feel totally naked if we do. That kind of fear?"

"Yeah, like I'm revealing aspects of myself that I'm not supposed to reveal. Like if I get a tear in my eye because someone's story really touched me, I have to turn my head away so they won't see me crying. It's like this little voice in me saying, 'Hey there, pull yourself together, dearie…'"

"Like you're not supposed to show them that you care. Or at least, not that way!"

Similarly, we touched on our weaknesses and vulnerabilities, sharing stories about those times when we felt we'd been less than helpful with our clients, or somehow had let them down. One especially poignant story related to the client suicide that had been touched on in our previous conversation and the very strong and painful feelings of failure this had generated for one of us at least a year or two afterwards. But fortunately, as we saw it at least, the story ended with a feeling of resolution around the incident rather than a continuing sense of remorse, guilt, and self-blame.

Our audience, however, appeared to have a somewhat different experience of the conversation than we had. They graciously thanked us for our demonstration, but in their reflections they seemed to convey a strange mix of anger and resentment over some of the things we'd said. In fact, to some extent I think we found ourselves feeling just a little attacked by them. One audience member, for example, said she felt that the story of the client's suicide had revealed the counselor's lack of feelings - indeed, his coldness -- towards his client. Further, she said that she was dismayed to hear that he no longer felt a sense of remorse for his "failure." Another felt that we were perhaps too self conscious about our work as health care providers, doubting that this was a feeling shared among other professionals in fields different from counseling and psychotherapy. We were far too "introspective," he said, and unable to just "leave it all at the door" when we went home.

In the end, the general tone of our audience's reflections left us with the sense that they had missed the spirit of our intent. We nonetheless thanked them for their honesty in reflecting back to us what they had felt as a result of our conversation. Initially we had wondered if because we were unfamiliar with one another they might feel constrained to give us their honest feedback, but this evidently was not an aspect of their experience. As they themselves explained, they weren't involved with any of us in an academic or personal relationship of any sort, and so didn't feel compromised in sharing with us how they experienced our talk.

Going Personal

Discussing this later, we had to consider that maybe we had revealed too much, or gone too far with our conversation. We had gone "too personal," and perhaps our honest admissions of failure and disappointment, or the stories we told that exemplified these feelings, were experienced as somewhat threatening for some of them. As one of us pointed out later, it was not that they could not identify with some of what we were sharing, but that they were perhaps able to identify too much. In effect, we had broken the code of silence and now we were feeling just a bit chastised for having done so. However, without the benefit of further conversation with our audience, we had to admit we were only speculating and that it would've been helpful if we could've debriefed our therapeutic failure conversation with them further.

I must admit that as a result of this experience, we considered abandoning our conversational research venture. Up to this point, for example, we had envisioned engaging in similar kinds of dialogues at conferences and research workshops together -- as one of us put it, to "take our conversations on the road." Our idea was not only to demonstrate what we were up to in terms of research. Rather, we wanted to invite others to engage and share with us their experiences of working as health care providers in various settings, and what that was like for them as well.

One idea, for example, was that audience members might actually join in on one of our conversations, hopefully feeling free to sit with us and voice their feelings and thoughts in front of a group of people they didn't know. Another was to do something similar to what we had done for my colleague's research workshop, perhaps inviting a small group of conference participants to engage one another in reflecting on both the theme and the particulars of one of our conversations while the rest of us listened in. Now, however, we wondered if this was such a good idea.

Reflecting Talk

Although we continue to have faith in our venture, since our talk about therapeutic failure we have had only one other similar conversation. This took place in front of the very distance education students who had read and completed assignments for the unit guide that contained our original talk. Each term, these students come twice to the university to attend four days of intensive workshops and small-group work to improve their counseling skills. Following this, they are then required to submit a videotape of a counseling session they've had with one of their clients for our feedback and evaluation.

One day as our conversation group was sitting around talking about these tapes and the evaluation process, it struck us that it might be interesting to have an open conversation in front of the students about what this experience was like for us. In keeping with our research venture, we thought we would also invite them to comment on our conversation in a reflecting team fashion, and in so doing perhaps share their experience of doing the assignment as well.

As it turned out, this was a rich and rewarding experience for both the students and us. In part, it reconfirmed our belief in what we were up to, as the audience reaction was quite positive and affirming. They felt that it helped to make the evaluation process more transparent. As well, it helped them to get to know us that much better as a result of some of the things we had said and shared. In addition, the students said that it gave them permission to voice their feelings and concerns in a context that felt, for some but not all, safe and egalitarian. At the same time, they pointed out that it modeled for them risking and being open, which is what they were expecting of themselves.

Reflecting on this event and comparing it with our previous experience before the research group, we wondered if the counseling students might perhaps have felt constrained by the presence of a power imbalance, naturally timid to share how they "really" felt in a context in which they might be scrutinized by their lecturers and, more importantly, their evaluators. Thus, they'd made it "easy" on us, not willing to risk saying anything that was too challenging of the status quo. We also surmised that, in keeping with what a member in the previous research audience had said, maybe counselors and psychotherapists were, in fact, more sensitive to their own processes, tending to be more self-reflexive than most other health care professionals. If so, it wouldn't be surprising that they'd "take" to the exercise in the way they did. At the same time, we had to consider the sense of familiarity and safety that had developed among us, seeing as we had grown familiar with one another in the context of the counseling program. In addition, the students had already been exposed to our initial "conversation" in the theories unit guide and so likely already felt a sense of comfort with the reflective process.

Any or all of these might've been the case. However, we had to acknowledge that among our students there were some who felt quite able to speak freely about their experience in the program. Indeed, they had given themselves permission in the past to voice their dissatisfaction with certain aspects of their training, and we were certain these individuals felt the same sort of freedom to do so in this reflective context as well. Thus, we concluded that their responses to our open conversation in front of them had been a similarly open and honest expression of their experience as well.

Although this last shared conversation felt quite affirming and validating for us, I'm sad to say that we haven't developed our research idea any further. Nor have we had any other similar conversations to the ones mentioned here - neither private nor public This is due more to practical difficulties, however, rather than to any lack of faith in ourselves or in our venture. Indeed, we feel our project has provided us with a very valuable learning experience. It has taught us not only what happens when you push the boundaries of qualitative research, but also the rewards that come when you dare to remove the mask of professionalism and risk sharing your more personal thoughts and feelings with others. At the same time, of course, having explored and participated in this different way of doing research, we felt that there were also aspects of our learning that it would be important to pass along to anyone interested in following up on or further developing these ideas.

Lessons Learned

During the initial stages of our undertaking, for example, it was vitally important to have a sense of safety and comfort among ourselves. As we were colleagues working together in a counseling program, we already enjoyed a certain familiarity with one another and each felt we could trust the other with what we chose to share. Despite this kind of group cohesion, however, during our initial tape-recorded conversation some were more reticent or reluctant to engage in the process of disclosing than others. Rather than seeing this as an impediment to open discussion, however, we found that these kinds of feelings had the potential to become part of the conversation, so that the process itself could be used to build safety and trust.

We also found that our sharing was useful in helping us to distinguish more clearly between personal and professional feelings, and to accept that it was not easy to remove our invisible white lab coats or to leave our professional masks behind. In doing so, we learned that the more difficult personal feelings we sometimes experienced in our work were shared by others, and that we were not alone in them. Without this kind of sharing and public acknowledgment, we run the danger of misinterpreting such feelings as a reflection of our incompetence rather than of our all-too-human limitations. This was particularly important when it came to sharing our shortcomings with our students. For all too often, the unwritten message modeled for counselors-in-training when they are presented primarily with "success" stories designed to teach them how to counsel is that therapeutic mishaps and mistakes never happen, and that you must by default be a failure or not know what you are doing if they do.

Further, we also discovered when we openly discussed our misgivings and personal feelings of doubt and frustration in front of students -- in effect modeling that they might do the same -- that many of them were more inclined to risk responding in kind, sharing some of their own similar

experiences with us. In effect, we had broken the unspoken and unwritten code of professional silence with them, and thus had challenged them to do the same. This not only helped to lower the walls of hierarchy that can often separate students from lecturers and supervisors, but more importantly it served to deepen the learning experience for both of us. As some of the students mentioned to us in their feedback, they felt as if we had made ourselves accessible to them in a way that might never otherwise have happened. As one put it, she felt that during the term she had been getting to know us professionally as lecturers and supervisors, but that now she was beginning to know us personally -- warts and all -- as well. For her, that had made all the difference in her decision to open up to us during our public forum, and to some of her colleagues on an even deeper, more intimate level later on.

We also learned that although it sometimes felt somewhat "scary" to let down our guards and more openly share our personal thoughts and feelings with our students, other professionals, and more especially with one another, that letting go these fears was in fact a kind of liberating experience. In effect, in discarding our invisible white lab coats we were giving ourselves permission to dare to be just who we are rather than the "professionals" that we sometimes felt we ought to present ourselves as being. Indeed, it was as if we felt ourselves being drawn closer to one another as well as to the audiences that we had performed ourselves for. Although we had perhaps helped to create misunderstanding in the process, we had at least engaged in a process of attempting to understand on a more personal level, which in the end we experienced as enriching for each of us.

I can't be sure how the experience changed us, although it did seem to change the ways in which we interacted with one another. Despite some of our philosophical and professional differences, members of the group who felt more comfortable being open about their experiences and feelings seemed to draw closer together in the days and months that followed our endeavor. Those who expressed feeling less at ease with our conversational project, however, seemed more mildly enthusiastic about continuing the experience. With this in mind, we concluded that it was important to caution ourselves not to err in the direction of having expectations of ourselves to open up and share our more personal feelings with equal enthusiasm on every topic that presented itself for discussion. Nor, we felt, should we expect others to necessarily warm to our endeavor.

Indeed, we acknowledge that there may be an inherent danger in allowing yourself to become personally vulnerable in the way that we are advocating, and that sometimes the risk may not be worth the outcome. As a result, in a research venture of this sort we came to feel that it was vital to give permission not only to ourselves but others to remain as silent participants in the conversation if it began to feel threatening, uncomfortable, or unsafe. As one of us later noted, it's unfortunate that we didn't continue with our conversational project, as these are the kinds of thoughts and feelings that could've formed the basis for further ongoing explorations and discussions.

Ultimately, however, despite the lull in our own ongoing get-togethers, I feel that there are certainly more conversations to be had, and that this could be a very exciting direction for other researchers to take in not only deconstructing the professional persona in the health care field, but in also exploring the personal. My hope, at least, is that in sharing some of our research

experiences, readers might consider engaging in a similar kind of exploration, and further developing and refining these ideas.

References

Andersen, T. (1991). *The reflecting team: Dialogues and dialogues about the dialogues*. New York: W. W. Norton.

Bohart, A. C. (1996). Reflections on failure cases. *Journal of Psychotherapy Integration, 5*, 155-158.

Bot, S. (1997). Frank revelations of a difficult therapy experience: Countertransference observations. *Women and Therapy, 20*, 111-117.

Coleman, S.B. (1985). *Failures in family therapy*. New York: Guilford.

Conran, T., & Love, J. (1993). Client voices: Unspeakable theories and unknowable experiences. *Journal of Systemic Therapies, 12*(2), 1-19.

Crawford, J., Kippax, S., Onyx, J., Gault, U., & Benton, P. (1992). *Emotion and gender: Constructing meaning from memory*. Thousand Oaks, CA: Sage.

Ellis, C. (1997). Evocating autoethnography: Writing emotionally about our lives. In W. G. Tierney & Y. S. Lincoln (Eds.), *Representation and the text: Re-framing the narrative voice* (pp. 112-139). Albany, NY: SUNY Press.

Ellis, C., & Bochner, A. P. (Eds.). (1996). *Composing ethnography: Alternative forms of qualitative writing*. Walnut Creek, CA: Altamira Press.

Ellis, C., & Flaherty, M. G. (Eds.) (1992). *Investigating subjectivity: Research on lived experience*. Thousand Oaks, CA: Sage.

Figley, C. R. (1995). Compassion fatigue as secondary traumatic stress disorder: An overview. In C.R. Figley (Ed.), *Compassion fatigue as secondary traumatic stress disorder in those who treat the traumatized* (pp. 1-20). New York: Brunner/Mazel.

Figley, C. R. (1996). Compassion fatigue: Toward a new understanding of the costs of caring. In H. B. Stamm (Ed.), *Secondary traumatic stress: Self care issues for clinicians, researchers, and educators* (pp. 3-28). Lutherville, MD: Sidran Press.

Frank, A. W. (1992). The pedagogy of suffering: Moral dimensions of psychological therapy and research with the ill. *Theory & Psychology, 2*, 467-485.

Frank, J. D., & Frank, J. B. (1991). *Persuasion & healing: A comparative study of psychotherapy* (3rd ed.). Baltimore: Johns Hopkins University Press.

Gergen, K. J., & Kaye, J. (1992). Beyond narrative in the negotiation of therapeutic meaning. In S. McNamee & K. J. Gergen (Eds.), *Therapy as social construction* (pp. 166-185). London: Sage.

Glaser, B. G., & Strauss, A. L. (1967). *Discovery of grounded theory: Strategies for qualitative research*. Chicago: Aldine.

Gold, J. R. (1996). Knowing and not knowing: Commentary on the roots of psychotherapeutic failure. *Journal of Psychotherapy Integration, 5*, 167-170.

Heron, J. (1996). *Co-operative inquiry: Research into the human condition*. Thousand Oaks, CA: Sage.

Mash, E. J., & Hunsley, J. (1993). Assessment considerations in the identification of failing psychotherapy: Bringing the negatives out of the darkness. *Psychological Assessment, 5*, 292-301.

McLennan, J. (1996). Improving our understanding of therapeutic failure: A review of the research. *The Australian Counselling Psychologist, 11*(2), 79-86.

McLeod, J. (1990). The practitioner's experience of counselling and psychotherapy: A review of the research literature. In D. Mearns & W. Dryden (Eds.), *Experiences of counselling in action* (pp. 66-79). London: Sage.

McNamee, S., & Gergen, K. J., (Eds.). (1992). *Therapy as social construction*. London: Sage.

Moursund, J. (1992). *The process of counselling and therapy* (3rd ed). Englewood Cliffs, NJ: Prentice-Hall.

Pearlman, L. A., & Saakvitne, K. W. (1995). *Trauma and the therapist: Counter-transference and vicarious traumatization in psychotherapy with incest survivors*. New York: Norton.

Pickett, M., Brennan, A. M. W., Greenberg, H. S., & Licht, L. (1995). Use of debriefing techniques to prevent compassion fatigue in research teams. *Nursing Research, 43*, 250-252.

Porter, N. (1995). Therapist self-care: A proactive ethical approach. In E. J. Rave & C. C. Larsen (Eds.), *Ethical decision making in therapy: Feminist perspectives* (pp. 247-266). New York: Guilford.

Reimers, S., & Treacher, A. (1995). *Introducing user-friendly family therapy*. London: Routledge.

Sells, S. P., Smith, T. E., Coe, M. J., Yoshioka, M., & Robbins, J. (1994). An ethnography of couple and therapist experiences in reflecting team practice. *Journal of Marital and Family Therapy, 20*, 247-266.

Smith, J. (1997). The therapist's experience of working with HIV/AIDS. *Journal of Systemic Therapies, 16*(1), 6-12.

Spinelli, E. (1994). *Demystifying therapy*. London: Constable.

Stamm, B.H. (1996). *Secondary traumatic stress: Self-care issues for clinicians, researchers, and educators*. Lutherville, MD: Sidran Press.

Strauss, A., & Corbin, J. (1990). *Basics of qualitative research: Grounded theory procedures and techniques*. Newbury Park, CA: Sage.

Stricker, G. (1996). Failures in psychotherapy. *Journal of Psychotherapy Integration, 5*, 91-93.

Sussman, M. B. (Ed). (1995). *A perilous calling: The hazards of psychotherapy practice*. New York: John Wiley & Sons.

Timms, N., & Blampied, A. (1985). *Intervention in marriage - the experience of counsellors and their clients*. Sheffield, UK: University of Sheffield Joint Unit for Social Services Research.

Wark, L. (1994a). Therapeutic change in couples' therapy: Critical change incidents perceived by therapists and clients. *Contemporary Family Therapy, 16*(1), 39-52.

Wark, L. (1994b). Client voice: A study of client couples' and their therapists' perspectives of therapeutic change. *Journal of Feminist Family Therapy, 6*(2), 21-39.

Author Note

[+]*Terry MacCormack, Ph.D.* lives and works in Sydney Australia as a clinical psychologist. His interests include private practice work as well as teaching, training, and clinical supervision. His research interests tend to focus on the process of psychotherapy and on building a theory of therapy based on client and therapist experiences of their meetings with one another. He is also working on a book about power in academic settings based on his qualitative explorations of the subjective experiences of graduate students in clinical psychology training programs.

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Correspondence regarding this article should be addressed to: Terry MacCormack, Ph.D., 7/82 Soldiers Ave., New South Wales, 2096 Australia; Email: terrymaccormack@yahoo.com.